



**NORTHEAST BRADFORD SCHOOL DISTRICT**  
526 PANTHER LANE ROME, PA 18837  
Phone: (570)744-2521 | Fax: (570)744-2933 | [www.nebpanthers.com](http://www.nebpanthers.com)  
NORTHEAST BRADFORD ELEMENTARY SCHOOL      NORTHEAST BRADFORD JR-SR HIGH SCHOOL

### **INFORMATION NEEDED FOR KINDERGARTEN ENROLLMENT**

#### ***Welcome to the Northeast Bradford School District.***

Kindergarten enrollment will be held at Northeast Bradford Elementary School on March 19-20, 2020. Children who are 5 years old on or before September 1<sup>st</sup> are eligible to start kindergarten in the **2020-2021** school year. Please call as soon as possible to schedule an appointment.

Please complete all forms attached. Our school nurse has included a confidential health history form, a physician's form and a dentist's form. The health history form should be completed by you and brought to registration. Your family doctor should complete the physician's form at your child's next physical examination. Your dentist should complete the dental form. If the examinations are done before registration, please bring them with you. If this is not possible, the physician and dental form may be returned to the school during the summer.

When you come to registration, you will need to bring these forms as well as the following information:

- **Your child's original birth certificate**

If you do not have a birth certificate for your child, you can contact the PA Department of Health for an application:

Division of Vital Statistics  
PO Box 1528  
New Castle, PA 16103  
Phone: (724) 656-3100

- **Your child's immunization records**

Commonwealth of Pennsylvania requires the following immunizations for new entries into kindergarten.

- 4 doses of DTP or DTaP or if medically advisable, DT or Td (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)
- 2 doses of MMR
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) vaccine or evidence of immunity

Please call the school nurse with questions regarding immunizations at (570) 744-2521, ext. 2224.

- **Proof of residency in our district.**

The state requires that parents provide the district with proof of residency. This can be any document that shows your name and street address to indicate you live in our district. Examples are driver's license, vehicle registration, lease, current tax bill, current utility bill, or current credit card statement.

We look forward to meeting you and your new student. If you have any questions, please call. We will be happy to help you.



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**STUDENT RESIDENCY QUESTIONNAIRE**

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child (ren). Thank you for your cooperation.

1. Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_
2. Person completing form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_
3. In what type of setting is the student living in now?

Check a box below-

**SECTION A**

- In an emergency or transitional shelter
- Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason.
- In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations.
- Other places not designed for, or ordinarily used as a regular sleeping accommodation for human beings

**CONTINUE** to Question 4 if you check any boxes in **SECTION A.**

**SECTION B**

- None of the choices in Section A apply



**If you checked this section, you do NOT need to complete the remainder of this form.**

4. Contact number for person completing the form: \_\_\_\_\_
5. Address where student is now living: \_\_\_\_\_
6. The student lives with: (check all that apply)
  - Parent(s) or legal guardian
  - Relative, friend(s), or other adult(s)
  - Alone
  - Other: \_\_\_\_\_



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## STUDENT ENROLLMENT FORM

### Student Info I

Last Name:	First Name:	Middle Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate:	Grade:	Is your child repeating this grade: No <input type="checkbox"/> Yes <input type="checkbox"/>	Nickname:
Please provide Physical Address- no P.O. boxes please::			

Has your child ever been a student in the Northeast Bradford School District? No <input type="checkbox"/> Yes <input type="checkbox"/>
<b>If yes, please give dates:</b>
Did your child attend nursery school or Head Start? No <input type="checkbox"/> Yes - nursery school <input type="checkbox"/> Head Start <input type="checkbox"/>
Does student have an IEP? No <input type="checkbox"/> Yes <input type="checkbox"/> Does Student have a 504? No <input type="checkbox"/> Yes <input type="checkbox"/>
With whom does student live?
Is there a court custody agreement? No <input type="checkbox"/> Yes <input type="checkbox"/> Shared Custody: No <input type="checkbox"/> Yes <input type="checkbox"/>
Legal document description: Custody Agreement <input type="checkbox"/> PFA <input type="checkbox"/> Guardianship Papers: Court Order <input type="checkbox"/> Affidavit <input type="checkbox"/>
Legal document included: No <input type="checkbox"/> Yes <input type="checkbox"/>
Custodial restrictions:
Is student in foster/court placement? No <input type="checkbox"/> Yes <input type="checkbox"/> <b>If yes, please attach copy of agency letter.</b>
Is student homeless or currently living with a resident family because of lack of housing? No <input type="checkbox"/> Yes <input type="checkbox"/>
Did your child previously receive free or reduced meals in school? No <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/>
Is student a single parent? No <input type="checkbox"/> Yes <input type="checkbox"/>

**Student Info II**

Birth City:	Birth State:	Birth Country:
Previous City:	Previous State:	Previous Country:
Previous School:		
Previous School Address:		
Does student have siblings who attend this school already? No <input type="checkbox"/> Yes <input type="checkbox"/>		
If "YES" please provide names:		
<b>If this student has siblings who attend NEB and will be using the same contact information, you do not need to fill out the following contact information.</b>		

**RACE & ETHNICITY DATA**

Ethnicity: <input type="checkbox"/> No, not Hispanic or Latino <input type="checkbox"/> Yes, Hispanic or Latino
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Multi-racial

### Contact Info

If you have children who already attend Northeast Bradford and wish to use the same contact information for this student, please provide the name of the student who is already attending and **you will not need to fill out the information below**. Phone numbers in highlighted fields will be used in our emergency messaging system *OneCall Now*.

Name \_\_\_\_\_ Grade: \_\_\_\_\_

#### C1 Primary Household Contact

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_ Send Mail \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Custody \_\_\_\_\_ Can Pick Up \_\_\_\_\_

#### C2 Secondary Household Contact

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_ Send Mail \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Custody \_\_\_\_\_ Can Pick Up \_\_\_\_\_

#### C3 Other Parent, if divorced or separated

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_ Send Mail \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Custody \_\_\_\_\_ Can Pick Up \_\_\_\_\_

#### C4 Emergency Contact

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Can Pick Up \_\_\_\_\_

C5 Emergency Contact

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Can Pick Up \_\_\_\_\_

C6 Emergency Contact

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_ Tertiary phone \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Send Email \_\_\_\_\_ Can Pick Up \_\_\_\_\_

**I CERTIFY THAT ALL INFORMATION ABOVE IS TRUE AND CORRECT.**

Signature:

Date:



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## HOME LANGUAGE SURVEY

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

<input type="checkbox"/> Northeast Bradford Elementary School	<input type="checkbox"/> Northeast Bradford Junior-Senior High School
Student's name:	Grade:
What is/was the student's first language:	
Does the student speak a language(s) other than English? Do not include languages learned in school. <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, specify the language(s).	
What language(s) is/are spoken in your home?	
Has the student attended any United States school in any 3 years during his/her lifetime? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, complete the following:	
Name of School:	
State:	Dates attended:
Name of School:	
State:	Dates attended:
Name of School:	
State:	Dates attended:

Person completing this form if other than parent /guardian:

Signature:

*The school district has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district in the future.*

## NORTHEAST MIGRANT EDUCATION PROGRAM FAMILY SURVEY

Date:
Family name: Address:
Phone:
Names of anyone under the age of 21 living in your home:

**Your children may qualify for a FREE educational program which includes year-round educational support.  
Someone will contact you if your children appear to be eligible for the program.**

Have you and/or your children moved from one school district to another within the last 3 years? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What types of work have you done or looked for in the last 3 years? (Check all that apply)	
	Dairy, horse, hog, veal or poultry farm
	Food processing plant (beef, pork, milk)
	Forestry: Timber cutting, thinning, transporting
	Fruit tree trimming
	Crop farming
	Milk truck driver
	Fruit or vegetable farm
	Christmas tree farm or nursery
	Mushroom plant
Please specify your current work:	

**Central Susquehanna Intermediate Unit  
Northeast Migrant Education Program  
PO Box 213, Lewisburg PA 17837**

**Call 570-523-1155, Extension 2331 for Migrant Education Information.**

OFFICIAL USE – FAMILY CONTACT LOG





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**TRANSPORTATION ASSIGNMENT**

Students needing transportation:

- |          |              |
|----------|--------------|
| 1. _____ | Grade: _____ |
| 2. _____ | Grade: _____ |
| 3. _____ | Grade: _____ |
| 4. _____ | Grade: _____ |
| 5. _____ | Grade: _____ |
| 6. _____ | Grade: _____ |

Address: \_\_\_\_\_

*To assist us in properly assigning your students, include information about landmarks near home (e.g. next to fire station, color of house, third house from intersection of \_\_\_\_\_ and \_\_\_\_\_ Roads. Also, if you know the number of the bus that picks up on your road or are aware of other NEB students living on your road, please list.)*

Location: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Parent's Cell Phone Number: \_\_\_\_\_



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## PHOTOGRAPHIC RELEASE FORM

Dear Parent or Guardian:

The Northeast Bradford School District requests your permission to use photographs or photographic images for educational purposes, including but not limited to: district websites, yearbook, publications and/or social media. Your consent is needed so that names, pictures and/or student creations may be published.

Please visit the district's website [www.nebpanthers.com](http://www.nebpanthers.com) often to stay updated with your child's school and district activities.

Student Name:	School:
Student Name:	School:
Student Name:	School:
Student Name:	School:

Please check to give or deny consent:

- Yes, my child(ren) may be photographed.
- No, my child(ren) may not be photographed. (If no, please indicate exceptions, such as yearbook, group photo, photo only - no name, name only -no photo, etc., on the back of this form.)

By granting permission, I understand that my consent will remain in effect until I notify the District in writing.

Parent/guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**STUDENT CONFIDENTIAL HEALTH RECORD**

<b>Student's Name</b>			
First:	Middle:	Last:	
Date of Birth:	Grade:	Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Father's Name:</b>		<b>Phone:</b>	
<b>Mother's Name:</b>		<b>Phone:</b>	
<b>Person with whom child lives if other than parent:</b>		<b>Phone:</b>	

<b>COMMUNICABLE DISEASES/CONDITIONS</b> – Has your child ever been diagnosed with any of the following diseases or conditions? Please check next to all that apply.		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> TB Tine test – Date:	<input type="checkbox"/> German Measles
<input type="checkbox"/> Emotional Problems		
<input type="checkbox"/> Varicella - Chicken Pox – Date of disease or age child was when had disease:		
<input type="checkbox"/> Varicella Vaccine – Date given:		
<input type="checkbox"/> Varicella lab evidence – Date:		
Vision problems (please check)	Hearing problems (please check)	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing aids	
<input type="checkbox"/> Difficulty seeing	<input type="checkbox"/> Difficulty hearing	
<input type="checkbox"/> Frequent redness	<input type="checkbox"/> Draining ears	
<input type="checkbox"/> Frequent watering	<input type="checkbox"/> Frequent ear infections	
<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> OPERATION(S) & DATE(S):	
<input type="checkbox"/> "Lazy" Eye		
Is your child highly allergic to anything such as foods, plants, insects, medicine? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:		
Does your child need a special diet or have any food problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:		
Do you think your child is fit to participate in all school sports, athletics, playground activities and/or gym? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, explain:		
Is your child presently under medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>Explain:</b>
Serious injury or illness in the past year or any other health problems:		

**MEDICAL / EMERGENCY CARE INFORMATION**

Physician:	Phone:
Dentist:	Phone:
Daily Medication (see attached medication policy)	
Name of medication:	Dosage: <span style="float: right;">At home <input type="checkbox"/> At school <input type="checkbox"/></span>
Does the district have permission to share health problems/needs with the staff? <input type="checkbox"/> No <input type="checkbox"/> Yes	

**HAS YOUR CHILD HAD ANY OF THE FOLLOWING? GIVE DETAILS:**

Chicken Pox:
Operations:
Recurring Illness:
Emotional Problems:
Serious Accidents:
Allergies:
List any illness or health problem you or your family physician feel should be known to school authorities:

By signing this document, I give permission for medical treatment to be given to my child in the event of an emergency, trauma, or condition requiring such treatment. I have reviewed and understand the above information to my satisfaction.

Parent signature:

Date:



Bureau of Community Health Systems  
Division of School Health

## Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

**PARENT / GUARDIAN / STUDENT:**  
Complete page one of this form **before**  
student's exam. Take completed form to  
appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:  
\_\_\_\_\_  
\_\_\_\_\_

Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)

Medicines  Pollens  Food  Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded <b>DURING</b> or <b>AFTER</b> exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other: _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.**

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes  No**

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**

(Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT  
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20 \_\_\_\_

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

ADDRESS

\_\_\_\_\_  
No. and Street      City or Post Office      Borough/Township      County      State      Zip

**REPORT OF EXAMINATION**

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment?      Yes       No

Treatment Completed      Yes       No

\_\_\_\_\_  
Date of Dental Examination

\_\_\_\_\_  
Signature of Dental Examiner

\_\_\_\_\_  
Print Name of Dental Examiner

\_\_\_\_\_  
Address