



## West Linn-Wilsonville School District 2019-2020 Kindergarten Registration Check-List

We welcome you and your child to Kindergarten! It will be a wonderful year filled with learning and growing experiences. Please begin by registering your child. The checklist below includes the items you will need to enroll your child for the 2019-2020 school year. Please make sure all your forms are included to complete the enrollment process.

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

1. Registration Form (two pages; be sure to sign and date)
2. Dual Language Application of Interest Form (If applicable)
3. Photo copy of Certified Birth Certificate (this can be from the state or the hospital). Children must be 5 years old by September 1 of the calendar year for which they are registering to enter Kindergarten.
4. Immunization Record - don't forget to sign and date this form  
Vaccines required for school entry:
  - a. DPT
  - b. Polio
  - c. Measles
  - d. Hepatitis B
  - e. Varicella or History of Chickenpox
  - f. Hepatitis A
5. Vision Screening Form (All students age seven or younger entering an educational program for the first time must submit vision screening/eye examination certification within 120 days of the student beginning school).
6. Dental Screening Certification (All students age seven or younger entering an educational program for the first time must submit dental screening certification within 120 days of the student beginning school).
7. Proof of residence/address (examples: current utility bill, rental agreement – please make sure that you cover sensitive information).

### Important Dates:

|                   |                                                                                                                                        |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| January 8, 2019   | Kindergarten Registration begins at all Primary Schools                                                                                |
| January 15, 2019  | Lowrie Dual Language Program Information Night                                                                                         |
| January 17, 2019  | Trillium Creek Dual Language Program Information Night 6:30 pm                                                                         |
| February 5, 2019  | Early Childhood Special Education (ECSE) Kindergarten Parent Meeting, 6:00 pm, West Linn-Wilsonville School District Office, Boardroom |
| February 6, 2019  | Dual Language Program Lottery (if necessary)                                                                                           |
| February 11, 2019 | Parents are notified of child's placement in Dual Language Program                                                                     |
| February 19, 2019 | Parent must confirm child's placement in Dual Language Program                                                                         |
| May 2019          | Kindergarten Open House in Primary Schools                                                                                             |

**TO REGISTER: PLEASE BRING THIS CHECKLIST WITH YOUR FORMS TO THE SCHOOL.**

3/27/18

Name \_\_\_\_\_

(Last Name, First Name)

## West Linn Wilsonville School District #3JT Registration Form

For Office Use Only:

Teacher/Counselor \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Grade Level \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Gender M \_\_\_\_\_ F \_\_\_\_\_ X \_\_\_\_\_ Birthplace \_\_\_\_\_  
 Ethnicity Hispanic/Latino? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Race (check all that apply - you must select at least one) \_\_\_\_\_ Native Hawaiian/Pac Islander  
 \_\_\_\_\_ American Indian/Alaskan Native \_\_\_\_\_ Black or African American \_\_\_\_\_ Asian \_\_\_\_\_ White

Other Emergency Contacts: The parties (include the Day Care Provider, if appropriate) listed below are authorized to pick up this child from school and to make decisions regarding cases of emergency, serious illness, or accident.

| Name  | Home Phone | Work Phone | Other Phone | Relationship |
|-------|------------|------------|-------------|--------------|
| _____ | _____      | _____      | _____       | _____        |
| _____ | _____      | _____      | _____       | _____        |
| _____ | _____      | _____      | _____       | _____        |

Student Cell Phone/Texting: Schools may begin contacting students via cell phone or texting messaging. Please provide the following information if your student has a cell phone or text messaging device.

Cell Number \_\_\_\_\_ Service Provider \_\_\_\_\_  
 \_\_\_ I do NOT approve of the school using my child's cell phone/test messaging for communication.

Siblings: Please list the names, ages, grades, and schools of any siblings:

| Name  | Age   | Grade | School |
|-------|-------|-------|--------|
| _____ | _____ | _____ | _____  |
| _____ | _____ | _____ | _____  |
| _____ | _____ | _____ | _____  |

Parent/Guardian Info: The address provided must be the student's primary residence.

Relationship \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Home Address \_\_\_\_\_ City/Zip \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ County \_\_\_\_\_  
 Email \_\_\_\_\_

Initial to Confirm the Above Address is the Student's Residence \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Home Phone Unlisted? Yes \_\_\_\_\_ No \_\_\_\_\_ Employer \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Additional Parent/Guardian (at same address):

Relationship \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Employer \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
 Email \_\_\_\_\_

Previous School(s): Name, Location, Dates:

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

Medical Conditions:

Please check all conditions that apply and elaborate below

|                                |                    |                         |
|--------------------------------|--------------------|-------------------------|
| ___ Life-Threatening Allergies | ___ Heart Disease  | ___ Orthopedic Problems |
| ___ Asthma                     | ___ Kidney Disease | ___ Hearing Problems    |
| ___ Seizure Disorder           | ___ Diabetes       | ___ Vision Problems     |

Details/Other Health Concerns \_\_\_\_\_  
 \_\_\_\_\_

Medications Taken/Dosage \_\_\_\_\_  
 \_\_\_\_\_

District Nursing Staff will be in touch regarding specifics of these situations.

Extra Mailing Information: Under certain circumstances, the district is willing to send second mailings, for example, to non-custodial parents. If a second mailing is desired, please provide the information below:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Email \_\_\_\_\_  
 Home Address \_\_\_\_\_ City/Zip \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Home Phone Unlisted? Yes \_\_\_\_\_ No \_\_\_\_\_ Employer \_\_\_\_\_  
 Other Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
 Describe the circumstances that you believe warrant a second mailing \_\_\_\_\_  
 \_\_\_\_\_

Legal/Custody Documents: Please list the names of anyone who has legal guardianship of this child \_\_\_\_\_

Are there legal documents concerning the custody of this child? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, you will need to provide copies of the documents when submitting this form.

Permission Denials:

Initial each item for which you deny permission.

\_\_\_ I **do not** approve of my child being photographed or videotaped for educational purposes, including usage of such on the school or district website.

\_\_\_ I **do not** want any of my family's contact information disclosed by the school district. This means that school directories will not include my family's address, phone number, or email.

\_\_\_ I **do not** want any other information about my child or my family to appear in any school publication. I understand that this means that my child will not be included in yearbooks, sports rosters, playbills, and other activity-related publications.

\_\_\_ (For HS age student) I **do not** approve of my student being included in data sent to the military for recruiting purposes.

(FRONT)

Please continue on the back side of this form

(FRONT)

Name \_\_\_\_\_  
(Last Name, First Name)

West Linn Wilsonville School District #3JT Registration Form

Teacher/Counselor \_\_\_\_\_

Special Services (please check any areas in which your child has received special services in the last year:

\_\_\_\_\_ Title I \_\_\_\_\_ Gifted Education \_\_\_\_\_ Special Education (IEP) \_\_\_\_\_ ESL (English as a Second Language) \_\_\_\_\_ 504 Plan  
Other \_\_\_\_\_

Emergency/Early Closure Plan (For Primary School Children Only). If school should close early, what should your child do? Please choose only two:

\_\_\_\_ Take the bus home and can get into the house \_\_\_\_ Take the bus and stay with \_\_\_\_\_ Will be picked up by \_\_\_\_\_  
\_\_\_\_ Is to walk home and can get into the house \_\_\_\_ Is to take the bus to \_\_\_\_\_ day care

Alternate Plan \_\_\_\_\_

Services: Is a parent or guardian of this student on active duty in the Armed Forces or the National Guard? Yes \_\_\_\_\_ No \_\_\_\_\_

Language Use Survey:

What language(s) does your child hear or use regularly in your household? Hear \_\_\_\_\_ Use \_\_\_\_\_

Describe the language(s) your child understands: ☐ No English ☐ Mostly another language and a little English ☐ English and another language equally  
☐ Only English ☐ Mostly English and a little of another language ☐ Tribal or Native Language

What language(s) do adults most frequently use when speaking/conversing to your child?

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_ Other Adults in the Home: \_\_\_\_\_ Child-care Providers: \_\_\_\_\_

What language(s) did your child speak/express from 0 – 4 years of age? \_\_\_\_\_

What language(s) does your child currently speak/express most frequently outside of school? \_\_\_\_\_

Does your child frequently participate in cultural activities that are in a language other than English? Please list the activity and how often your child participates in the activity (for example: once/week, 2 times/week, once a month, etc. \_\_\_\_\_

Is there anything else you think the school should know about your child's language use? \_\_\_\_\_

Parent Questions: In what language(s) do you want to receive information from the school (if available)?

Father/Guardian: Oral \_\_\_\_\_ Written \_\_\_\_\_ American Sign Language \_\_\_\_\_

Mother/Guardian: Oral \_\_\_\_\_ Written \_\_\_\_\_ American Sign Language \_\_\_\_\_

Have you moved during the last three years for the purpose of obtaining seasonal/temporary employment in agriculture, forestry, or fishing? ☐ Yes ☐ No

Has this student ever missed more than 3 months of school? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

All information on both sides of this form is accurate to the best of my knowledge.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

What is your relationship to the student? (i.e., parent, grandparent, etc.) \_\_\_\_\_

For office use only

☐ Verified proof of residency Document provided/examined \_\_\_\_\_ and verified by (initials) \_\_\_\_\_ Date \_\_\_\_\_  
(check box) (type of document)

# Language Use Survey

The purpose of this survey is to determine if your child's current language exposure and use might make your child eligible to receive English Learner (EL) services.

Student Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_  
 School: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. What language(s) does your child hear or use regularly in your household (i.e., spoken, media, music, literature, etc.)? hear \_\_\_\_\_ use (i.e., ASL) \_\_\_\_\_
2. Describe the language(s) your child understands.
  - ☐ No English
  - ☐ Mostly another language and a little English
  - ☐ English and another language equally
  - ☐ Mostly English and a little of another language
  - ☐ Tribal or Native Language
  - ☐ Only English
3. What language(s) do adults most frequently use when speaking/conversing to your child?  
 Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_  
 Other Adults in the Home: \_\_\_\_\_ Child-care Providers: \_\_\_\_\_
4. What language(s) did your child speak/express from 0-4 years of age? \_\_\_\_\_
5. What language(s) does your child CURRENTLY speak/express most frequently outside of school?  
 \_\_\_\_\_
6. Does your child frequently participate in cultural activities that are in a language other than English? Please list the activity and how often your child participates in the activity (for example: once/week, two times/week, once a month, etc.). \_\_\_\_\_  
 \_\_\_\_\_
7. Is there anything else you think the school should know about your child's language use? \_\_\_\_\_  
 \_\_\_\_\_

Parent Questions: In what language(s) do you want to receive information from the school (if available)?

Father/Guardian:  
 Oral \_\_\_\_\_ Written \_\_\_\_\_ American Sign Language \_\_\_\_\_

Mother/Guardian:  
 Oral \_\_\_\_\_ Written \_\_\_\_\_ American Sign Language \_\_\_\_\_

Will you need interpretation/translation for?: Meetings \_\_\_\_\_ Conferences \_\_\_\_\_ Paperwork \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

What is your relationship to the student? \_\_\_\_\_ (i.e., parent, grandparent, etc.)



## WEST LINN – WILSONVILLE SCHOOL DISTRICT

### 2019-2020 Dual Language Program Application of Interest Form

Student Name \_\_\_\_\_ Home School \_\_\_\_\_  
 Parent(s) Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Day/Cell phone \_\_\_\_\_  
 Email \_\_\_\_\_

☐ Yes, I would like my child placed in the Dual Language (Spanish) Kindergarten.

I understand this is a K-5 program. I understand that enrollment for this program is subject to a lottery process should interest exceed the class capacity, therefore the form is due by January 31, 2019. The lottery will be held on February 6, 2019 if needed.

We have a 50:50 model which means that 50% of the instruction is in Spanish and 50% of the instruction is in English.

Please mark your school location preference:

- ☐ Lowrie Primary - the program at Lowrie is a Two-Way immersion program, meaning that half of the students speak Spanish as their primary language and half of the students speak English as their primary language.
- ☐ Trillium Creek Primary - the program at Trillium Creek is primarily a One-Way immersion program as almost all of the students are native English speakers, learning Spanish as their second language.
- ☐ Either

Dual Language Kindergarten lottery process (should there be more interest than capacity) involves:

- 1) A completed Kindergarten Registration Packet, including this Application Form turned in to your neighborhood school by January 31, 2019.
- 2) All children with an Application of Interest Form will be entered into the lottery drawing on February 6, 2019 at 10:30 am at the District Office in the Boardroom. The lottery is a public process; parents are welcome to observe.
- 3) Notification to parents of child's placement in the Dual Language Program will be sent on February 11, 2019.
- 4) Parents must confirm intent to accept the Dual Language placement by February 19, 2019, 4:00 pm; otherwise, the opening will be made available to the next child on the waiting list.

**\* Dual Language Program - Application of Interest Form due by January 31, 2019 \***



# Oregon Certificate of Immunization Status

## Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

|                                                                        |                               |                                                    |                                         |                                                                                                          |
|------------------------------------------------------------------------|-------------------------------|----------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------|
| Child's Last Name<br><i>Apellido</i>                                   | First<br><i>Primer Nombre</i> | Middle Initial<br><i>Segundo Nombre</i>            | Birthdate<br><i>Fecha de Nacimiento</i> | <div>Complete<br/>for all</div> <div>Up-to-<br/>date</div> <div>Medical</div> <div>Non<br/>medical</div> |
| Mailing Address<br><i>Dirección</i>                                    | City<br><i>Ciudad</i>         | State<br><i>Estado</i>                             | Zip Code<br><i>Código Postal</i>        |                                                                                                          |
| Parents' or Guardians' Names<br><i>Nombre de los padres o guardian</i> |                               | Home Telephone Number<br><i>Número de Teléfono</i> |                                         |                                                                                                          |

| Vaccines                                                                                                                        | Dose 1     | Dose 2     | Dose 3     | Dose 4     | Dose 5     |
|---------------------------------------------------------------------------------------------------------------------------------|------------|------------|------------|------------|------------|
| Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)                                                                                   | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) | (mm/dd/yy) |
| Booster Dose Tdap                                                                                                               |            |            |            |            |            |
| Polio (IPV or OPV)                                                                                                              |            |            |            |            |            |
| Varicella (Chickenpox) [VZV or VAR]<br><input type="checkbox"/> Check here if child has had chickenpox disease _____ (mm/dd/yy) |            |            |            |            |            |
| Measles/Mumps/Rubella (MMR)                                                                                                     |            |            |            |            |            |
| <i>or</i>                                                                                                                       |            |            |            |            |            |
| Measles vaccine only                                                                                                            |            |            |            |            |            |
| Mumps vaccine only                                                                                                              |            |            |            |            |            |
| Rubella vaccine only                                                                                                            |            |            |            |            |            |
| Hepatitis B (Hep B)                                                                                                             |            |            |            |            |            |
| Hepatitis A (Hep A)                                                                                                             |            |            |            |            |            |
| Haemophilus Influenzae Type B (Hib)<br>(Only children less than 5 years)                                                        |            |            |            |            |            |

**I certify that the above information is an accurate record of this child's immunization history.**

Signature\* \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

Update Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

|                                     |
|-------------------------------------|
| <b>For school/facility use only</b> |
| School/facility Name                |
| Student ID Number                   |
| Grade                               |

**Continued On Reverse Side**



# Oregon Certificate of Immunization Status, Page 2

## Oregon Health Authority, Immunization Program

|                                      |                               |                                         |                                         |
|--------------------------------------|-------------------------------|-----------------------------------------|-----------------------------------------|
| Child's Last Name<br><i>Apellido</i> | First<br><i>Primer Nombre</i> | Middle Initial<br><i>Segundo Nombre</i> | Birthdate<br><i>Fecha de Nacimiento</i> |
|--------------------------------------|-------------------------------|-----------------------------------------|-----------------------------------------|

| Recommended Vaccines | Recommended Vaccines                                       | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|----------------------|------------------------------------------------------------|--------|--------|--------|--------|--------|
|                      | Pneumococcal (PCV)<br>(Only in children less than 5 years) |        |        |        |        |        |
|                      | Meningococcal (MCV4, MPSV4)                                |        |        |        |        |        |
|                      | Human Papilloma Virus (HPV)<br>(9 years or older)          |        |        |        |        |        |
|                      | Influenza (Flu)                                            |        |        |        |        |        |
|                      | Other Vaccine<br>Please specify:                           |        |        |        |        |        |
|                      | Other Vaccine<br>Please specify:                           |        |        |        |        |        |

### For medical exemptions:

Please submit a **letter** signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

**For Immunity Documentation** (history of disease or positive titer): Please submit a **letter** signed by a licensed physician stating:

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

### Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ A health care practitioner
- ☐ The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- |                                                        |                                      |
|--------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria/ Tetanus/Pertussis | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio                         | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Varicella                     | <input type="checkbox"/> Hib         |
| <input type="checkbox"/> Measles/Mumps/Rubella         |                                      |

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

### Optional:

ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

- ☐ Religious belief    ☐ Philosophical belief    ☐ Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

(OFFICE ONLY) Student ID Number:

Date Enrolled:

## VISION HEALTH SCREENING CERTIFICATION

## STUDENT INFORMATION

|                        |                                                                 |        |        |
|------------------------|-----------------------------------------------------------------|--------|--------|
| Last Name (LEGAL NAME) | First Name                                                      | Middle | Suffix |
| Date of Birth          | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F |        |        |

## VISION HEALTH SCREENING REQUIREMENTS

## Student Vision Screening or Eye Exam Requirements

OAR 581-021-0031

1. All students age seven or younger entering an educational program for the first time must submit vision screening/eye examination certification within 120 days of the student beginning school, that the student received:

A. A vision screening or an eye examination; and

B. Any further eye examinations or necessary treatments or assistance of the powers or range of vision of the eye.

2. Vision screenings must be provided by a person licensed by the Oregon Board of Optometry, Oregon Medical Board, a health care practitioner, school nurse, employee of an education provider, or another person who has completed instruction on how to perform vision screenings.

3. Certification of vision screening is not required if the educational program receives a statement that certification was submitted to a prior education provider or if the student's or parent's religious beliefs are contrary to vision screening.

4. Failure to meet the requirements of OAR 581-021-0031 may not result in prohibiting the student from attending school.

## VISION SCREENING OR EYE EXAMINATION RESULTS

|                                  |      |                                                          |                          |                                           |  |
|----------------------------------|------|----------------------------------------------------------|--------------------------|-------------------------------------------|--|
| Childs Name                      |      |                                                          |                          | Date of Exam                              |  |
| Screening or Examing Entity Name |      |                                                          |                          | Phone Number                              |  |
| Right                            | Left | Corrective Lenses                                        | <input type="checkbox"/> | Results vary slightly from normal limits. |  |
| 20/                              | 20/  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | Results are not within normal limits.     |  |

Are there any special instructions?

Physician Signature

Date

## NON-MEDICAL EXEMPTION

I have reviewed the requirements of vision screening or eye examination for students age seven or younger entering an educational program. My child is being raised as an adherent to a religion the teachings of which are opposed to vision screening or eye examinations and I request that my child be exempted from such requirement.

Parent or Guardian Signature

Date

## OTHER EDUCATIONAL ENTITY STATEMENT

I have met the vision screening or eye examination certification requirement by providing certification to another educational entity.

Educational Entity Name:

Parent or Guardian Signature

Date

## PARENT/GUARDIAN SIGNATURE

The information provided on this form is true and accurate of this date.

Parent or Guardian Signature

Date



## West Linn-Wilsonville School District 3Jt

Administration Building/Nursing Services

22210 SW Stafford Road • Tualatin, OR 97062 • (503) 673-7041 or Fax (503) 673-7003 • www.wlww.k12.or.us

### Dental Screening Certification Form

State law now requires a child who is 7 years of age or younger to have a dental screening before entering school for the first time. (HB 2972 (2015))

#### IF YOUR CHILD HAS ALREADY RECEIVED A DENTAL SCREENING

Parent/Guardian:

- If you know your child has already had a dental screening, please check the box below, fill out this section and sign it.
- Please return this form to the school office.

☐ My child \_\_\_\_\_ has received a dental screening.  
(First Name) (Last Name)

Parent/Guardian or Dental Provider

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### TO OPT-OUT OF THE DENTAL SCREENING REPORTING REQUIREMENT

Parent/Guardian: You may choose to have your child opt-out of the required dental screening reporting due to a reason listed below. Please fill out this section and sign it. Then return this form to the school office.

My child was not screened due to the following: (please check all that apply):

- ☐ We already submitted a certification form at a previous school.
- ☐ The dental screening is contrary to student or families religious beliefs.
- ☐ The dental screening is a burden.

**The dental screening is a burden for the student or the parent or guardian of the student when:**

- A. The cost of obtaining the dental screening is too high;**
- B. The student does not have access to a screener or;**
- C. The student was unable to obtain an appointment with a screener**

Parent/Guardian

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_