Sachem Central School District
Student Registration Form

STUDENT INFORMATION: LIST NAME AS APPEARS ON BIRTH CERTIFICATE

Last Name of Student    First Name of Student    Middle Name (not initial)

Address

Mailing Address if Different

IS THE STUDENT HISPANIC, LATINO, OR OF SPANISH ORIGIN?  _________YES  _________NO

Child’s Ethnic Code    Gender:  M or F
1. American Indian/Alaskan Native    Date of Birth  
2. Asian  
3. Black    Birth City and State  
4. White  
5. Native Hawaiian/Pacific Islander    Household Language if not English

Parent/Guardian #1

Last Name    First Name    Marital Status    Relationship to Child

Address (Write SAME if not different from child)

Home Phone    Cell Phone    Work Phone

Parent/Guardian #2 (Please list all parents on the birth certificate even if address is unknown)

Last Name    First Name    Marital Status    Relationship to Child

Address (Write SAME if not different from child)

Home Phone    Cell Phone    Work Phone

* Who does child live with?  Parents_____    Mom _____    Dad _____    Legal Guardian

* Are there any special custody regulations regarding your child?  (Circle One)  YES    NO  (if yes, please provide a copy of the court order)

* Is enrollment related to homelessness?  (Circle One)  YES    NO

* Name and Address of Current or Previous School

Grade  

* Has this child ever attended Sachem Schools, applied for transportation from Sachem or applied for services before including as a pre-schooler?  (Circle One)  YES    NO  If yes, please list last date and school attended

* Does this child receive any Special Education services?  (Circle)  YES    NO  *Has your child been declassified with support services?  YES    NO  

If yes, please check type of service(s) received.  SPECIAL CLASS    RESOURCE ROOM    RELATED SERVICES

* Does this child receive any ESL/ENL Services?  (Circle)  YES    NO  *Has your child ever received ESL Services?  YES    NO

* Please list all brothers and sisters that live in your home under the age of 21. If none, please write N/A.

Name    Date of Birth    Grade    School

Parent/Guardian Signature ____________________________________________________________ Date ____________________________
RESIDENCY QUESTIONNAIRE

Name of LEA:  

Name of School: __________________________________________________________

Name of Student: ____________________________  ____________________________  ____________________________  

Last  First  Middle

Gender:  Male _____  Female _____  Date of Birth  ____/____/_____  Grade: ________

Address: __________________________________________________________  Phone ______________

________________________________________  ______________________________________

The answer you give below may 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 may also be entitled to transportation and other services.

Where is the student currently living?  (Please check one)

_____  In Permanent Housing (house, apartment, trailer)

_____  In a Shelter

_____  With Another Family because of loss of housing or as a result of economic hardship

_____  In a Hotel/Motel

_____  In a Car, Park, Bus, Train or Campsite

_____  Other (please describe) ______________________________________________________

Print Name of Parent, Guardian  
(or Student if Unaccompanied Youth)  

Signature of Parent, Guardian  
(or Student if Unaccompanied Youth)

________________________  
Date

If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.
The above listed student has enrolled in the Sachem Central School District. Please send all applicable records pertaining to this student TO THE SCHOOL INDICATED ON THE REVERSE SIDE OF THIS LETTER. Thank you.

Immunization Records/Current Physical/Health Records

Standardized Test Data/NYS Assessments

Attendance Record

Withdrawal Grades

Most Recent Report Card

Science Labs

Transcript

NYSESLAT Scores

_________________________  _______________________
Parent or Guardian Signature                  Date
Cayuga Elementary School  
865 Hawkins Avenue  
Lake Grove, NY 11755

Chippewa Elementary School  
31 Morris Avenue  
Holtsville, NY 11742

Gatelot Avenue Elementary School  
65 Gatelot Avenue  
Lake Ronkonkoma, NY 11779

Grundy Avenue Elementary School  
950 Grundy Avenue  
Holbrook, NY 11741

Hiawatha Elementary School  
97 Patchogue-Holbrook Road  
Lake Ronkonkoma, NY 11779

Lynwood Avenue Elementary School  
50 Lynwood Avenue  
Farmingville, NY 11738

Merrimac Elementary School  
1090 Broadway Avenue  
Holbrook, NY 11741

Nokomis Elementary School  
1515 Holbrook Road  
Holbrook, NY 11741

Tamarac Elementary School  
50 Spence Avenue  
Holtsville, NY 11742

Tecumseh Elementary School  
179 Granny Road  
Farmingville, NY 11738

Waverly Avenue Elementary School  
1111 Waverly Avenue  
Holtsville, NY 11742

Wenonah Elementary School  
251 Hudson Avenue  
Lake Grove, NY 11755

Sagamore Middle School  
57 Division Street  
Holtsville, NY 11742

Samoset Middle School  
51 School Street  
Lake Ronkonkoma, NY 11779

Seneca Middle School  
850 Main Street  
Holbrook, NY 11741

Sequoya Middle School  
750 Waverly Avenue  
Holtsville, NY 11742

Sachem High School North  
212 Smith Road  
Lake Ronkonkoma, NY 11779  
Attn: Loretta Burns

Sachem High School East  
177 Granny Road  
Farmingville, NY 11738  
Attn: Guidance
Dear Parent of Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

**Student Name:**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

**Date of Birth:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

**Parent PERSON IN PARENTAL RELATION INFO:**

| Last Name | First Name | Relation to Student |

**Home Language Code**

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### Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student’s home or residence?

   - English
   - Other [specify]

2. What was the first language your child learned?

   - English
   - Other [specify]

3. What is the Home Language of each parent/guardian?

   - Mother [specify]
   - Father [specify]
   - Guardian(s) [specify]

4. What language(s) does your child understand?

   - English
   - Other [specify]

5. What language(s) does your child speak?

   - English
   - Other [specify]
   - Does not speak

6. What language(s) does your child read?

   - English
   - Other [specify]
   - Does not read

7. What language(s) does your child write?

   - English
   - Other [specify]
   - Does not write

---

**THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:**

<table>
<thead>
<tr>
<th>School District Information:</th>
<th>Student ID Number in NYS Student Information System:</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Name</td>
<td>Number</td>
</tr>
</tbody>
</table>
Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.
   Yes*  No  Not sure
   ☐  ☐  ☐  *If yes, please explain:

   How severe do you think these difficulties are?  ☐ Minor  ☐ Somewhat severe  ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?  ☐ No  ☐ Yes*  *Please complete 10b below

10b. **If referred for an evaluation, has your child ever received any special education services in the past?
   ☐ No  ☐ Yes – Type of services received:

   Age at which services received (Please check all that apply):
   ☐ Birth to 3 years (Early Intervention)  ☐ 3 to 5 years (Special Education)  ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?  ☐ No  ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school?

__________________________
Signature of Parent or of Person in Parental Relation

__________________________
Month  Day  Year
Date

Relationship to student:  ☐ Mother  ☐ Father  ☐ Other:__________________________

__________________________
Name of English Speaking Contact

__________________________
Phone Number of Contact

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING HLQ

NAME: ____________________________  POSITION: ____________________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: ____________________________  POSITION: ____________________________

ORAL INTERVIEW NECESSARY:  ☐ No  ☐ Yes

**DATE OF INDIVIDUAL INTERVIEW: ____________________________

OUTCOME OF INDIVIDUAL INTERVIEW:  ☐ ADMINISTER NYSTELL
                                          ☐ ENGLISH PROFICIENT
                                          ☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSTELL

NAME: ____________________________  POSITION: ____________________________

DATE OF NYSTELL ADMINISTRATION: ____________________________

PROFICIENCY LEVEL ACHIEVED ON NYSTELL:
                                          ☐ ENTERING  ☐ EMERGING  ☐ TRANSITIONING  ☐ EXPANDING  ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:
STUDENT NAME ________________________________________________________

DATE OF BIRTH ___________________

HEALTH HISTORY – PAGE 1
If your child has had any of the following, please describe and include the dates:

Allergies:
  Environmental
  Food
  Medication

Anemia

Sickle Cell

Sickle Cell Trait

Asthma/Medication Used

Cancer

Cystic Fibrosis

Diabetes/Medication Used

Insulin Dependent

Heart Disease

Heart Surgery

Hearing Loss
  Loss ________________ r __________ l __________
  Has your child received services for this hearing problem? ____________________________

Chronic Ear Problems

Hemophilia/Bleeding Disorders

Gastrointestinal Disease

Hospitalizations/Operations
  _____ Reason ____________________________________________________________

Vision Problem
  Loss ________________ r __________ l __________
  Has your child received services for this vision problem? ____________________________
### Student Name

______________________________

### Date of Birth

______________________________

#### Health History – Page 2

<table>
<thead>
<tr>
<th>Condition</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoliosis</td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
</tr>
<tr>
<td>Concussion</td>
<td>Other</td>
</tr>
<tr>
<td>Serious Injuries</td>
<td></td>
</tr>
</tbody>
</table>

#### Seizure Disorders

- Grand Mal
- Petit Mal
- Focal
- Other

#### Illnesses (please circle):

- Chicken Pox – Doctor’s verification is needed
- Measles
- Mumps
- German Measles
- Rheumatic Fever
- Pertussis

Is there anything concerning your child’s health that the school should know in order to provide special care?

Yes ___________________________    No ________________________________

If yes, please explain:  ______________________________________________________________________

________________________________________________________________________________________

Please be advised that a yearly examination by your family physician is advisable. Physical examinations are required for all new entrants and must be dated within 12 months of the date your child enters school.

Physicals are also mandated for students entering Kindergarten, grades 2, 4, 7 and 10. Again, the physical must be dated within 12 months.

These examinations are performed for the purpose of detecting problems in their early stages with the hope of directing attention to them for proper medical treatment.
Dear Parent/Guardian:

During the 2015-2016 school year, the opportunity may arise for your child’s image/photograph or work to be included in a classroom or school project that could be used in one of the following ways:

- Posted on the school or district web pages
- Appear in videos made during a student presentation of their project, or in broadcasts or videos demonstrating multimedia in general
- Used in a printed publication such as a newspaper or magazine
- As a demonstration or example in an educational workshop/class/conference
- Submitted as contest entries
- Recorded to appear in a school-related programs or news broadcast to be used by a local television station or school/county project

Posted student work may be accompanied by a first name only to be used as identification, but any posted student images WILL NOT include your child’s name, without additional express written permission. Under no circumstances will an address or phone number for any student be included in any such posting.

While the Sachem Central School District values the merits associated with the use of the district web pages, associated websites and media outlets, we are also cognizant of the fact that this content is accessible through the Internet on a worldwide basis. We also understand that there are individuals in this world who misuse information that is available through the Internet. While we do not suggest that any of the information that is on the Sachem web pages has been misused, or will be misused, it is important that the appropriate adult/parent/guardian grant permission for the our use of pictures of students on our web pages.

---

**WEB PAGE PICTURES**

I  [ ] do  [ ] do not authorize the Sachem School District to use any pictures of my child

______________________________________________, grade _____, on the Sachem web pages and associated websites in the 2015-2016 school year.

__________________________________________  (Parent or guardian signature)  ______________________ (Date)

PLEASE RETURN TO YOUR CHILD’S HOMEROOM TEACHER.
PLEASE USE ONE FORM FOR EACH CHILD.
Dear Parent/Guardian:

During the 2016-2017 school year, the opportunity may arise for your child’s image/photograph or work to be included in a classroom or school project that could be used in one of the following ways:

- Posted on the school or district web pages
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**WEB PAGE PICTURES**

I  □ do  □ do not authorize the Sachem School District to use any pictures of my child

________________________________________, grade _______ , on the Sachem web pages

and associated websites in the 2016-2017 school year.

________________________________________  __________________________________

(Parent or guardian signature)  (Date)

PLEASE RETURN TO YOUR CHILD’S HOMEROOM TEACHER.
PLEASE USE ONE FORM FOR EACH CHILD.
NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE). Sports physical must be dated within a year of previous physical and will be valid for the entire school year.

**Sachem Central School District**

Physical Examination Form

Date of Examination

Name

Last

First

Phone

Grade

Birth Date

, 20

Address

No.

Street

Town

Zip

Family Physician

Phone

Gender: Male  Female

**IMMUNIZATIONS / HEALTH HISTORY**

Immunization Record Attached

Sickle Cell Screen: Positive  Negative  Not Done  Date:

No Immunizations Given Today

PPD: Positive  Negative  Not Done  Date:

Tetanus Date:

Elevated Lead: Yes  No  Not Done  Date:

Immunizations Given Since Last Health Appraisal:

Dental Referral: Yes  No  Not Done  Date:

Significant Medical/Surgical History:

See Attached

Allergies: LIFE THREATENING

Food

Insect

Seasonal

Medication

Other

**PHYSICAL EXAM**

Check here if entire exam normal

Height

Weight

Blood Pressure

Check (✓) Equals Normal Finding:

Asthma

Skin:

Diabetes Type 1  Type 2

Lungs:

Hyperlipidemia

Heart:

Hypertension

Hernia:

Scoliosis: Negative  Positive:

Urinalysis: Protein  Sugar

Tanner: I.  II.  III.  IV.  V.

Specify any abnormalities:

**MEDICAL APPROVAL RECOMMENDED**

SPORTS CATEGORIES: Sports participation in the following categories is recommended as follows for the school year 20____ to 20____

Please initial all that apply:

- CONTACT/COLLISION (Field Hockey, Football, Lacrosse, Soccer, Wrestling)
- LIMITED CONTACT/IMPACT (Baseball, Basketball, Diving, Gymnastics, Softball, Volleyball)
- STRENUOUS NON-CONTACT (Cross Country, Track & Field, Swimming, Tennis, Cheerleading, Kickline/Dance)
- NON-STRENUOUS/NON-CONTACT (Bowling, Golf)

For unmarked categories, state reasons and provide medical conditions below.

**PHYSICIAN INFORMATION:**

Name of Physician (Print/Type/Stamp)

Address

Phone

Signature of Physician

Date

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.
Preparticipation Physical Examination Questionnaire  

To be completed and signed by a parent or guardian

1. Have you had a medical illness or injury since your last check-up or sports physical?
   - YES □  NO □

2. Have you ever been hospitalized overnight?
   - YES □  NO □

3. Have you ever had surgery?
   - YES □  NO □

4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?
   - YES □  NO □

5. Have you ever taken any supplements or vitamins to help you improve your performance?
   - YES □  NO □

6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
   - YES □  NO □

7. Have you ever had a rash or hives develop during or after exercise?
   - YES □  NO □

8. Have you ever been dizzy or passed out during or after exercise?
   - YES □  NO □

9. Have you ever had chest pain during or after exercise?
   - YES □  NO □

10. Have you ever had high blood sugar (diabetes)?
    - YES □  NO □

11. Have you ever been diagnosed with anemia?
    - YES □  NO □

12. Have you ever had racing of your heart or skipped heartbeats?
    - YES □  NO □

13. Have you ever had high blood pressure?
    - YES □  NO □

14. Have you ever been told you have a heart murmur?
    - YES □  NO □

15. Has any family member or relative died of heart problems or of sudden death before age 50?
    - YES □  NO □

16. Have you had a severe viral infection?
    - YES □  NO □

17. Has a physician ever denied or restricted your participation in sports for any heart problems?
    - YES □  NO □

18. Have you ever been diagnosed with blood or bleeding disorders?
    - YES □  NO □

19. Have you ever had a kidney or bladder problem (absence of a paired organ)?
    - YES □  NO □

20. Have you ever had a head injury or concussion?
    - YES □  NO □

21. Have you ever been knocked out, become unconscious, or lost your memory?
    - YES □  NO □

22. Have you ever had a seizure or convulsion?
    - YES □  NO □

23. Do you have frequent or severe headaches?
    - YES □  NO □

24. Do you cough, wheeze, or have trouble breathing during or after activity that prevents you from playing?
    - YES □  NO □

25. Do you have asthma or lung disease?
    - YES □  NO □

26. Do you have seasonal allergies that require medical treatment?
    - YES □  NO □

27. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or position (for example, knee brace, foot orthotics, retainer on your teeth, hearing aid)?
    - YES □  NO □

28. Have you ever had any problem with your ears or hearing?
    - YES □  NO □

29. Do you tire more easily than you feel you should?
    - YES □  NO □

30. Have you ever had any problem with your eyes or vision?
    - YES □  NO □

31. Have you ever had dental health problems?
    - YES □  NO □

32. Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?
    - YES □  NO □

33. Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports?
    - YES □  NO □  

   If yes, check appropriate box and explain below.
   - Head □  Elbow □  Hip □  Neck □  Forearm □  Thigh □  Back □ Wrist □  Knee □  Chest □  Hand □  Shin/Calf □  Shoulder □  Finger □  Ankle □  Upper Arm □  Foot □

FEMALES ONLY

34. Has there been a recent change in menstrual patterns?
    - YES □  NO □

35. At what age did you experience your first menstrual period?
    - YES □  NO □

36. When was your most recent menstrual period? ___/___/___

37. How much time do you usually have from the start of one period to the start of another?
    - YES □  NO □

38. How many periods have you had in the last year? _________

39. What was the longest time between periods in the last year? _________

Explain “Yes” Answers Here (Identify each answer with question number)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

RISK ACKNOWLEDGEMENT FORM

I give permission for ______________________ to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage or contest without proper medical clearance.

Further, I acknowledge that participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range from minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities.

I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appropriate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided by family physicians and retain the right of final approval.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian ________________________________ Date ________________
Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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

Month Day Year

Will this be your child’s first oral health assessment? □ Yes □ No

School: ____________________________ 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/ Dental Hygienist

I. The dental health condition of _______________________________ on__________ (date of assessment)

The date of the assessment 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/ Dental Hygienist’s name and address

(please print or stamp)

Dentist’s/Dental Hygienist’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 ½ mm 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):________________________________________

II. 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.