CENTRAL ACADEMY OF OHIO
REGISTRATION CHECKLIST – NEEDED FORMS AND RECORDS

Student's Name: _____ **Grade Applying for:** _____**School Year**_____

Forms you must provide the school before the first day of school.

- ☐ Application for Enrollment
- ☐ Home District Questionnaire
- ☐ Request for Student Records
- ☐ Special Education Services Questionnaire
- ☐ Medication Administration Permission Form
- ☐ Home Language Survey
- ☐ Internet/Computer Acceptable Use Policy
- ☐ Photo Consent/Denial Policy
- ☐ Student-Family Emergency Information
- ☐ Free and Reduced Price School Meals Family Application (1 per family)
- ☐ Student Residency Questionnaire
- ☐ Health History/Vision Screening/Hearing Screening to be filled out by family physician
- ☐ Dental Exam Form to be filled out by student's dentist

Records you must provide the school before the first day of school.

- ☐ Certified Copy of Birth Certificate
- ☐ Copy of Child's Social Security Card and/or Passport/visa/immigration papers
- ☐ Copy of Last Report Card from previous school (if applicable)
- ☐ Immunization Record (available from child's pediatrician)
- ☐ Proof of Residency (mortgage or lease bill or agreement, utility bill)
- ☐ Copy of Custody or Adoption paperwork (if applicable)

WITHOUT THE ABOVE INFORMATION, WE CANNOT ENROLL YOUR CHILD!

CAO 2727 Kenwood Blvd, Toledo, OH 43606 phone: 419-205-9800 fax: 419-205-9899 Updated 2012

ENROLLMENT APPLICATION / CENTRAL ACADEMY OF OHIO K-6

STUDENT INFORMATION

Name: (Last, First, MI)	Native Language: (First language spoken by student)
Street Address:	Language Spoken at Home:
City, State, Zip	Social Sec. #:
Date of Birth: Gender: Male | Female Place of Birth:	Is student a citizen or national of the US? ____Yes ____No If No Is student a lawful permanent Resident? ____Yes ____No If Yes (Alien #)A _____
Current Grade: School Attended Last Year:	Is the student an alien authorized to attend public school in the US? If Yes Alien/Admission #:_____
Legal District of Residence:	How long has student been in US? ____months ____ yrs.
Is your child being served by a 504 plan due to health issues? ____Yes ____No	Did your child receive English as a Second Language services from the previous school attended? ____Yes ____No _____Don't know

Ethnicity:
(1) Hispanic/Latino of any race (2) American Indian or Alaska Native (3) Asian (4) African American
(5) Native Hawaiian/Other Pacific Islander (Having origins in people of Hawaii, Guam, Samoa or other Pacific Island)
(6) White (Having origins in people of Europe, the Middle East or North Africa) (7) Two or more races

Reason for admission(Circle One)
(1) Student Transferred from Home School in Ohio (2) Student transferred from out of state/out of country
(3) Student transferred from a private school in Ohio
(4) Student enrolling for the first time in Ohio public school/community school because of age -KG
(5) Not enrolled in an Ohio Public district or community school since 2003 for a reason other than listed above.
(6)Transferred from another Ohio public/community school

☐ I certify that the child I am enrolling at the Academy has not been previously expelled from school, nor is expulsion pending.

☐ The above-named child that I am enrolling has been previously expelled from a school. I authorize access to all school records and further authorize communication with the school(s) listed below regarding this matter. I understand my child's admission to the Academy will be at the discretion of the Academy Administration and Board.

PARENT INFORMATION

Father's Name (Last, First):	
Address: (If different than child's)	
Employer/Occupation:	Email Address:
Home Phone:	Work/Cell Phone:
Mother's Name (Last, First):	
Address: (If different than child's)	
Employer/Occupation:	Email Address:
Home Phone:	Work/Cell Phone:
Is either parent working as a seasonal worker on a farm or in a fishery? ____Yes ____No If Yes Who_____	With whom does the child live? Mother / Father / Both /Others Is a custody decree in place? Yes / No /Pending

INFORMATION OF SIBLING(S) CURRENTLY ENROLLED IN CENTRAL ACADEMY OF OHIO

Name: Grade:	Name: Grade:	Name: Grade:	Name: Grade:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE DATE

FOR OFFICE USE ONLY

Application Date:_____ Active:_____ Date Records Sent:_____ Graduated:_____

Start Date:_____ Waiting List:_____ Moved/Transfer:_____ Withdrawn:_____

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Central Academy of Ohio
2727 Kenwood, Toledo, Ohio
Phone: 419.205.9800 Fax: 419.205.9899

Admissions Policy

The Academy is a public charter school (an Ohio community school) that is open to any Ohio resident. The Academy does not deny admission to anyone based on intellectual or athletic ability, measures of achievement or aptitude, physical handicaps, religion, creed, race, gender, color, or national origin.

Application Process

There are two enrollment periods at The Academy. There is an open enrollment period for students interested in attending the Academy for the first time. The re-enrollment time period is for students returning to the Academy for another year.

Open Enrollment

After accommodating all re-enrolling students, siblings have second priority.

If there are more sibling applicants than there are spaces available, the Academy will perform a random selection drawing to determine which students are selected for the spaces available. Public officials will conduct the random selection.

New students have the next priority. All new students who do not get in will be placed on the waiting list according to their order in the lottery selection. Applicants who apply after the lottery will be added on the list in the order they enroll.

Students who have been expelled from other schools due to major offenses will not be admitted to the Academy. Only legal guardians or parents may enroll a student.

Re-enrollment

Interested students must re-enroll for the following school year by submitting an application form by the deadline established by the Academy. Whenever spaces become available during the academic year, families on the waiting list will be contacted. If interested, the child must be registered immediately. Otherwise, the next person on the list will be contacted until all spaces are filled. It is very important to update your contact information so you do not miss the opportunity when it comes. Registration and waiting lists will NOT carry over to the following academic year. Interested families must fill out a new Student Enrollment Application for each academic year.

Home District Questionnaire – Central Academy of Ohio

Parent's Name: _____

Student's Name: _____

Grade: _____

School district student is coming from: _____

Do you feel your home district provided the program necessary to meet your child's academic and social needs, and in an environment that you felt was safe?

_____

Why did you choose to leave your home district?

_____

1. Did someone in your home district recommend our school? (circle one) **YES | NO**
    a. If yes, by whom?

        _____
2. How did you hear about us?

    _____

Thank you for taking the time to fill out this survey. We know that you child's experience at our academy will be a rewarding one!

Return completed form to Central Academy, 2727 Kenwood Blvd, Toledo, 43606 / Fax: 419-205-9899

Requests for Student Records – Central Academy of Ohio

We have just enrolled the following student. Please forward all records, including medical records, social and psychological evaluations, and special education records that would assist us in placing and evaluating this student. Thank you.

STUDENT INFORMATION

Student's Full Name: _____

Student Birth Date: _____ Grade_____

PREVIOUS DISTRICT INFORMATION

School Name:_____

School District:_____

School Address: _____

School Phone Number: _____

School Fax Number : _____

Today's Date: _____

PARENTAL INFORMATION AND APPROVAL

Signature of Parent/Guardian: _____

Address_____ City _____State _____Zip _____

Telephone _____ Cell_____

Return completed form to Central Academy, 2727 Kenwood Blvd, Toledo, 43606 / Fax: 419-205-9899

Special Education Services Questionnaire – Central Academy of Ohio

Student Name: _____ Grade: _____

1. Have you ever attended an I.E.P.C. (Individualized Educational Planning Committee) meeting where your child's eligibility for Special Education was discussed? (Circle One) **YES | NO**
   If Yes, where and when:_____
   _____

2. Is your child currently enrolled in Special Education or has s/he received special education services in the past? (Circle One) **YES | NO**

   If YES, please describe the services received:

   _____
   _____

3. Did your child receive any other special services, such as social work referrals to other sources, counseling, tutoring, etc.? (Circle One) **YES | NO**

   If Yes, please explain:

   _____
   _____
   _____
   _____
   _____

4. If your child has been a part of a Special Education program, do you have a copy of your child's current I.E.P. (Individualized Education Plan)? (Circle One) **YES | NO**
   If No, please obtain and provide the IEP to the school before the first day of school.

5. Do you feel your child is a candidate for Special Services? (Circle One) **YES | NO**
   If Yes, please explain: _____

6. Have you ever had discussions with any school personnel regarding your child being tested for academic, behavior or emotional concerns? (Circle one) **YES | NO**
   If so, what was their position:_____

7. When is the best time to contact you by phone? _____
   at what phone number can you be reached? _____

Parent Name (Print):_____

Parent Name (Signature):_____

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Medication Administration Permission Form – Central Academy of Ohio

Student Name: _____

Date form received by the Academy: ____/_____/_____

Grade: _____ Class #: _____ Birth Date: ____/____/_____

TO BE COMPLETED BY THE PHYSICIAN	
Name of medication:	
Dosage:	
** Medicine Type (circle one): Tablet / Liquid / Inhaler / Injection / Nebulizer / Other:	
Instructions: _____	
Start Date: Stop Date: OR ☐ As Needed (via phone verification)	
Restrictions/Side Effects:	
Storage Requirements:	
Physician Name:	Phone Number:

**FORM MUST BE SIGNED BY THE PHYSICIAN – See below

TO BE COMPLETED BY PARENT/GUARDIAN

☐ I request that my child, _____ receive the above medication at school according to the standard school policy.

☐ I certify that my child, _____ is both capable and responsible, and I am requesting that he/she be allowed to self-administer the above medication at school according to the standard school policy.

REQUIRED SIGNATURES

IMPORTANT NOTE: A physician signature is required regardless of whether the medication is over-the-counter or prescription. So, for example, this would include Tylenol, cold or allergy medicine, etc.

Physician Signature: _____ Date: ____/____/_____

Telephone: _____

Parent Signature: _____ Date: ____/____/_____

Relationship (MUST be parent/guardian): _____

Telephone: _____

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Home Language Survey - Central Academy of Ohio

Name of Student: _____ Age: _____

In order to determine the number of students who speak a language other than English we are requesting the following information:

1. Country of Birth: _____ Grade: _____

2. Is English the first language that the student learned to speak? (Circle one) YES | NO
   If NO, what is the first language that the student learned to speak? _____

3. Is English regularly (most of the time) spoken at home? (Circle one) YES | NO
   If NO, then what is the language spoken at home? _____

4. Was the student born in the U.S.? (Circle one) YES | NO
   If no, what date did the student move to the U.S.? _____

If your response to <u>any</u> of the questions above was NO:
How many years has the student gone to school in the US? _____
Is the student a U.S. Citizen? ☐ Yes ☐ No
Assess the student's language proficiency in your opinion. (Check all that apply)

____ Speaks no English	____ Reads no English	____ Writes no English
____ Speaks limited English	____ Reads limited English	____ Writes limited English
____ Speaks English well	____ Reads English well	____ Writes English well

If you answered YES to <u>any</u> of the questions above:
We are required to do an English Language Proficiency Assessment (ELPA) with your child. This is a simple language assessment tool to evaluate English language skills and will determine the language needs of your child. Once the assessment is completed we will notify you of your child's proficiency level. If your child is eligible for English language services, your consent is needed prior to participation in the program.
_____ Check if you give consent Signature: _____

SIGNATURE REQUIRED REGARDLESS OF YOUR ANSWERS

Parent/Guardian's Name (Print): _____

Signature: _____ Date: ___/___/_____

Address: _____

Phone Number: _____ Cell Number: _____

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Student Internet/Computer Acceptable Use Policy – Central Academy

Internet services are available to all students for the purposes of instruction, curriculum support, and communication. E-mail, network, and Internet access is to be used ONLY for these purposes.

Students are expected to conduct themselves ethically and be mindful of all applicable laws and regulations. They should be familiar with procedures for accessing email and/or the Internet and have participated in training provided by the school. Students should have specific information objectives and/or search strategies formulated before they access the Internet. School policy states that ***ALL students must have a signed Acceptable Use Policy form on file before they are allowed to use the Internet independently.***

The following are unacceptable uses of e-mail/Internet by students who access the network through school accounts using school-owned equipment and may result in the revocation of Internet privileges or, depending on the nature of the offense, detention or suspension.

Unacceptable use includes but is not limited to:

- Sending or displaying offensive messages or pictures
- Using obscene, harassing, or insulting language
- Violating copyright laws or fair-use practices
- Trespassing in others' folders, documents, or files
- Using the network for commercial or political purposes
- Using the network to access inappropriate materials
- Intentionally damaging computers, computer systems, or computer networks
- Using other's passwords
- Indiscriminate personal use – purchases, personal emailing, or "instant messaging"
- Downloading software without permission of school administration or network technician.
- Other behaviors in violation of Academy policy, state statutes, or federal laws

Communication over networks is not considered private. Network supervision and security maintenance may require monitoring of directories, messages, or Internet activity. The Academy reserves the right to access stored records in cases where there is reasonable cause to expect wrong-doing or misuse of the system.

Student Internet/Computer Acceptable Use Policy – SIGNATURE REQUIRED

Student Name:_____Grade:_____

I have read the Student Internet Acceptable Use Policy. I agree to follow the rules contained in this policy with an understanding that consequences could entail revocation of Internet privileges, or depending on the nature of the offense, detention or suspension. I will receive a copy of this signed Policy and a copy will be kept in my file.

Student Signature: _____Date: _____

Parent Signature: _____ Date: _____

Return completed form to Central Academy, 2727 Kenwood Blvd, Toledo, 43606 / Fax: 419-205-9899

Photo Consent/Denial Policy – Central Academy of Ohio

In an effort to keep the community up-to-date on events, the Academy will, on occasion, invite local media representatives into our school to photograph special programs and events. Media representatives register at the main office upon their arrival and are always supervised by school staff while the media representative takes photos or video publications. We do not allow media representatives to interview students on school property unless academy personnel accompany them.

Academy personnel will also take pictures of classroom activities and/or individual students from time to time for either release to the local media, use in the Academy web site, or for Academy media or brochures (Photos only). The student's name, school, and grade will be used in the yearbook only.

Permission to photograph a student either individually or in a group is assumed, until specific documentation (THIS FORM) is returned with a signature. This information will be kept on file in the student's records.

I, _____(Parent/Guardian Full Name), am the legal guardian of _____(student's name) who will be in _____ grade in 2011-2012.

Home Address:

_____

_____

PLEASE INDICATE YOUR PREFERENCES BELOW:

☐ **YES** I give permission for my child's **picture** to be used in school or school-related media publications.

☐ **NO** I DO NOT give permission for my child's **picture** to be used in school or school related media publications.

AND

☐ **YES** I give permission for my child to be **interviewed** in school or school-related media publications.

☐ **NO** I DO NOT give permission for my child to be **interviewed** in school or school-related media publications.

Parent Signature:_____ Date:_____

Work Phone #:_____ Cell Phone #: _____

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Family Emergency Form Central Academy of Ohio

*All students in the household who are attending Central Academy of Ohio **MUST** be listed below*

Last Name	First Name	D.O.B.	Grade	Does your child have any health issues or allergies?

ADDRESS: _____ **CITY:** _____

STATE: OH ZIP CODE: _____ **HOME PHONE NUMBER:** _____

Who does the child live with? ☐ Both parents ☐ Mother ☐ Father ☐ Other_____

Is a divorce decree in place? ☐ Yes ☐ No ☐ Pending If yes, please submit a copy for the student file.

Father's Name:	Cell phone number:
Place of Employment:	Work phone number:
Mother's Name:	Cell phone number:
Place of Employment:	Work phone number:
Guardian's Name:	Cell phone number:
Place of Employment:	Work phone number:

In case of emergency, you MUST list at least 2 people we can contact:

Name	Relationship	Phone Numbers

If none of the parties can be contacted, I instruct Central Academy of Ohio to contact:

Doctor's Name: _____ Phone Number: _____

If the designated parties are unavailable, I understand that appropriate emergency care deemed advisable by the school authorities will be sought. Any special directions appropriate to my child/ren have been listed above. I certify that this information is true and accurate, to the best of my ability. I will not hold Central Academy of Ohio or any other affiliates responsible in the case of injury or death.

DISMISSAL AGREEMENT

By signing this form I am in an agreement with Central Academy of Ohio's dismissal agreement.

☐ My child/ren listed above will be walking to and from school.

☐ My child/ren listed above will be driven to and from school.

Other than parent my child/ren can ONLY be picked up by the parties listed below:

Full Name	Relationship	Phone Numbers

I understand that Central Academy of Ohio is not responsible for my child/ren after 3:30 P.M.

Parent/Guardian Signature: _____ Date: _____

Return completed form to Central Academy, 2727 Kenwood Blvd, Toledo, 43606 / Fax: 419-205-9899

Student Residency Questionnaire – Central Academy of Ohio

Student's Name: _____

Academy Name: _____

This questionnaire is given to ALL students to ensure our academy remains in compliance with federal law. Your answers will help academy staff determine if the student is eligible for certain rights under federal law and supportive services.

The student lives in the following situation:

- ☐ Owner-occupied home
- ☐ Rental unit
- ☐ Emergency shelter or transitional housing*
- ☐ Motel/hotel*
- ☐ Campground*
- ☐ Public or private place not designed for or ordinarily used as regular sleeping accommodation for humans, including cars, parks, public spaces, abandoned buildings, substandard housing, or bus or train stations*
- ☐ Foster care placement for 6 months or less*
- ☐ Long-term, stable, cooperative living arrangement
- ☐ Temporary, shared housing with friends, family or others due to:
  - ☐ Loss of personal housing* (due to reasons such as eviction, inability to pay rent, destruction or damage to home, abuse or neglect, unhealthy conditions, parental abandonment or incarceration)
  - ☐ Economic hardship*
  - ☐ Other, similar reason: _____*

*Living in these situations may qualify you for services, including transportation, school supplies, educational advocacy, and community referrals.

Parent name (printed): _____

Parent Signature: _____

Date: _____

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Central Academy of Ohio
2727 Kenwood, Toledo, Ohio
Phone: 419.205.9800 Fax: 419.205.9899

IMPORTANT NOTE REGARDING VISION & HEARING SCREENINGS

Please make sure your physician has fully completed the **vision** and **hearing** screening sections of the health appraisal form. The Ohio Department of Health requires this be done as outlined below:

Children to be screened:

1. *All children in kindergarten, first, third, fifth, seventh and ninth grades.*
2. *All new and transfer students regardless of grade.*
3. *All hearing-impaired children, annually.*
4. *All children referred by a teacher.*

This is a required minimum; additional grades may be screened

Thank you,

Central Academy of Ohio

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

HEA 4240 8/06

Please return completed form to Central Academy, 2727 Kenwood Blvd, Toledo / Fax: 419-205-9899

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

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Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

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Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____
_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____
_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____
_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____
_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

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Ohio Department of Health • School and Adolescent Health

(Dental) Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4243 8/06

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