ST. GREGORY PARISH SCHOOL

"WHERE FAITH AND KNOWLEDGE MEET."

Thank you for your interest in Saint Gregory Parish School. It is our mission to provide quality education in a safe, Christian environment for all students. Saint Gregory School has been serving the North East and surrounding communities since its inception in 1941. We are proud of our school and the work that we do expressed through our mission statement: Saint Gregory School- "Where Faith and Knowledge Meet" - Nurturing Christian Leadership One Student at a Time. Programs and services include:

- Partnership with Mercyhurst University
- Saint Gregory-Mercy Scholarship - tuition scholarship to attend Mercyhurst University
- Saint Gregory School offers a faith based education with strong academic programs in Preschool, Pre- Kindergarten and K-8th Grade. Before and after school care.
- Saint Gregory School is accredited through Middle States Association of Colleges and Catholic Schools.
- Saint Gregory's multi-age structure allows for individualized academic instruction.
- SGS students consistently perform above national average in standardized testing.
- School Wide Science Program enhanced with Starlab, field trips to Mercyhurst University, Carnegie Science Programs, Invention Convention, Science Fair and day and overnight camping at Camp Notre Dame.
- Academic enrichment and academic support through reading and math specialists.
- Speech Therapy on site.
- Bowling and Swim classes supplement our 2 times per week physical education classes.
- Library, Art, Choir, Computer and Spanish Instruction; Multi-Age Interest Clubs.
- School and community based service projects. Liturgy and prayer services.
- Participation in county and diocesan academic competitions.
- Sports include:
    - Biddy Soccer and Biddy Basketball – K-4th grade
    - Co-Ed Varsity and JV Soccer Teams
    - Boys and Girls Varsity and JV Basketball
    - Cross Country 1st-8th Grade

We welcome your questions and interest in our school.

Sincerely, Nancy L. Pierce

Nancy L. Pierce School Principal

Mercyhurst COLLEGE

Saint Gregory-Mercy Scholarship

A K-16 Commitment to Catholic Education

Mercyhurst College believes in the commitment to Catholic identify and Mercy heritage, a commitment to a culture and community where faith, reason, and action intersect.

Today many families will make a conscious and long-term commitment to Catholic education (K-12), and Mercyhurst College wants to recognize the significance of that commitment to faith and academics by providing the Saint Gregory-Mercy Scholarship.

This Scholarship will be offered to those students who will be, or are currently enrolled in Level I at Saint Gregory Thaumatugus Catholic School in North East, PA beginning the Fall of 2009, remain at Saint Gregory's until graduation at 8th grade, enroll at Mercyhurst Preparatory School for 9th grade, and graduate from Mercyhurst Preparatory School.

The Saint Gregory-Mercy Scholarship will provide a 75% reduction in tuition to all students who qualify for admission to Mercyhurst. This reduction will be applied to the balance owed to the college for tuition and fees, after subtracting all other need-based and merit based financial aid for which the student may be eligible, including the typical federal student loan. For example, if tuition and fees is $25,000 and the student qualifies for $12,000 in financial aid, the balance owed would be $13,000. The scholarship would be valued at 75% of $13,000 or $9,750, and the student would owe the college $3,250.

Thomas J. Gamble, Ph.D.
President, Mercyhurst College

11 July 2009
Date

Michael Lyden, Ph.D.
Vice President of Enrollment, Mercyhurst College

7/13/09
Date

Diocese of Erie
Application Form
Elementary and Middle Schools

Saint Gregory Parish School
140 West Main Street
North East, PA 16428

Name of School: _____ City: _____

Dear Parents/Guardians,

Thank you for your interest in a Catholic school in the Diocese of Erie where excellence in education is a tradition. With faith in Jesus Christ and commitment to living and teaching Gospel values, we educate the student spiritually, intellectually, emotionally, physically, and socially.

Please complete this application and return it to the school office. Once all necessary documents have been received, your application will be reviewed and you will be contacted. All information will be held confidential according to the Family Educational Rights and Privacy Act (FERPA) regulations. Completion of this application does not guarantee enrollment. In addition, it should be noted that based on a review of the data received through this application process, the student may be accepted on a provisional basis for a specified time period.

Thank you again for your interest in Catholic education.

Rev. Nicholas J. Rouch
Vicar for Education

Please **PRINT** all information.

KINDERGARTEN
HALF DAY _____
FULL DAY _____

CHILD INFORMATION

Date _____

Name _____ Male _____ Female _____ Grade Child Would Be Entering _____
LAST FIRST MIDDLE

Date of Birth ____/____/____ Birth Certificate No. _____ Place of Birth _____ Religion _____
MONTH DAY YEAR CITY STATE

Address _____ Phone _____
HOUSE NO. STREET APT. NO. LOT NO. CITY STATE ZIP CODE

Child lives with: (Please Check) Both Parents _____ Mother _____ Father _____ Other _____ Legal Custody with _____ **(Must have Court Papers)**

Baptism _____
DATE CHURCH LOCATION CERTIFICATE VERIFIED

First Eucharist _____
DATE CHURCH LOCATION CERTIFICATE VERIFIED

Public School District of Residence _____ School Last Attended _____ From Grade _____ to Grade _____
NAME ADDRESS CITY STATE ZIP CODE

List all schools the child has previously attended	Grade(s)	Year(s)

Did child ever repeat a grade? No _____ Yes _____

Does child have difficulty learning? No _____ Yes _____

Does child have any behavioral problems No _____ Yes _____

List all auxiliary services child has received: (e.g., Title I, Speech Therapy, Act 89) _____

Check all special programs child has attended: _____ Counseling _____ Early Intervention _____ ELL/ESL _____ Emotional Support _____ Gifted _____ Learning Support
_____ Life Skills _____ Mental Health _____ Remedial _____ Wraparound _____ Other _____

Has child previously been offered an Individualized Education Program (IEP)? No _____ Yes _____ If yes, list date/grade _____ Chapter 15 - 504 Plan? No _____ Yes _____ If yes, list date/grade _____

What language(s) does the child speak? _____ What language(s) is spoken in the home? _____

FAMILY INFORMATION

FIRST/LAST NAME	HOME ADDRESS	EMPLOYER'S NAME	WORK ADDRESS	WORK PHONE	HOME PHONE	CONTRIBUTING PARISHIONER OF:
FATHER						
MOTHER						
STEP-PARENT						
STEP-PARENT						
OTHER						

Other Children Living in Home

FIRST/LAST NAME	RELATIONSHIP TO APPLICANT	BIRTHDATE

Child's Physical Description at Time of Application.

EYE COLOR	HAIR COLOR
HEIGHT	WEIGHT

HEALTH INFORMATION

Original immunizations records are required. The school will make copies to insert in the application.

Does child have health insurance coverage? No _____ Yes _____

Name of Physician or Clinic: _____ Phone Number: _____

Has child ever had surgery? No _____ Yes _____

Type of Operation: _____ Date: _____

Does child have allergies? No _____ Yes _____ Type: _____

Allergy Medication: _____

Does child have allergies to any medication? No _____ Yes _____ Type _____

List prescription medications child is currently taking: _____

Records were copied on: _____ DATE

Initials: _____

Medical Conditions:

Diabetes:	No _____	Yes _____	Heart Problems:	No _____	Yes _____
Epilepsy:	No _____	Yes _____	Asthma:	No _____	Yes _____
Other:	_____				

OTHER INFORMATION

In order to properly plan for an incoming student, the school needs to know if there is any educational, developmental, psychological, behavioral, social, or medical history that affects the student's learning.

	Please check No or Yes.		If Yes, please briefly describe.
Special Educational Program:	No _____	Yes _____	_____
Early Intervention Program:	No _____	Yes _____	_____
Educational History:	No _____	Yes _____	_____
Developmental History:	No _____	Yes _____	_____
Psychological History:	No _____	Yes _____	_____
Medical History:	No _____	Yes _____	_____
Physical Conditions:	No _____	Yes _____	_____
Other:	No _____	Yes _____	_____

By placing my signature below, I (we) verify that all information is accurate and complete. I (we) realize that failure to provide accurate information about my (our) child may jeopardize enrollment at this school. I (we) further verify that no information has been omitted.

_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PLEASE PRINT NAME	DATE
_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PLEASE PRINT NAME	DATE

For School Use Only

_____ REGISTRATION ACCEPTED

_____ REGISTRATION PROVISIONALLY ACCEPTED

_____ REGISTRATION DENIED

_____ DATE

_____ PRINCIPAL SIGNATURE

Pennsylvania School Code 13-1304-A states in part: "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction or injury to another person, or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child _____, (circle one) was/ was not previously suspended or expelled from any public or private school of the Commonwealth of Pennsylvania or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction or injury to another person or for any act of violence committed on school property.

School from which student was suspended/expelled _____

Dates of suspension/expulsion _____

Reason(s) for suspension/expulsion _____

I understand that this form shall be maintained as part of the student's disciplinary record. I further understand in making this statement that I am subject to penalties under 24 P.S. 13-1304-A9b) and 18 Pa.C.S.A.4904 relating to falsification to authorities, and that any willful false statement made on this form shall be a misdemeanor of the third degree.

I swear or affirm that the facts contained herein are true and correct to the best of my knowledge, information and belief.

_____ DATE

_____ SIGNATURE

Home Language Survey

Used to determine a primary or home language other than English.
Please type or print all responses.

Student's Name: _____
Student's Date of Birth: _____
Student's Age: _____ Student's Grade: _____
Country of Origin; _____
List Other Countries of Residence: _____
_____
Parent/Guardian's Name: _____
Parent/Guardian's Telephone Number: _____

#1. What was the first language your child learned to speak? _____

#2. Does your child speak a language other than English? _____
If yes, what is that language(s)? _____
(Do not include the language learned at school.)

#3. What language(s) is/are spoken in your child's home? _____
_____

Survey Conducted/Completed By: _____
Parent/Guardian's Signature: _____
Date: _____

Do NOT include Foreign Exchange Students – this does not apply to them.

Place in student's Permanent Record Folder.

Rev. March 2009

DIOCESE OF ERIE
CATHOLIC MISSION
MEMORANDUM OF UNDERSTANDING

As a parent/guardian of a student in a Catholic School, I understand, affirm and support the following:

1. The primary purpose of a Catholic school education is to form students in the values of Jesus Christ and the teachings of the Catholic Church.

2. Catholic schools are distinctive religious educational institutions operated as programs of the Catholic Church; they are not private schools but are administered and supported by the sponsoring parish(es), the diocese or religious community.

3. Attending a Catholic school is a privilege not a right.

4. While academic excellence and involvement in extracurricular activities (i.e., sports, clubs, etc.) are important, fidelity to the Catholic identity of the school is the fundamental priority.

5. The school and its administration have the responsibility to ensure that Catholic values and moral integrity permeate every facet of the school's life and activity.

6. In all questions involving faith, morals, faith teaching and church law, the final determination rests with the diocesan Bishop.

As a parent/guardian desiring to enroll my child in a Catholic school, I accept this memorandum of understanding. I pledge support for the Catholic identity and mission of this school and, by enrolling my child, I commit myself to uphold all the principles and policies that govern a Catholic school.

Father:	Mother:	Guardian:
_____	_____	_____
Printed	Printed	Printed
_____	_____	_____
Signature	Signature	Signature

Student's Name (please print): _____

School: _____

Date: _____

APPLICATION MUST BE ACCOMPANIED BY A SIGNED AND DATED MEMORANDUM OF UNDERSTANDING.

NORTH EAST SCHOOL DISTRICT
HEALTH HISTORY

THIS FORM MUST BE COMPLETED
(ONE FORM PER STUDENT)

STUDENT NAME _____ Gender ___Male ___Female

Date of Birth _____ Place of Birth _____

Current Address _____ Phone _____

Parent's/Guardian's Names _____

Grade _____ School Last Attended _____

Family Physician _____ Phone _____

Is your water supply from the North East Borough? Yes _____ No _____

If NO, has your child had fluoride treatments? _____

HEALTH HISTORY: Please list any serious illnesses or communicable diseases _____

_____

Allergies? _____

IMMUNIZATION HISTORY: Please list dates

DPT (Combination Diptheria-Pertussis-Tetanus) – 4 Required
1)_____ 2)_____ 3)_____ 4)_____ Booster _____

MCV 1)_____ TDAP 1)_____

POLIO-SABIN VACCINE – 4 Required
1)_____ 2)_____ 3)_____ 4)_____ Booster _____

MMR (Combination Measles-Mumps-Rubella) – Required 1)_____ 2)_____

HEPATITIS A 1)_____ 2)_____

HEPATITIS B – 3 Required 1)_____ 2)_____ 3)_____

HIB VACCINE – 3 Required 1)_____ 2)_____ 3)_____

If applicable:
CHICKEN POX (Date child had chicken pox) _____ OR
VACCINE 1)_____ 2)_____

(continued on back)

MEDICAL INFORMATION

1. Is your child's vision impaired?.....Yes No
   If yes, is he/she under a doctor's care?.....Yes No
   What is the problem?_____

2. Is your child's hearing impaired?.....Yes No
   If yes, is he/she under a doctor's care?.....Yes No
   What is the problem?_____

3. Does your child have a speech or language problem? .....Yes No
   If yes, is he/she being treated for the problem?.....Yes No
   What is the problem? _____

4. Does your child have any other physical illness or handicap which might affect normal progress or participation in the usual school program?.....Yes No
   If yes, please explain _____
   _____

5. Does your child have any emotional or behavioral problem which might affect school performance or participation?.....Yes No
   If yes, please explain _____
   _____

6. Is your child on any long-term medication? .....Yes No
   If yes, please specify _____
   _____

7. Has your child been restricted by a doctor as far as physical activity in school is concerned?.....Yes No
   If yes, please submit a statement from your doctor specifying the nature and duration of the restriction.

8. Does your child have any health condition which might require emergency action when he/she is at school? (i.e. seizures, bee sting allergy, bleeding problem, diabetes, heart problem, etc).....Yes No
   If yes, please specify_____

9. Do you have: _____ Medical Insurance
   _____ Medical Card
   _____ Other (please explain) _____

10. Would you like to discuss this information with any of the following:
    _____ School Nurse _____ Counselor
    _____ Teacher _____ Principal

_____
Signature of Parent/Guardian

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20____

Print name of examiner _____

Print examiner's office address_____ Phone_____

Signature of examiner_____ MD ☐ DO ☐ PAC ☐ CRNP ☐

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

H514.027 (08/2011)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough/Township | County | State | Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address