

# Welcome To Wellsville Central School



## New Student Checklist

- Proof of Residency in Wellsville Central School District
  - \*Utility Bill (**Gas or Electric only please**)
  - \*Statement from landlord
  - \*Tax bill
  - \*CAN NOT BE A DRIVERS LICENSE**
- Completed Registration Packet (attached)
- Copy of Birth Certificate
- Immunization Records
- Allegany County Schools health Certificate/Appraisal Form(attached)
- Parent/Guardian Photo Identification
- Copy of Custody Papers and/or Order of Protection (if applicable)
- Department of Social Services Foster Placement Form (if applicable)

***Please notify your previous school district that we will be contacting them for the following records to complete the enrollment process:***

- ✓ Exit Grades for Current Quarter (if student transferred mid-quarter)
- ✓ Current Class Schedule
- ✓ Current Report Card
- ✓ Copy of Current Science Lab
- ✓ School Transcripts
- ✓ Attendance Records
- ✓ Health Records (immunizations and last physical exam)
- ✓ New York State Test Scores
- ✓ Special Education Records (IEP, Social History, and Psychological Reports)



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# Wellsville Central School Student Registration Form

Today's Date: \_\_\_\_\_

## Student Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Current Grade: \_\_\_\_\_ Nickname if any: \_\_\_\_\_ Gender M F

Date of Birth: \_\_\_\_\_ Date of first polio vaccination: \_\_\_\_\_

Social Security #: \_\_\_\_\_ (optional)

## Residence Address:

Street: \_\_\_\_\_

Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone # \_\_\_\_\_

## Mailing Address: (if different than residence)

P.O. Box/Street: \_\_\_\_\_

Town: \_\_\_\_\_ Zip: \_\_\_\_\_

## Ethnic Group: (please select one)

White (not Hispanic origin)

Black (not Hispanic origin)

Hispanic

Asian or Pacific Islander

American Indian or Alaskan Native

## Please check all that Apply:

Has this student ever attended Wellsville Schools – if so when \_\_\_\_\_

Has this student skipped a grade – if so which grade \_\_\_\_\_

Has this student ever repeated a grade – if so which grade \_\_\_\_\_

Residing in the Wellsville School District

Enrolling from outside the Wellsville School District (non-foster care)(Please request tuition policy)

Eligible for Free and Reduced Lunch

Currently in Foster Care

Agency Responsible for placement: \_\_\_\_\_

Actual Home School District: \_\_\_\_\_

Migrant

Foreign Exchange Student

English Language Learner

Immigrant/Refugee:

Date entered US \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Home Language \_\_\_\_\_

## Homeless Designation:

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, or birth certificate. Student who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

1. living with an adult who does not have legal custody
2. living in a motel, hotel or camping grounds
3. your family is living with a relative or friends
4. awaiting foster placement
5. or other similar situations due to the lack of alternative, adequate housing

### **You must check one of the following:**

\_\_\_ I am currently living in one of the above eligible conditions, and I am interested in learning more about my educational rights. If this box is checked the office must immediately notify the homeless liaison for a review of the case.

\_\_\_ The above conditions do not apply to me

\_\_\_ I wish to maintain my privacy



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**Parent/Guardian Information:** Please complete ALL information below:

**\*Note:** We presume both NATURAL parents share custody in divorce or legal separation agreements unless and until we receive a copy of the court order or separation agreement that pertains to the child's custody. Non-custodial parents are legally able to obtain school records unless otherwise noted in court documents.

**Mother's Name:** \_\_\_\_\_ Student resides with: Yes No  
Address: \_\_\_\_\_  
RD, PO Box AND/OR Street, Town, State, Zip, County

Home Telephone Number: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Student resides with: Yes No  
Address: \_\_\_\_\_  
If different from above RD, PO Box AND/OR Street, Town, State, Zip, County

Home Telephone Number: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**Step Parent or Legal Guardian:** \_\_\_\_\_ Student resides with: Yes No  
Address: \_\_\_\_\_  
RD, PO Box AND/OR Street, Town, State, Zip, County

Home Telephone Number: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**Parents Are:**  
Married \_\_\_\_\_ Divorced \_\_\_\_\_  
Separated: Legally \_\_\_\_\_ No Legal Agreement \_\_\_\_\_  
Custody: Joint \_\_\_\_\_ One parent has custody\* \_\_\_\_\_

**\*We will need a copy of the custody agreement**  
Custody Papers on File? Yes No Order of Protection on File? Yes No  
Comments: \_\_\_\_\_

Names, ages, birth dates and grades of siblings:  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I hereby certify that the student listed on this registration form actually resides at the address specified on Page 2 within the Wellsville Central School District boundaries. I further certify that all the information I have provided on this registration form is true and correct. I understand that I must immediately notify the Wellsville Central School District if the residency of the student changes from the address listed on this registration form.

I authorize the request of student records from previous schools and give permission to the Wellsville Central School District to verify telephone numbers, addresses, and employment. I understand that if the district believes that the information on this form is no longer correct or that the child being registered no longer lives at the address provided, the Wellsville Central School District has the right under New York State Law to investigate and to withdraw the child from the Wellsville Central School District

Please be advised that the provision of false information on this registration form could constitute a crime. In addition, the Wellsville Central School District reserves its right to recover from parents, legal guardians or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in the Districts schools with authorization and/or under false pretenses. I HAVE READ AND UNDERSTAND THIS NOTICE

Parent (Guardian) Signature: \_\_\_\_\_

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



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**Previous School This Child Attended:**

School Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Dates of Attendance at this School:

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

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

**My Child Received the Following Services:**

Academic Intervention Services (AIS)

If so, for what subjects: \_\_\_\_\_

Was your child classified under the Committee of Special Education? Yes No

Special Education Services (please specify program):

Self-contained classroom \_\_\_\_\_

Resource Room \_\_\_\_\_

504 Plan \_\_\_\_\_

Speech Therapy

Occupational Therapy

Physical Therapy

Visual Therapy

Counseling

Other (please specify): \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the information provided above is true to the best of my knowledge.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



*Wellsville Elementary*  
*50-98 School Street*  
*Wellsville, NY 14895*  
*Phone: (585) 596-2105 Fax: (585) 596-2120*

**FAX REQUEST**

Date: \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_

RE: New Student Registration

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The student listed has enrolled in the Wellsville Central School District. Please fax or mail the items checked below as soon as possible. Thank you.

- Exit Grades for Current Quarter
- Current Report Card
- NYS Test Scores
- Attendance Records
- Health Records (**immunization and last physical exam**)
- Copy of Birth Certificate
- Discipline Reports\*\*
- Special Education Records (**if applicable**) to include: **IEP, Social History, and Psychological Reports**
- \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Parental permission is no longer required when authorized school personnel request records according to the Family Education Rights and Privacy Act, Final Rule on Education Records, Federal register, June 17, 1976, Vol. 41, No. 118, Page (4673).**

\*\*I hereby authorize the release of discipline information for the student listed above.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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**WELLSVILLE CENTRAL SCHOOL DISTRICT  
126 WEST STATE STREET  
WELLSVILLE, NEW YORK 14895**

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**Healthcare provider** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

**Healthcare provider** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

**Healthcare provider** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize my child's physician(s) listed above as well as Zahi Kassas, MD, acting school physician, to exchange the following information with Wellsville Central school staff, including:

- |   |   |
|---|---|
| <input type="checkbox"/> School Nurse           | <input type="checkbox"/> Immunizations/physical exams to comply with NYS regulations                          |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Social History   |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychological evaluations/reports  |
| <input type="checkbox"/> Speech Therapist       | <input type="checkbox"/> Medical clearances as needed following an injury or change in condition              |
| <input type="checkbox"/> Audiologist            | <input type="checkbox"/> Medical orders required for therapy needs; evaluations                               |
| <input type="checkbox"/> Vision Department      | <input type="checkbox"/> Authorization for medications during the school day or on school trips               |
| <input type="checkbox"/> Admissions officer     | <input type="checkbox"/> Medical condition/ treatment plans that may have an impact in the school environment |
| <input type="checkbox"/> School Psychologist    | <input type="checkbox"/> Physician referral for services (OT, PT)   |
| <input type="checkbox"/> School Social Worker   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> _____                  |   |

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release; however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

**I waive my right to receive a copy of this notice.**

\_\_\_\_\_  
(Signature of student over 18 or Parent/Guardian)\*\*

\_\_\_\_\_  
(Date)

\*\*If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: \_\_\_\_\_

**This form complies with all HIPAA regulations.**

Revised 10/10 KLDH



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## Wellsville Elementary New Student Health History

Today's Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Childs Physician \_\_\_\_\_ Phone number \_\_\_\_\_ Last visit \_\_\_\_\_

Childs Dentist \_\_\_\_\_ Phone number \_\_\_\_\_ Last visit \_\_\_\_\_

Childs Eye Dr. \_\_\_\_\_ Phone number \_\_\_\_\_ Last visit \_\_\_\_\_

Childs ENT \_\_\_\_\_ Phone number \_\_\_\_\_ Last visit \_\_\_\_\_

Other Dr. \_\_\_\_\_ Phone number \_\_\_\_\_ Last visit \_\_\_\_\_

Has your child ever been hospitalized? Yes No Where \_\_\_\_\_

When \_\_\_\_\_ Why \_\_\_\_\_

Has your child had surgery? Yes No If yes, please list: \_\_\_\_\_

Does your child have any allergies? Yes No Please list: \_\_\_\_\_

What is the reaction? \_\_\_\_\_ Does your child have an Epi-Pen? Yes No

Please mark any of the following your child may have experienced and please explain.

Ear infections \_\_\_\_\_

Frequent colds \_\_\_\_\_

Chicken pox \_\_\_\_\_

Measeles \_\_\_\_\_

Vision problems? \_\_\_\_\_

Does your child wear glasses? Yes No Contacts? Yes No \_\_\_\_\_

Nose bleeds \_\_\_\_\_

Pneumonia \_\_\_\_\_

Seizures \_\_\_\_\_

Unconsciencsness \_\_\_\_\_

Mumps \_\_\_\_\_

Diabetes \_\_\_\_\_

Hearing problems \_\_\_\_\_

Speech problems \_\_\_\_\_

Asthma \_\_\_\_\_

Diagnosed ADD or ADHD \_\_\_\_\_

Physical disabilities \_\_\_\_\_

Bleeding disorders \_\_\_\_\_

Does your child take any medication? Yes No If yes, please specify what it is and what it's for \_\_\_\_\_

### Please describe the following for your child if applicable:

How does your child handle anger? \_\_\_\_\_

How does your child relate to other children? \_\_\_\_\_

How does your child relate to adults? \_\_\_\_\_

What are your child's fears? \_\_\_\_\_

Describe your child's personality \_\_\_\_\_

Please attach any additional information that you think we should know.



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## Transportation Information

Please complete and return this form to the Elementary School  
50-98 School St. Wellsville, NY 14895

\_\_\_ My child(ren) will be self-transported to school

\_\_\_ My child(ren) will be self-transported from school

\_\_\_ My child(ren) needs to ride a bus (complete form below)

Student(s) Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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

\_\_\_ **My address has changed**

- Will your child be getting on the bus in the morning at the above address? Yes\_\_ No\_\_
- Will your child be getting off the bus in the afternoon at the above address? Yes\_\_ No\_\_

*If you answered no to either question above, please fill out the remainder of this form*

Alternative **morning** pick up information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

Alternative **afternoon** drop off information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

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



Wellsville Central School  
126 West State Street  
Wellsville, NY 14895

Dear Parent/Guardian:

As a part of your child's requirements for school, a physical examination has been required for students in grades Prekindergarten, Kindergarten, 2, 4, 7 and 10. A law was recently enacted that expands health screenings to include the **dental health** of students in New York State.

Currently and in the future, when we require that your child have a physical examination, we will be requesting a **dental certificate**, as well. On the reverse side is a certificate available for you to take to your child's dentist. Once it is completed, it should be returned to the School Nurse, as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

Sincerely,

Hope Gilfert, R.N.  
High School Nurse  
Phone: 585-596-2167  
Fax: 585-596-2130

Kathy Darrow-Holla, R.N.  
Middle School Nurse  
Phone: 585-596-2147  
Fax: 585-596-2130

Rebecca Joyce, R.N.  
Elementary School Nurse  
Phone: 585-596-2117  
Fax: 585-596-2120

Rose Mary Vossler, R.N.  
Elementary School Nurse  
Phone: 585-596-2107  
Fax: 585-596-2120

(OVER)



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**WELLSVILLE CENTRAL SCHOOLS  
DENTAL HEALTH CERTIFICATE**

**Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.**

**Section 1. To be completed by Parent or Guardian (Please Print)**

Child's Name: Last First Middle

Birth Date: / / Sex:  Male  Female Will this be your child's first visit to a dentist?  
Month Day Year  Yes  No

School Name: Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?  
 Yes  No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination, with x-rays, if necessary, to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 2. To be completed by the Dentist**

I. The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam)  
NOTE: The date of the exam needs to be within 12 months of the start of the school year in which it is requested.

**Check one:**

- Yes, the student listed above is in fit condition of dental health to permit his/her attendance at the public schools.  
 No, the student listed above is NOT in fit condition of dental health to permit his/her attendance at the public schools.  
 NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's name and address (please print or stamp)**

**Dentist's Signature**

**Optional Sections – If you agree to release this information to your child's school, please initial here:** \_\_\_\_\_

**II. Oral Health Status (check all that apply)**

- Yes  No **Caries Experience / Restoration History:** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries:** Does this child have an open cavity? [At least 1/2mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions, as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No **Dental Sealants Present?**

Other problems (specify): \_\_\_\_\_

**III. Treatment Needs (check all that apply)**

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.  
 May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.  
 Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



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# ALLEGANY COUNTY SCHOOLS

## HEALTH CERTIFICATE / APPRAISAL FORM

*NYSED requires an annual physical exam for new entrants, students in Grades Universal Pre-K or K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).*

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_  
 Student's Primary Doctor/Physician: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

**Please attach current immunizations.**

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Dental Referral:  Positive  Negative  Not done Date: \_\_\_\_\_

**Significant Medical/Surgical History:**  See attached \_\_\_\_\_

**Allergies:**  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

### DATE OF PHYSICAL EXAM: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Urinalysis: \_\_\_\_\_  
 Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

*Referral*

Body Mass Index: _____	Vision – without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision – with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision – Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

**EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_  
 Specify any abnormality (use reverse of form, if needed): \_\_\_\_\_

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form  
 Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_  
 If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed:  Yes  No Student may self-carry and self-administer medication:  Yes  No  
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school, or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**  
 \_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball, soccer, basketball.  
 \_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifleman, weight train, crew, dance, track, run, walk, rope jump, roller skating.
- Specify medical accommodations needed for school:** \_\_\_\_\_  None
- Known or suspected disability:** \_\_\_\_\_  Please monitor
- Restrictions:** \_\_\_\_\_  Please monitor
- Protective equipment required:**  Athletic Cup  Sport goggles/impact resistant eyewear  Helmet  Other: \_\_\_\_\_

### ADDITIONAL INFORMATION, if known

**Specify current diseases:**  Asthma  Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension  Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)  
 Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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