PRESCHOOL

WELCOME TO PERRY COUNTY PRESCHOOL

Attached are forms your child will need to have completed before school starts in August.

- **Certified Copy of the Birth Certificate**
  Billfold Size NOT Acceptable
  Visit Kentucky Cabinet for Health and Family Services web site to order online.
- **Physical Examination**
  Physical may be done 12 months prior to enrollment.
- **Valid Immunization Certificate**
  Immunization Certificates must be obtained from your child's doctor, health department, or clinic.
- **Eye Examination**
  Eye Examination must be performed by an Optometrist or Ophthalmologist.
- **Dental Examination**
- **Proof of Income**
  W2 or Check Stub
  Completion of HIF Form (Household Income Form)

If you have any questions, please call 439-5813 or your local school and ask about preschool registration.

- Buckkhorn Elementary (606) 398-7176
- East Perry Elementary (606) 436-3423
- Robinson Elementary (606) 436-8931
- R.W. Combs Elementary (606) 476-2518
- Viper Elementary (606) 436-3837
- West Perry Elementary (606) 439-6438

PERRY COUNTY SCHOOLS

Perry County Schools

ENROLLMENT FORM

2025-2026

Child's Last Name	**First Name**	**Middle Name**
Preferred Name	**Child's SS #** **Date of Birth**	**Grade** **Age**
Race ***(circle):*** White Black Bi Racial Asian Hispanic Pacific Islander American Indian Other **Home Language** ***(circle):*** English Spanish Chinese Other (please list)_____		**Sex** M or F **Language**

911 Physical Address (Required)	**Apt/Lot #**	**City**	**State**	**Zip**
Mailing Address (If different)		**City**	**State**	**Zip**

Primary Parent(s)/Legal Guardian(s) Information

(The Primary Guardian is the one with whom the student lives. Proof of legal custody /guardianship required if applicable)

Name_____

Address_____

Home Phone ( )_____**Cell Phone( )**_____

Email_____

Relationship to child:_____Lives in household with student: __Yes __ No

Employer_____ Phone_____

Name_____

Address_____

Home Phone ( )_____**Cell Phone( )**_____

Email_____

Relationship to child:_____ Lives in household with student: __Yes __ No

Employer_____ Phone_____

ADDITIONAL CHILDREN/ADULTS LIVING IN THE Household

First Name	Middle	Last Name	DOB	Gender	Relation to Student	School Attending

Total number of people living in the home:_____

Include EVERYONE (anyone not listed above)

Transportation: (choose the one that applies most often)	**Transportation provided by Perry County Schools:**	**Child Care:**
___*Bus* *Bus #* _____ ___*Parent Pickup* *Car tag #* _____	___*one way* ___*Both Ways* ___*more than 1 mile* ___ *less than 1 mile*	_____**YES** _____**No** Provider_____ Phone_____

Special Services:

Special Education/504	___Yes	___No	___Suspected	
Disability/Special Need	___Yes	___No	___Suspected	(If yes, please explain)
Speech Problem	___Yes	___No	___Suspected	
Vision	___Yes	___No	___Suspected	
Gifted and Talented	___Yes	___No	___Suspected	

Please list any medical condition(s) that your child has that we should be aware of (if any):

Emergency Contacts: Please list in order of priority

Person	Relationship	Phone

PERSONS ALLOWED TO PICK UP STUDENT(S) OTHER THAN LEGAL GUARDIANS

Persons listed are required to show driver's license in order to pick up the student. Anyone not on this list will not be allowed to pick your child up under any circumstance.

Name	Name

Detailed directions to your home

*** I confirm that I am the parent or legal guardian of this student. I hereby certify that the information given on this form is true and accurate and that the address listed is my legal residence. If any changes are made during the year, I will notify the school with the changes.**

Date

Parent/Guardian Signature

PERRY SCHOOL DISTRICT

Dear Parent/Guardian:

Our school is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. The CEP provision is available to schools with a high percentage of economically disadvantaged students. Under CEP all students receive a breakfast/lunch at no charge for the entire school year. However, to determine eligibility to receive additional benefits for your child(ren) you will need to complete a household and income form.

1. DO I NEED TO FILL OUT A FORM FOR EACH CHILD? No. *Use one Household and Income Form for all students in your household.* We cannot use a form that is incomplete, so be sure to fill out all required information. Return the completed form to school.

2. MY CHILD(REN) ALREADY RECEIVE MEALS AT NO CHARGE AT SCHOOL. WHY SHOULD I COMPLETE THIS FORM AS WELL? Many state and federal programs use socioeconomic status (that is, household and income information) to determine eligibility for their programs. In addition, the primary state funding calculation uses socioeconomic status. By completing this form your school is able to determine your child(ren)'s eligibility for additional programs. Regardless, your child(ren) will still receive meals at no charge.

3. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro rated share of expenses), do not include them.

4. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

5. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.

6. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HIS/HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to his/her basic pay because of his/her deployment and it wasn't received before s/he was deployed, combat pay is not counted as income. Contact your school for more information.

If you have other questions or need help, call 606 439 5813.

SINCERELY,

Stephanie Wooton

Stephanie Wooton, FRAM COORDINATOR

INSTRUCTIONS FOR APPLYING

Part 1: All Household Members (a **household member is any child or adult living with you**) **All applicants should complete this part**. List the name of each household member, the name of the school each child attends, and the child's grade. If the child is a foster child, check the box for foster child. If a household member has no income, check the box for no income. All household members, including foster children, should be included here. If you need additional space, attach a separate piece of paper.

If your child is homeless, a migrant or a runaway, follow these instructions.

Part 2: Check the appropriate category and call 606-439-5813.
Part 3: Skip this part.
Part 4: Sign the form.

If you have foster child(ren) only, follow these instructions. You do not need to fill out a separate form for each foster child in your household. (If there are both foster children and non-foster children in your household, follow the instructions below for All Other Households).

If all children in the household are marked as foster children in Part 1:
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form.

ALL OTHER HOUSEHOLDS, including WIC households, households with non-foster children and households with both foster children and non-foster children, follow these instructions:

Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from **this month or last month**.

- **Section 1–Name**: List all household members who have income.
- **Section 2 –Gross Income and How Often It Was Received:** List the income for each household member. Check the box to tell us how often the person receives the income – weekly, every other week, twice a month, or monthly.

  Earnings from work: List the **gross income,** not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Net income should *only* be reported for self-owned business, farm, or rental income.

  Welfare, Child Support, Alimony: List the amount each person receives, and check the box to tell us how often.

  Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits: List the amount each person receives, and check the box to tell us how often they receive it.

  All Other Income: List Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income received weekly, every other week, twice a month, or monthly. **Do not include income from KTAP, SNAP, WIC, federal education benefits and foster payments received by your family from the placing agency.**

  If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: An adult household member must sign the form. Please include your address and phone number in the event the FRAM Coordinator has a question about your information.

HOUSEHOLD AND INCOME FORM

[illegible] is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP, all children in the school will receive a breakfast/lunch at no charge regardless of income or completion of this form. However, to determine your child(ren)'s eligibility for various <u>additional</u> state and federal program benefits, please complete, sign and return to school **a single application per household**

PART 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> people living in your household (First, Middle Initial, Last)	**School the child attends** or indicate "NA" if household member is not in school	Grade Level	*Check if a foster child (legal responsibility of the state welfare agency or court). If <u>all</u> children listed below are foster children, skip to Part 5 to sign this form*	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

PART 2. HOMELESS, MIGRANT, RUNAWAY STATUS

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call 606-439-5813

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

PART 3. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once. If you provided a case number in Part 2, you do **<u>not</u>** need to provide income information. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

☐ **DECLINE TO PROVIDE INCOME** -- Check this box if you don't wish to provide your income information, your SES status will automatically be "Paid".

1. NAME (List only household members with income, including any students in the home who have income)	**2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Public assistance, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits, All Other Income	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 4. SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN)

I certify (promise) that all information on this form is true and that all income is reported. I understand that the school will get state and federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child(ren) may lose benefits.

Sign here ______________________ Print name: ______________________ Date ____________

Address: ______________________ City ______________________ State: _Zip Code __________ Phone Number: ______________________ Cell Phone Number: ______________________

Non Discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, gender identity, age, or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215) 656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.

Privacy Notice

The Kentucky Department of Education is requiring schools to collect the information on this form. You do not have to give this information, but if you do not, we cannot determine your child's eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal programs to help them evaluate, fund, or determine benefits for their programs, with auditors for program reviews, and with law enforcement officials to help them look into violations of program rules. Regardless, all students enrolled in a Community Eligibility Provision school will receive meals at no charge.

HOUSEHOLD CHECKLIST

- ☐ Have you included all your children as household members?
- ☐ For each household member receiving income, is the frequency checkbox checked?
- ☐ Have you signed the form?

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice A Month ☐ Month ☐ Year Household size: _____

Categorical Eligibility _____ SES Code: Free_____Reduced_____Paid_____

FRAM Coordinator: _____ Date: _____

VS-33
(Rev 1 30 2013)

BIRTH

Kentucky
UNBRIDLED SPIRIT

COMMONWEALTH OF KENTUCKY
STATE REGISTRAR OF VITAL STATISTICS

APPLICATION FOR A CERTIFIED COPY OF BIRTH CERTIFICATE

Certificates of Birth that occurred in Kentucky since 1911 are on file in this office

Please Print or Type All Information Required On This Form

BIRTH CERTIFICATE INFORMATION						
1. Full Name at Birth	*First*		*Middle*		*Last*	
2. Date of Birth	*Month*	*Day*	*Year*	*Sex*	*Age Last Birthday*	
3. Place of Birth	*Kentucky City or Town*		*Kentucky County*		*Name of Hospital*	
4. Mother's Maiden Name	*First*		*Middle*		*Last*	
5. Father's Name	*First*		*Middle*		*Last*	

If this child has been adopted, please give original name if known:

_____

What is your relationship to the person whose certificate is being requested?

_____

Signature and telephone number of the person requesting this certificate:

_____ _____
Signature Telephone

DO NOT WRITE IN THIS SPACE	
Volume	
Certificate	
Year	
Date	
Searched by	

Certificates may also be ordered by the following methods:

Internet: Certificates may be ordered on the internet using a credit card (Visa, MasterCard, Discover or American Express) or check. An additional charge card fee will apply. This is in addition to the fee for each certified copy requested. Certificates requested via internet, www.vitalchek.com/kentucky-express-birth-certificates.aspx, may be returned by overnight courier for the cost of the additional shipment fee if that record is available.

Telephone: Orders may be placed by telephone using a credit card (Visa, MasterCard, Discover or American Express) or check. An additional charge card fee will apply. This is in addition to the fee for each certified copy requested. Certificates requested via telephone may be returned by overnight courier for the cost of the additional shipment fee. The telephone number to place your order is (800) 241-8322, choose option 1.

Mail: Orders are accepted by mail, using a check or money order in U.S. dollars drawn on a U.S. bank for payment. It can take up to 30 working days to process your request from the date payment is posted. Mail to Vital Statistics, 275 East Main Street 1E-A, Frankfort, KY 40621. The Office of Vital Statistics telephone number is (502) 564-4212.

Walk-In: You may order a certified copy of the birth record by coming to this office. The office is located at the address above. Orders are accepted for same day issuance from 8:00 AM until 3:30 PM Monday through Friday.

FEES

A fee is to be paid for certified copies or records, or for a search of the files or records when no copy is available. The fee for a certified copy of a birth certificate is $10.00 U.S. Additional copies are $10.00 U.S. each. Make check or money order payable to "Kentucky State Treasurer." This fee is non refundable.

_____ Certified Copies @ $10.00 each
How many

Total Amount Enclosed _____

THIS SECTION MUST BE COMPLETE FOR ALL ORDERS

REQUESTORS INFORMATION:

_____ NAME

_____ MAILING ADDRESS

_____

_____ CITY, STATE, ZIP CODE

COMMONWEALTH OF KENTUCKY
IMMUNIZATION CERTIFICATE

(Required for each child enrolled in day care center, certified family child care home, other licensed facility which cares for children, preschool programs, and public and private primary and secondary schools.)

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle)

Name of Parent of Guardian: _____ _____

Address: _____ _____
(Street) (City) (State) (Zip Code)

_____ _____
DATES IMMUNIZATIONS WERE ADMI**

Diphtheria, Tetanus, Pertussis* #1 ___/___/___

Hib** ___/___ #4 ___/___/___

PCV (Pneumococ** ___/___/___

Polio ___/___ #4 ___/___/___

___ or Adult dose: #1 ___/___/___ #2 ___/___/___

V ___/___/___ #4 ___/___/___

___/___ or child has had chickenpox or zoster disease (X) ___

Td ___ or Td #1 ___/___/___ Meningococcal #1 ___/___/___

*DTaP for adol 11 through 15 years of age. **Hib not required at 5 years of age or more. ***Alternative two dose series of approved adult hepatitis B vaccine

This child is current for immunizations until ___/___/___, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, or nurse designee) (Date)

_____
(Name of Office or Licensed Healthcare Facility)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky
UNBRIDLED SPIRIT

KDE/DDS KDESHSOO2

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: M F Grade: _____

Date of Birth: _____ Age: _____ yrs _____ months Preferred Language: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

_____

_____

_____

Current Prescribed Medications to be taken daily at school: _____

_____

_____

_____

Significant Historical Information: _____

_____

_____

_____

SCREENING RESULTS:

BP: _____ Height: _____ (ft.) _____ (inches) Weight _____ lbs. BMI _____ BMI% _____

Vision	Right 20/_____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
	Left 20/_____		Hearing - Left	Passed ☐	Failed ☐	Referred ☐

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

General appearance	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Gross dental (teeth and gums)	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Head/scalp/skin	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Abdomen/Genitalia	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Extremities/back	☐ Normal ☐ Abnormal _____	Refer/Tx: _____
Neuro	☐ Normal ☐ Abnormal _____	Refer/Tx: _____

(Over)

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

_____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

_____

Recommendations (Attach additional sheet if necessary): _____

_____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☐ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☐ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

Physician/APRN/PA/EPSDT Provider

Address: _____ Telephone: _____

KDE/DSS

Kentucky Eye Examination Form for School Entry

KDESHS004

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ Date of Vision Examination: _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ف Amblyopia ف Strabismus ف Glaucoma ف Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ف YES ف NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

ف Normal ف Myopia ف Hyperopia ف Astigmatism ف Strabismus ف Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ف YES ف NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ف Educate (parents/patients) about eye/vision disorders and needed vision care
- ف Counsel (parents/patients) regarding eye safety
- ف Stress importance of early, preventative eye care
- ف Recommend re-examination, as appropriate

Signed: _____ Date: _____

Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

OAS/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advan registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five or six (6) year old is enrolled in public school.

Student Name: _____
Last First Middle

Birth date: ____/____/____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____
Name Relationship

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Exam/Screening ____/____/____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number: _____ Screening Date: _____

Screener's Signature: _____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ Registered Nurse with training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

OH-12

3/16/2015

Bus Monitor Information Sheet

Three & Four (4) Year Olds (Preschool)

Date: _____

Child's Name: _____

Name of Parent/Guardian: _____

Address: _____

_____

Home Telephone: _____

Work Telephone: _____

_____

In case of emergency, early school dismissal, etc. contact me or one of the following relatives/neighbors:

Name _____ Relationship _____

Phone _____ Address _____

Name _____ Relationship _____

Phone _____ Address _____

Name _____ Relationship _____

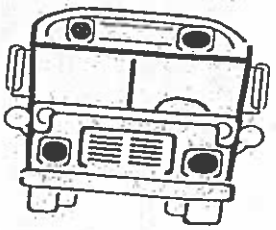
Phone _____ Address _____

Permission to be Photographed or Videotaped

I hereby give permission for _____ to
Child's Name
participate in videotaping, pictures, etc, as part of the school wide activities at _____ Elementary. I understand the videotape and pictures of my child may be used for educational purposes such as: newspaper articles, television highlights, educational or school websites, yearbook or school displays, etc.

_____ _____
Signature of Parent or Guardian Date

Field Trip Permission Form



Several times during the year, children from our school go on field trips to various places. In order to save time, we have made a <u>permanent</u> field trip notice. This permission slip will be used for ALL field trips during your child's enrollment at _____ Elementary. You will be notified of any trip and/or any cost before the trip is taken.

_____ has my permission to participate in all class field trips.
Child's name

_____ _____
Signature or Parent or Guardian Date

PERRY COUNTY PUBLIC SCHOOLS

PRESCHOOL / KINDERGARTEN SOCIAL AND DEVELOMENTAL HISTORY

DENTIFYING INFORMATION Social Security # _____

Child's Name: _____ Date of Birth: _____

P.O. Box Address: _____

911 Address: _____ Phone: _____

State & Zip: _____

Direction to the home: _____

_____

_____

Father's Name: _____	Mother's Name: _____ *(First, Maiden, Last)*
Age: _____	Age: _____
Occupation: _____	Occupation: _____
Address *(if different from child)* *(P O Box & 911 address)* _____ _____ _____	Address *(if different from child)* *(P O. Box & 911 address)* _____ _____ _____
Phone Number _____	Phone Number _____

Marital Status of Parents: Married ____ Separated ____ Divorced ____ Widow(er) ____

Child Lives With: Both Parents ____ Mother ____ Father ____ Relative/Guardian ____

Name of Child's Caregiver, Address, Phone and Relationship (If not parents):

_____

_____

Other Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name of Brother & Sisters	Age	Sex	Grade	At Home
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

BIRTH HISTORY

Mother's health during pregnancy: Good _____ Fair_____ Poor _____

Age of mother at child's birth: _____

Doctor who delivered child _____ Birthplace _____

List any medication taken during pregnancy: _____

Was the pregnancy full term? _____ If not, explain _____

How long was labor? _____ Babies Birth Weight _____

List any difficulties with birth and during the first four weeks of life (specify): _____

_____

GROWTH AND DEVELOPMENTAL

How old was your child when he/she: Sat Alone _____ Used Sentences _____
Walked Alone ___ Toilet trained _____ Said Single Words _____

Compared to others in family, motor development was: Slow _____ Average _____

Compared to others in family, speech development was: Slow _____ Average _____

SOCIAL / BEHAVIOR HISTORY

Check the following that applies to your child:

_____ Nail biting _____ Bedwetting _____Thumb sucking _____Sleep problems

_____ Frequent Temper Tantrums _____Abnormal Aggressiveness _____Destructiveness

_____ Pronounced Disobedience _____Extremely Shy _____Inactive _____Excitable

_____ Overactive _____Friendly _____Independent _____ Moody

CHILDHOOD ILLNESS:

Hard Measles (Rubeola)	_____	German Measles (Rubella)	_____	Chicken Pox	_____
High Blood Pressure	_____	Meningitis	_____	Mumps	_____
Diabetes	_____	Seizures	_____	Asthma	_____
Vision Difficulties	_____	Frequent Colds	_____	Head Injury	_____
Scarlet Fever	_____	Heart Murmur	_____	Pneumonia	_____

Is your child currently immunized for his/her age? ___Yes ___No

If not, explain _____

Does your child have frequent ear infections? _____

Has your child's hearing been tested? _____ When _____

Has your child's eyes been checked by a doctor? _____ When _____

HILDHOOD ILLNESS CONT.

ıes your child wear glasses? ___Yes ___No

st any other important or persistent illness, injuries, accidents and or

erations child may have had:

Conditions	Age	Treatment	Length of Hospital Stay

IEALTH HISTORY

amily doctor who usually cares for your child:

Jame: _____ Address / Phone _____

ıentist's Name: _____ Address / Phone _____

ıate of last dental visit _____

'RESENT HISTORY

ıoes your child have allergies (explain) _____

_____

[s your child taking any medication? _____

ıoes he/she eat well? _____

Has your child ever been seen by a specialist?(ENT,Neurologist, Psychologist, Orthopedist, etc.)

_____

_____

If so, Why? _____

Specialist's Name, Address and Phone: _____

_____

_____

CHILDHOOD ILLNESS CONT.

Does your child wear glasses? ___Yes ___No

List any other important or persistent illness, injuries, accidents and or operations child may have had:

Conditions	Age	Treatment	Length of Hospital Stay

HEALTH HISTORY

Family doctor who usually cares for your child:

Name: _____ Address / Phone _____

Dentist's Name: _____ Address / Phone _____

Date of last dental visit _____

PRESENT HISTORY

Does your child have allergies (explain) _____

_____

Is your child taking any medication? _____

Does he/she eat well? _____

Has your child ever been seen by a specialist?(ENT, Neurologist, Psychologist, Orthopedist, etc.)

_____

_____

If so, Why? _____

Specialist's Name, Address and Phone: _____

_____

_____