

*Welcome  
To  
Wellsville Central School*



**Pre K Student  
Checklist**

- Proof of Residency in Wellsville Central School District
  - \*Utility Bill (**Gas or Electric only**)
  - \*Statement from landlord
  - \*Tax bill
  - \*CANNOT BE A DRIVER'S LICENSE**
- Completed Registration Packet (attached)
- Copy of Birth Certificate (will not accept souvenir hand-written certificates)
- Immunization Records
- Allegany County School's 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)

**Our Pre K Program is a full day. There are 54 slots available. If there are more than 54 students registered, we will have a lottery drawing in April to see who gets in.**

**Any remaining students will be added to a wait list in the order of the lottery drawing. Anyone registering after the drawing will be added to the wait list in the order they are submitted.**

Packet Updated: 1/2019



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# Wellsville Central School Pre K Student Registration Form

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

**Student Information:**

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

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

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

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

**Residence Address:**

**Mailing Address: (if different than residence)**

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

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

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

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

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

**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:**

- Residing in the Wellsville School District
- Eligible for Free and Reduced Lunch
- Currently in Foster Care  
Agency Responsible for placement: \_\_\_\_\_  
Actual Home School District: \_\_\_\_\_

Migrant

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. Students 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Emergency Contacts:** (List at least one)

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

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

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

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

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

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

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

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

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

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



**Previous School This Child Attended:** (Headstart, Montessori, etc)

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

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

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

Dates of Attendance at this School:

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

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

**My Child Received the Following Early Intervention Services:**

- Refer to CSE
- Was your child classified under the Committee of Special Education? Yes No
- Special Education Services (please specify program):
  - Self-contained classroom \_\_\_\_\_
  - 504 Plan \_\_\_\_\_
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Visual Therapy
- Counseling
- Other (please specify): \_\_\_\_\_

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

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:** \_\_\_\_\_



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

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

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

Primary 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 _____            |                                                                                                              |

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 Parent/Guardian/  
or Student- if over 18 years old)\*\*

\_\_\_\_\_  
(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 Universal Pre-K/ Kindergarten Health History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Type of Delivery: Vaginal / Cesarean and Full term / Premature  
Any pregnancy Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain \_\_\_\_\_  
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 \_\_\_\_\_
- Measles \_\_\_\_\_
- Vision problems? \_\_\_\_\_
- Does your child wear glasses? Yes No \_\_\_\_\_
- Nose bleeds \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Seizures \_\_\_\_\_
- Unconsciousness \_\_\_\_\_
- 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 \_\_\_\_\_

Did your child attend day care or preschool? Yes No Where? \_\_\_\_\_

May WES contact previous school for information regarding your child? Yes No

### **Please describe the following for your child:**

Eating habits \_\_\_\_\_ Sleep habits/bedtime \_\_\_\_\_ Stays dry at night? \_\_\_\_\_

Independent in bathroom? \_\_\_\_\_ Needs help? \_\_\_\_\_ Can your child dress him/herself? \_\_\_\_\_

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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Wellsville Central School

126 West State Street

Wellsville, NY 14895

Dear Parent/Guardian:

As a part of your child's requirements for school, as of 07/01/2018, a physical examination is required for students in Prekindergarten or Kindergarten, and in Grades 1, 3, 5, 7, 9 and 11. A law was recently enacted that expands health screenings to include the **dental health** of students in New York State.

We would like to request that your child have a physical examination and 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. These forms may also be found on the school's website at <http://www.wellsvilleschools.org/domain/91>.

Sincerely,

Hope Gilfert, RN  
Secondary School Nurse, Grades 9-12  
Phone: 585-596-2167  
Fax: 585-596-2130

Kathy Darrow-Holla, RN  
Secondary School Nurse, Grades 6-8  
Phone: 585-596-2147  
Fax: 585-596-2130

Heather Hoffman, RN  
Elementary School Nurse, Grades 3-5  
ICS Nurse  
Phone: 585-596-2117  
Fax: 585-596-2114

Rose Mary Vossler, RN  
Elementary School Nurse, Grades Pre-K-2  
Phone: 585-596-2107  
Fax: 585-596-2120

Revised 02/01/18



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**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental

<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____

<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Type: _____ Date of last seizure: _____

<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____

**Risk Factors for Diabetes or Pre-Diabetes:**  
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 Percentile (Weight Status Category): <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and >
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

Height:	Weight:	BP:	Pulse:	Respirations:
<b>TESTS</b>	Positive	Negative	Date	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
<input type="checkbox"/> Additional Information Attached		





Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic		<input type="checkbox"/> Colostomy Appliance*		<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*		<input type="checkbox"/> Medical/Prosthetic Device*		<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment		<input type="checkbox"/> Sport Safety Goggles		<input type="checkbox"/> Other:
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER				
Medical Provider Signature:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				



## 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, Pre-K or K, 1, 3, 5, 7, 9 & 11. 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 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Month	Day	Year	Grade:	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No				

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.	
<b>Check one:</b>	
<input type="checkbox"/> Yes, the student listed above is in fit condition of dental health to permit his/her attendance at the public schools.	
<input type="checkbox"/> 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: _____	
<b>II. Oral Health Status (check all that apply)</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Caries Experience / Restoration History:</b> 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].	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Untreated Caries:</b> 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].	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Dental Sealants Present?</b>	
Other problems (specify): _____	
<b>III. Treatment Needs (check all that apply)</b>	
<input type="checkbox"/> No obvious problem. Routine dental care is recommended. Visit your dentist regularly.	
<input type="checkbox"/> May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.	
<input type="checkbox"/> Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.	



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# 2019-2020 Pre-K TRANSPORTATION INFORMATION

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

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

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

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

\_\_\_\_\_ My child will be self-transported **TO** school

\_\_\_\_\_ My child will be self-transported **FROM** school

\_\_\_\_\_ My child needs to ride a bus (answer questions below)

- 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 continue with the rest of this form.*

## Morning Pickup information:

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

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

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

## Afternoon Drop Off information:

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

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

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

## Wellsville Central School Transportation Building

2407 County Road 44, Wellsville, NY 14895

Or by email to: [alittle@wsv.org](mailto:alittle@wsv.org)

Please call 585-593-5450 with any questions. Thank you



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