Kinder Academy, Inc
Preschool Application
for Academic Year
2024-2025

To qualify:

1. Child must be at least 3 years old on or before September 1, 2024 and not be age-eligible for kindergarten; and,
2. Child and family must live in Philadelphia, PA; and,
3. Family must meet current Head Start or PA Pre-K Counts income guidelines; and,
4. Child's complete Preschool Application, forms and required supporting documents, must be submitted to and received by the appropriate preschool program:
    - To apply for a Kinder Academy preschool program hand-deliver your child's application to:

Kinder Academy - Castor
7332 Elgin Street
Philadelphia, PA 19111
267-571-6800

Kinder Academy – Trinity
6901 Rising Sun Avenue
Philadelphia, PA 19111
267-839-0039

Kinder Academy – Oxford
900 E. Howell Street
Philadelphia, PA 19149
267-571-5661

Kinder Academy – Rhawnhurst
7922 Bustleton Avenue
Philadelphia, PA 19152
215-728-7700

Kinder Academy – Parkwood
3001 Byberry Road
Philadelphia, PA 19154
215-728-7700

Kinder Academy, Inc
Preschool Application for
Academic Year
2024 – 2025

Thank you for your interest in our preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to a preschool program. For your best chance at acceptance, please submit your child's completed application **as soon as possible**.

Complete ALL necessary steps below. As you collect each item, check off the box.
Applications will not be accepted without all supporting documentation.

- ☐ I have filled out the entire application.
- ☐ I have proof of child's date of birth (Birth certificate, Passport health insurance card, etc.).
- ☐ I have documentation of family income (Tax forms, 4 consecutive paystubs, or financial support letter. 1040 tax form is the preferred document).
- ☐ I have proof of Philadelphia residency (bill, lease, etc.).
- ☐ I have my child's health insurance card.
- ☐ I have my child's physical (health assessment within the year) and immunizations.
- ☐ I have proof of child's dental visit (within the year).
- ☐ I have picture identification of parent/guardian (Current State or Federal Photo ID).
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance (if applies to you).
- ☐ I have a custody order (if applies to you).
- ☐ I have a foster letter (if applies to you).
- ☐ I have a homeless verification letter/shelter letter (if applies to you).

PRIMARY PARENT

The adult who is primarily responsible for the care and well-being of the child.

First Name:		**Last Name:**	
Date of Birth:		**Gender:** ◯ Male ◯ Female	
Primary language:		**Other language(s):**	
Home Address:			
Apt./Unit #:	**City:**	**State:**	**Zip Code:**
Phone #:		**Email Address:**	
# of People in household		**# of People in family**	

Marital Status Select one	◯ Married	◯ Single	◯ Widowed	◯ Separated/Divorced
Relationship to Child Select one	◯ Parent/Step-Parent		◯ Grandparent	
	◯ Foster/Kinship Parent, related to child		◯ Foster Parent, not related to child	
	◯ Guardian, related to child		◯ Guardian, not related to child	
	◯ Other (specify):		◯ Teen Parent – parent was under the age of 18 when child was born	
Race/Ethnicity Select all that applies	☐ Hispanic or Latino/a	☐ American Indian	☐ Asian	
	☐ Black or African American	☐ Multi-Racial or Bi-Racial	☐ Native Hawaiian	
	☐ Pacific Islander	☐ White	☐ Other (specify):	
Education Select highest Diploma/Degree earned or highest Grade Level completed	◯ High School Diploma	◯ GED	◯ ESL – English as a Second	
	◯ Some college/Vocational/Associates		◯ Bachelors/Advanced degree	
	◯ 11th Grade	◯ 10th Grade	◯ 9th Grade or lower	
Employment, School, Job Training Select all that applies	☐ Employed/Self-Employed	☐ Unemployed/Not Employed	☐ Disabled	
	☐ Member of the U.S. military on active duty	☐ Veteran of the U.S. military		

Do you have health insurance? *If 'Yes', name of health insurance provider:*						☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No	**Are you receiving mental health treatment?**			☐ Yes	☐ No
Do you receive benefits?	☐ WIC	☐ SNAP	☐ Medical	☐ TANF Cash		☐ SSI	

SECONDARY PARENT

An adult who shares in the care of the child.

First Name:		**Last Name:**	
Date of Birth:		**Gender:** ☐ Male ☐ Female	
Employment, School, Job Training Select all that applies	☐ Employed/Self-Employed	☐ Unemployed/Not Employed	☐ Disabled
	☐ Member of the U.S. military on active duty	☐ Veteran of the U.S. military	

LOCATIONS

CHOOSE THE LOCATION(S) WHERE YOU WOULD LIKE: Your child may be selected for your second choice. Do not put a location that you are not willing or able to take your child regularly and on time. Transportation is not provided.

1st Location Choice:	**2nd Location Choice:**

PREK CHILD

First Name:	**Last Name:**
Date of Birth:	**Gender:** ◯ Male ◯ Female

Race/Ethnicity Select all that applies	☐ Hispanic or Latino/a	☐ American Indian	☐ Asian
	☐ Black or African American	☐ Multi-Racial or Bi-Racial	☐ Native Hawaiian
	☐ Pacific Islander	☐ White	☐ Other (specify):

Primary language:		**Other language(s):**		
Child is receiving Early Intervention services:	☐ IEP	☐ EFSP	☐ ER	☐ Suspected
Child's mother and/or father is currently incarcerated:			◯ Yes	◯ No

HOUSING

Housing Information Select your current situation	◯ Own	◯ Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing – Since what date?	◯ Transitional housing – Since what date?
	◯ Rent	◯ Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.	◯ Train or bus station, park or in car- Since what date?
	◯ Shelter – Since what date?	◯ Hotel/Motel, camping ground or other similar situation due to lack of alternative, adequate housing or due to the loss of housing– Since what date?	◯ Apartment or house lacking utilities (water, heat, electricity, etc.)
	Secondary Care Giver lives with Family?		◯ Yes ◯ No
	Another person over the age of 18 living in the household?		◯ Yes ◯ No

Optional Information	New to the country?	☐ Yes	☐ No
	Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?	☐ Yes	☐ No

FAMILY INCOME

Primary Caregiver Income			Secondary Caregiver Income		
Employment Type	**Amount**	**Frequency**	**Employment Type**	**Amount**	**Frequency**
☐ Employment			☐ Employment		
☐ SSI/ TANF CASH			☐ SSI/ TANF CASH		
☐ Unemployment			☐ Unemployment		
☐ Other:_____			☐ Other:_____		

I understand that this information will be used to create my Parent Portal COPA account, and I will receive an email with my sign-in information at the email given on this form. I understand that my application is not complete until I sign in and upload my all supporting documentation.

Guardian Signature:_____ Date:_____

Staff Signature: _____ Date:_____

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CHILD'S HEALTH HISTORY

Child's Name _____ Date of Birth _____

Parent/Guardian Name _____ Today's Date_____

PREGNANCY and BIRTH INFORMATION

Did mother visit the physician fewer than 2 times during pregnancy? ☐ No ☐ Yes ~ If Yes, explain_____

_____

Did mother or child stay in the hospital for medical reasons longer than usual? ☐ No ☐ Yes ~ If Yes, explain_____

_____

Place of birth _____ Birth weight _____ lbs. _____ oz.

Type of delivery: ☐ Vaginal ☐ C-Section (please explain why)

_____

Was your child born more than 3 weeks before or after due date? ☐ No ☐ Yes ~ If Yes, please explain

_____

Were there any problems with the mother or child:

During pregnancy: ☐ No ☐ Yes ~ If Yes, explain _____

During delivery: ☐ No ☐ Yes ~ If Yes, explain _____

After delivery: ☐ No ☐ Yes ~ If Yes, explain _____

During pregnancy did the mother use: ☐ Cigarettes ☐ Alcohol ☐ Drugs ☐ Prescription Medicine

Is this child's mother/guardian pregnant now? ☐ No ☐ Yes

CHILD'S HOSPITALIZATIONS and ILLNESSES

Overnight hospitalization: ☐ No ☐ Yes ~ If Yes, explain _____

Emergency Room Visit: ☐ No ☐ Yes ~ If Yes, explain _____

Serious Accident: ☐ No ☐ Yes ~ If Yes, explain _____

Serious Illness: ☐ No ☐ Yes ~ If Yes, explain _____

Surgery: ☐ No ☐ Yes

If Yes: Type of surgery_____

Date of surgery _____ Name of Hospital_____

Problems or complications_____

Seizures ☐ No ☐ Yes

If Yes:

Type of seizure_____

Reaction_____

Duration_____

Medication _____

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Child's Name _____ Today's Date _____

Part I: Place a check mark in the **No** or **Yes** column next to each item. For all **Yes** responses, please explain in the **Comments** column.

DOES YOUR CHILD	NO	YES	COMMENTS
Wear glasses	☐	☐	
Have a lazy eye, crossed eyes, wandering eyes, other eye conditions	☐	☐	
Have a history of ear infections, tubes in ears, hearing loss, wear hearing aid	☐	☐	
Have excessive colds, sore throats, coughing episodes, or snores loudly	☐	☐	
Have a history of asthma or bronchitis	☐	☐	
Have a heart murmur, a resolved heart murmur, rheumatic fever or other heart conditions	☐	☐	
Have a history of anemia, sickle cell disease, elevated lead level or other blood conditions such as G6PD, hemophilia, etc.	☐	☐	
Have or had an umbilical or inguinal hernia	☐	☐	
Have reflux, stomach pain, diarrhea, constipation	☐	☐	
Have a feeding tube	☐	☐	
Have trouble urinating, urinary tract infection or kidney disease	☐	☐	
Wear diapers/pull-ups	☐	☐	
Have diabetes (If Yes, please indicate Type I or Type II diabetes)	☐	☐	
Have rashes, eczema, hives, boils	☐	☐	
Have neuropathy, muscle tics, spina bifida, muscular dystrophy, cerebral palsy	☐	☐	
Wear leg braces	☐	☐	
Use a cane, walker or wheelchair	☐	☐	
Have (or had) polio, chicken pox, measles, mumps, scarlet fever, whooping cough	☐	☐	
Have car sickness	☐	☐	
Have allergies due to medication or food	☐	☐	
Have allergies due to seasonal changes, animals or other	☐	☐	
Take medication daily or on an 'As Needed' basis	☐	☐	

Please share with us any health concerns you have for your child

_____

_____

_____

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POLICIES AND CONSENT FOR EMERGENCY MEDICAL CARE AND SCREENINGS

This form will be taken with the child when emergency medical care is needed.

Child's Name: _____

The parent is responsible for making arrangements for alternative care for your child if he/she is ill, needs close supervision or has a contagious condition and cannot attend preschool. The parent is also responsible for transportation if your child has an illness or minor injury while at preschool, not sufficiently severe to warrant emergency medical transportation.

In the event your child becomes seriously ill or injured and requires immediate medical attention, he/she will be accompanied by a School District of Philadelphia staff person and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify the parent at once. Under the Medical Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that both Early Childhood and the hospital be able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's preschool teacher informed about how to reach you when you are not at home or at work/school.

Parents are responsible for the costs of medical treatment if their child is injured. Please contact Early Childhood Health Services if your child needs medical insurance.

A Doctor's note will be required before your child can return to preschool if he/she has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requiring a long absence or surgery, etc.) or certain cases of injury (needing doctor's care, cast or brace, special activities, etc.). If you have any doubt, please obtain a Doctor's note whenever your child goes for medical care.

CONSENT FOR EMERGENCY MEDICAL CARE AND PREVENTIVE SCREENINGS

My signature below indicates that I give consent for:

1. The administration of minor first aid to my child by preschool classroom staff
2. The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for ongoing care
3. My child to participate in the Office of Early Childhood screening program which may include, but is not limited to; developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of the School District of Philadelphia receive screenings during the school year.

Signature of Guardian: _____ Date: _____

If you have any questions about the above information, please speak with a representative from Early Childhood Health Services.

Early Childhood Use Only

Name of Early Childhood Location: _____

Signature of Early Childhood Staff: _____ Date: _____

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Child Social Development

Parent/Guardian: Please complete the entire form to the best of your knowledge. Your answers will help us to better understand and assist your child while enrolled in preschool.

Child's Name _____ Date of Birth _____

Parent/Guardian Name _____Today's Date _____

1. Please list the activities your child enjoys _____
2. Please list the activities your child does not enjoy _____
3. Does your child take a nap? ☐ No ☐ Yes ~ If Yes, when? _____ For how long? _____
4. What time does your child usually: Go to sleep at night? _____ Wake up in the morning? _____
5. Does your child sleep with a light on? ☐ No ☐ Yes
6. Does your child have bedtime routine? ☐ No ☐ Yes ~ If Yes, please describe _____
   _____
7. Does your child have trouble sleeping? ☐ No ☐ Yes ~ If Yes, please describe _____
8. _____
   a) What words or actions does your child use to indicate that s/he needs to use the bathroom?
   _____
   b) Does your child use diapers/pull ups? Yes☐ No☐ If yes, when?_____
9. How does your child act with children s/he does not know? _____
10. How does your child act with adults s/he does not know? _____
11. Please tell us what your child is afraid of _____
12. How do you comfort your child? _____
13. Does your child have difficulty expressing what s/he wants? ☐ No ☐ Yes
14. Do you have difficulty understanding your child? ☐ No ☐ Yes ~ If Yes, please explain how you communicate:
    _____
15. Have there been big changes in your child's life within the last 6 months? ☐ No ☐ Yes ~ If Yes, please describe _____
16. Children learn to do things at different ages. So that we can better fit our program to meet your child's needs, please tell us, as best as you can remember, what age your child began the following tasks?

TASK	AGE		TASK	AGE
Sit up without help			Toilet trained	
Crawl			Respond to directions	
Walk			Play with toys	
Talk			Use crayons	
Feed and dress self			Understand what is said	

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NUTRITION HISTORY

Child's Name _____ Today's Date _____

1.What foods does your child like? _____

2.What foods does your child dislike? _____

3.Place a check mark in the No or Yes column next to each question:

	No	Yes
Does your child take vitamins?		
Do the vitamins contain iron?		
Do the vitamins contain fluoride?		
Are the vitamins prescribed by a doctor?		
Is your child on a special diet?		
Is the diet recommended by a doctor?		
Has there been a noticeable change in your child's appetite in the last month?		
Does your child drink from a bottle?		
Does your child eat or chew things that aren't food? (ex: dirt, clay, paint chips)		
Does your child have trouble chewing or swallowing?		
Does your child often have diarrhea?		
Does your child often have constipation?		
Do you have any concerns about what your child eats?		
Are you receiving WIC?		
Are you receiving Food Stamps?		

4. Place a check mark under the column that indicates the approximate number of times a week your child eats the following foods:

	0	1	2	3	4	5	6	7	7+
Milk ~ whole, skim, low fat, lactose free									
Cheese, yogurt									
Eggs									
Peanut butter									
Beans, peas, soy, tofu, lentils									
Nuts, seeds									
Beef, chicken, turkey									
Fish, shellfish									
Rice, noodles, bread, tortillas, crackers, cereal									
Green vegetables, spinach, collard greens									
Winter squash, pumpkin, sweet potatoes, carrots									
Oranges, grapefruit, tomatoes, broccoli, fruit juice									
Other fruits and vegetables									
Oil, butter, margarine, jams, jellies, olive oil									
Cakes, cookies, sodas, fruit drinks, candy									

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5. Where do you usually take your child for health care services (Medical Home)?

Name _____

Address _____ Zip _____ Phone number _____

6. Where do you usually take your child for dental care services (Dental Home)?

Name _____

Address _____ Zip _____ Phone number _____

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CHILD'S MEDICAL CONCERNS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

The Office of Early Childhood Education recognizes the fact that some children have a medical condition that requires prescribed medication. When the prescribed medication is to be administered during preschool hours, a representative from Early Childhood Health Services, with written permission, will train the staff at your child's preschool to administer the medication to your child. Written permission is given by submitting form MED-1: Request for Administration of Medication, completed by you and your child's health care provider for each medication. **At no time will medication be given to your child without a completed MED-1.**

Please check one box and complete as necessary – use additional paper if needed:

☐ At this time, my child does not have a medical condition.

☐ My child has the following medical condition(s):
A representative from Early Childhood Health Services may contact you for more information.

1. Diagnosis or medical condition:

_____

☐ Does not require medication to be administered

☐ Requires medication to be administered **DAILY** Medication name, dose and times

_____

☐ Requires medication to be administered **AS NEEDED** Medication name and dose

_____

2. Diagnosis or medical condition:

_____

☐ Does not require medication to be administered

☐ Requires medication to be administered **DAILY** Medication name, dose and times

_____

☐ Requires medication to be administered **AS NEEDED** Medication name and dose _____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is a change to the information indicated above.

_____ _____ _____

Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

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CHILD'S DIETARY or FOOD RESTRICTIONS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

The Child and Adult Care Food Program (CACFP) provides a daily nutritional breakfast, lunch and snack for your child while enrolled in preschool at no cost to families. A monthly menu, posted in each location, lists the foods and beverages that your child is offered at each meal. The Office of Early Childhood Education recognizes the fact that certain foods, due to medical, religious or other reasons, are restricted from some children's diets. Please tell us about your child. This information will be shared with your child's nutritional, health and instructional staff. If your child has a non-disabling dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a food allergy which requires the administration of an **EPI-PEN, Benadryl or other medication**, please let us know immediately so that we can begin the process required to train the preschool staff.

Please check one box and complete as necessary – use additional paper if needed:

☐ At this time, my child does not have a dietary or food restriction.

☐ My child has the following dietary or food restriction(s):

1. Name of restricted food: _____
   ☐ Medical – please indicate reaction and treatment: _____
   _____
2. Name of restricted food: _____
   ☐ Medical – please indicate reaction and treatment: _____
   _____

The information on this form is true to the best of my knowledge. I will inform my child's teacher if any of this information changes.

_____ _____

Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: Date: _____

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FAMILY INTEREST SURVEY

Head Start is committed to providing workshops and training opportunities that meet the needs of parents and caregivers. We want these opportunities to be interesting, informative, helpful and fun. Throughout the year you will receive information through many different resources such as information flyers, workshops and parent meetings. Please take a few minutes to complete the survey below to assist us in better serving you this year.

Family Name: _____Child's Name: _____

CHILD DEVELOPMENT
- ☐ Ages 3-5
- ☐ Infants and toddler's
- ☐ Reading with children
- ☐ Potty training
- ☐ Discipline
- ☐ Other_____

MENTAL HEALTH
- ☐ Building relationships
- ☐ Building self – esteem
- ☐ Stress management
- ☐ Death, dying & grief support
- ☐ Understanding anger
- ☐ How to deal with fear
- ☐ Dealing with substance abuse (alcohol or drugs)
- ☐ Domestic violence
- ☐ Counseling resources
- ☐ Bullying
- ☐ Time management
- ☐ Becoming trauma informed
- ☐ Other_____

PARENTING/ FAMILY LIFE
- ☐ Child support laws
- ☐ Peer pressure issues
- ☐ Step parenting & blended families
- ☐ Grandparents raising children
- ☐ Childcare after school
- ☐ Divorce / separation
- ☐ Sibling rivalry
- ☐ Fatherhood
- ☐ Caring for the elderly
- ☐ Custody Issues
- ☐ Co-parenting/communication
- ☐ Child Abuse laws
- ☐ Other_____

HOME MANAGEMENT
- ☐ Budgeting / money management
- ☐ Credit counseling
- ☐ Law on Renters rights
- ☐ Cost saving household tips
- ☐ Furniture / appliances
- ☐ Housing repairs / weatherization
- ☐ Energy assistance
- ☐ Using coupons
- ☐ Housing
- ☐ Other_____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

○ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
○ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
○ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
○ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
○ NONE

DIAPER CREAM AND ANY TYPE OF SUNSCREEN MAY BE APPLIED AS NEEDED:
○ YES ○ NO IF NO, PLEASE EXPLAIN YOUR ANSWER

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
○ YES ○ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

○ YES ○ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name _____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes

   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:

   Dental Examination _____ Teeth Cleaning _____ Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes

   If Yes, type of dental treatment _____

   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit _____

Dental Office Stamp

_____

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

_____