



Martinsville City Public Schools

Empowering Success One Learner At A Time

Preschool Programs

2021 - 2022

About our Programs:

- Each classroom has a licensed teacher and a highly-qualified paraprofessional
- Provide bus transportation to/from school daily – only preschool students ride our buses and each bus has an assistant riding both morning and afternoon
- Offer breakfast, lunch and snack to all students daily
- Follow Martinsville City Public Schools calendar and inclement weather policy
- Provide a full day schedule - 8:00 AM - 2:45 PM
- Provide the opportunity to participate in local and out-of-town field trips to enhance student learning
- Provide various opportunities for parent involvement throughout the school year
- Partner with Boys & Girls Club of the Blue Ridge to offer an after-school program

**School schedule & after-school program offerings are subject to change based on COVID-19 restrictions.*

The following are required when applying to any MCPS Preschool Program:

- ✓ Be three or four years of age by September 30, 2021
- ✓ Be a resident of the City of Martinsville (residency verification required)
- ✓ Submit a completed application (all parts must be completed for consideration)
- ✓ Submit all required documentation (list attached)
- ✓ Signed Parent Agreement

All Preschool Classes are located at:
Clearview Early Learning Center
800 Ainsley Street
Martinsville, VA 24112
276 - 403 - 5800



Required Documents for Preschool Application

The following documents must be submitted with your child's preschool application. Applications will not be reviewed until all supporting documentation is on file.

- **Child's State Issued Birth Certificate**
- **VA School Entrance Health Form** – completed after 8/9/2020
(form attached – must be completed by parent and physician and must include immunization record)
- **Proof of Income** – Proof of income must be submitted for each parent, guardian, or legal custodian who is working or receives income from other sources.
 - **2020 Income Tax Returns OR W-2's (preferred)**
 - Pay stubs for the past four weeks
 - SNAP, TANF, SSI - Letter from issuing agency indicating how much assistance is received monthly
- **Proof of Residency** – You must provide **two** of the following documents:
 - Rent receipt from the current month or one month previous to when the application is submitted. The rent receipt must show the name of the person paying rent; property address; rental company name, address, and phone number
 - Lease or mortgage agreement from the current month or one month previous to application date
 - City of Martinsville Personal Property tax statement or receipt (must include address of residency)
 - City of Martinsville Utility Bill (current month)
 - Voter Registration Card
 - Current Driver's License or DMV issued photo ID
 - Bank Statement or Loan Statement (no older than 45 days)
 - Home Owner/Rental/Car Insurance statement (must be current)
 - SNAP or TANF statement of benefits from Department of Social Services (must have physical address, no PO Boxes)

***Please note – all documents submitted for proof of residency must include the name and address of the person completing the application. The address must be the physical address where the child resides. Additional documents may be requested at the discretion of the Director.**

Martinsville, Henry, Patrick, and Franklin County Resources



Martinsville/Henry County

Clinical Services	Phone Number
Ridgeway Family Practice	276-956-2233
Bassett Family Practice	276-629-1076
Piedmont Community Services	276-632-7128
Health Department	276-638-2311
MedAssist	276-632-2246
Children's Medical Center	276-632-9714
Davis Pediatric Dentistry	276-790-3457
Kids First Dental	276-201-1800
Martinsville Family Dentistry	276-632-6219
PATHS Community Medical Center	276-632-2966
Piedmont Virginia Dental Health	276-632-7727
Children's First Pediatrics	276-638-5437

Franklin County

Clinical Services	Phone Number
Free Clinic-Bernard Healthcare Center	540-489-7500
Piedmont Community Services	540-483-0582
Tri-Area Community Health – Ferrum	540-365-4469
Franklin Dental Associates	540-483-5241
Park Dental Solutions – Rocky Mount	540-483-7577
Crooked Road Family Dentistry – Rocky Mount	540-483-5544
Henritze Dental Group – Rocky Mount	540-483-3368
Carilion Children's Pediatric Medicine – Rocky Mount	540-484-0350
Health Department	540-484-0292

Patrick County

Clinical Services	Phone Number
Caring Heart Free Clinic	276-694-5031
Piedmont Community Services	276-694-4361
Tri-Area Community Health – Laurel Fork	276-398-2292
Health Department	276-693-2070
Patrick County Family Practice	276-694-4466

**Martinsville City Public Schools
Preschool Application 2021 - 2022**



Please check below the program for which you are applying:

- VPI-3 Program (My child will be 3, but not 4, on or before September 30, 2021)
 VPI-4 Program (My child will be 4, but not 5, on or before September 30, 2021)

Are you a resident of the City of Martinsville? Yes No

***Please note – if you are not a resident of the City of Martinsville, your child does not qualify for the MCPS Preschool Program. Out of Zone requests are not accepted for preschool students.**

Child's Full Name _____
First Middle Last

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Date of Birth: _____ Gender: Male Female

What is the student's first language? _____

What is the primary language spoken at home? _____

Does the student speak any language other than English? Yes No

If yes, what language(s)? _____

What is the student's preferred language when speaking:

with family? _____

with friends? _____

Student Information

Is your child completely toilet trained? (even when napping) <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Explain:
Has your child previously attended a preschool or daycare program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:
Does your child have any diagnosed emotional or behavioral issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:
Does your child have any diagnosed medical conditions such as asthma, allergies, diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:
Has your child been found eligible for Special Education or speech services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:
Do you know of any students related to your child who are applying for the MCPS preschool program (brother/sister, cousin, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:

Do you have any concerns about your child's development in any of the following areas? Please explain any areas of concern.

- Physical Development _____
 - Vision _____
 - Speech _____
- Does your child speak in sentences of at least four words most of the time? Yes No
- Hearing _____
 - Behavior _____

If you have any other concerns about your child's development that have not been previously indicated, please tell us about those concerns below.

Family Information

Mother/Guardian Information	Father/Guardian Information
Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Cell phone:	Cell phone:
Date of Birth:	Date of Birth:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	Employer:
Last grade completed/GED?	Last grade completed/GED?

Marital Status: Married Separated Divorced Single Widowed

If parents are divorced, who has legal custody of the child? _____

***If you have legal custody orders, a copy must be provided to the school office.**

Child lives with: Both Parents Mother Father Guardian _____

Number of Adults in Household: _____ Number of Children in Household: _____

Please list child's siblings living in the home:

Name: _____ Date of Birth: _____ School: _____

Name: _____ Date of Birth: _____ School: _____

Name: _____ Date of Birth: _____ School: _____

Name: _____ Date of Birth: _____ School: _____

Name: _____ Date of Birth: _____ School: _____

Name: _____ Date of Birth: _____ School: _____

Please check all that apply

Social Services is involved in the family (does not include food stamp cases)

Name of Case Worker_____

Government Assistance Currently Receiving

SNAP (food stamps)

TANF

Medicaid/FAMIS

Does your child have medical insurance coverage? Yes No

If yes, please indicate coverage type

Medicaid FAMIS Private Insurance Provider Name_____

Please check all that apply

Our living arrangement is temporary (if checked, please complete the student residency questionnaire.)

Moved two or more times in the past year

Parent(s) had difficulty reading and/or learning in school

Parent receives or has received mental health services

Parent/Guardian has a serious physical condition which requires ongoing medical care

Parent or Guardian currently incarcerated

Admission to the Martinsville City Public Schools Preschool Program is determined by level of need. Areas of need are evaluated and scored based on the information you provide with this application. Therefore, all parts of the application must be completed, and all required documentation must be submitted, in order for the application to be reviewed. Space is limited. Once the program is full, students not accepted to the program will be placed on a waiting list, and will be called if space becomes available.

You will be notified of acceptance to the MCPS Preschool Program by mail. *If your mailing address is different from your home address please be sure to indicate that on the application. Acceptance letters are generally mailed by Mid-June. Please notify the office if you have any changes in contact information.

Parental Agreement

Martinsville City Public Schools offers this family focused, school-readiness preparatory program for families who meet program qualifications. This program is optional and is a privilege for those to which it is offered. The purpose of the program is to offer children the opportunity to prepare for kindergarten in a full day, public school environment. In order to participate in this program, the following guidelines must be followed.

Attendance and Transportation

School Hours & availability of Boys & Girls Club after-school program are subject to change based on restrictions due to COVID-19.

- The school day begins at 8:00 a.m. Students may arrive no earlier than 7:45 a.m. The school day ends at 2:45 p.m. Car riders must be picked up by 2:50 p.m. An after-school program is offered through Boys & Girls Club of the Blue Ridge. A separate application must be completed for the after-school program.
- Bus transportation – Preschool only buses transport students to & from school. A parent or other adult listed on the student's authorized pick-up list is required to be at the bus stop to receive your child daily. Students will not be allowed to get off the bus without an authorized adult at the bus stop and will be returned to the school. Excessive returns to school can put your child's preschool enrollment in jeopardy.
- After 5 unexplained absences, the family's participation in the program will be jeopardized and a meeting with the teacher and/or Director will be scheduled.
- After 5 tardies per month, a meeting with the teacher and/or Director will be scheduled.

Family Involvement

- Parents agree to have at least one home visit (at the address where the student resides) with the teacher each school year. ***Subject to change based on restrictions due to COVID-19.***
- Parents are required to attend scheduled parent-teacher conferences and parent/child/family events throughout the school year.
- Parents are required to cooperate with the school in handling any discipline or learning problems that may arise.
- Parents are required to report any changes of address and/or phone number to the school immediately.
- Parents are expected to conduct themselves in a professional and respectful manner at all times. Disruptive and/or disrespectful behavior of the parent may result in your child's removal from the program.

By signing this application, I agree that:

- All information provided is true and accurate to the best of my knowledge.
- The administrators of Clearview Early Learning Center have my permission to verify any of the information provided on/with this application.
- I understand that all information will remain confidential and will only be released to necessary personnel.
- If my child is accepted to the MCPS Preschool Program at Clearview Early Learning Center, I will adhere to the policies and guidelines of MCPS and CELC.

Signature _____

Date _____

**Please return the completed application and required documents to:
Clearview Early Learning Center
800 Ainsley Street
Martinsville, VA 24112**

Martinsville City Public Schools

Ethnicity and Race Questionnaire

Student's Name: _____ School: _____ Grade: _____

Please answer **BOTH** Question 1 and Question 2. If both questions are not answered school personnel are required to select one for both.

Question 1: Is this student Hispanic or Latino? (choose only one)

- No, not Hispanic or Latino
- Yes, Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

Question 2: What is the student's race? (choose one or more)

- American Indian or Alaska Native (a person having origins in any of the original peoples of North and South America [including Central America], and who maintains tribal affiliation or community attachment)
- Asian (a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)
- Black or African American (a person having origins in any of the black racial groups of Africa)
- Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)
- White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

Parent/Guardian Signature _____

Date: _____

Student Signature _____

Date: _____

Completed by School Designee _____

Date: _____

Title _____

***Information must be kept securely for 3 years from the date obtained.**

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____
 Student's Name: _____
 Student's Date of Birth: ____/____/____ Sex: ____ State or Country of Birth: _____ Middle Main Language Spoken: _____
 Student's Address: _____ City: _____ State: _____ Zip: _____
 Name of Parent or Legal Guardian 1: _____ Phone: ____-____-____ Work or Cell: ____-____-____
 Name of Parent or Legal Guardian 2: _____ Phone: ____-____-____ Work or Cell: ____-____-____
 Emergency Contact: _____ Phone: ____-____-____ Work or Cell: ____-____-____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): _____

List all prescription, over-the-counter, and herbal medications your child takes regularly: _____

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: None FAMIS Plus (Medicaid) FAMIS Private/Commercial/Employer sponsored

I, _____ (do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Signature of person completing this form: _____ Date: ____/____/____

Signature of Interpreter: _____ Date: ____/____/____

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**

Part II - Certification of Immunization

Section I

**To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: _____
Last First Middle Mo. Day Yr.

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubcola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): ____/____/____

Student's Name: _____ Date of Birth: (____|____|____)

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap:[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; Pncum:[____]; Measles:[____]; Rubella:[____]; Mumps:[____]; HBV:[____]; Varicella:[____]

This contraindication is permanent: [____], or temporary [____] and expected to preclude immunizations until: Date (Mo., Day, Yr.): [____|____|____].

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): [____|____|____]

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): [____|____|____]

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)**

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/____ Sex: M F

Health Assessment	Date of Assessment: ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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TB Screening: <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified																																																		
Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																		
EPSDT Screens Required for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
Developmental Screen	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

Hearing Screen	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___ Left ___ Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)					Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested			
	Distance	Both	R	L	Test used:		
		20/	20/	20/			
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen							

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____	
	Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc) Restricted Activity Specify: _____	
	Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	Medication, Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	Special Diet Specify: _____	
	Special Needs Specify: _____	
	Other Comments: _____	

Health Care Professional's Certification (Write legibly or stamp) <input type="checkbox"/> By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).	
Name: _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ Fax: _____	Email: _____