MAPLE HEIGHTS CITY SCHOOL DISTRICT
Requirements and Registration Application

FULL DAY, TUITION BASED PRESCHOOL Enrollment Packet

Preschool enrollment is currently being done at the Curriculum Office located at the Board of Education, 5740 Lawn Avenue, Maple Heights, OH 44137. Appointments are required for registration. After completing the packet please call (216) 587-6100, ext. 3401 for an appointment. The registration process must be completed before students are officially enrolled.

Weekly cost of tuition is based on household income, please call the curriculum office to schedule an appointment to come in and discuss. An initial $400 payment is due at the time of enrollment. Payments must be made to the school building at least 1 week in advance and late payments will be subject to a fee of $25. Two or more nonpayment or late payments in a row will result in your child being removed from the program.

The following items are required for each student:

- **Student Birth Certificate** (Student Social Security Card – Optional)
  Original or Certified Copy (must be legible)

- **Certified Custody/Guardianship Papers (if Applicable)**
  Legal Transfer of Custody/Guardianship, Journal Entry or Divorce Decree

- **Medical Statement/Immunization Records & Dental Form** (See attached forms)

- **Parent/Legal Guardian Driver License or State I.D.**
  Originals Only, Copies not Accepted

- **$400 Enrollment Payment**
  Accepting Cash, Money Order (Made out to Maple Hts. City Schools) & Check (if doesn’t clear, you will be charged an additional $35)

- **Proofs of Residency** – items showing your name at your current Maple Heights address will be required.
  Three Current Forms of Documentation: One (1) from Category 1 and Two (2) from Category 2

  **Category 1 (Provide One Item)**
  - Home Owner’s Mortgage Statement, Deed or Property Tax Statement
  - City of Maple Heights Occupancy Report
  - Section 8 Documentation
  - Valid and Current Lease/Rental Agreement
  - Owner Affidavit and Proof of Ownership

  **Category 2 (Provide Two Items)**
  - Voter Registration Card
  - Utility Bill
  - Cable or Cell Phone Bill
  - Bank Statement
  - Pay Stub
  - Valid & Current Driver License or State I.D. with Maple Hts. Address
  - Municipal Income Tax Records
  - Credit Card Statement
  - Car or Home/Renter’s Insurance Declaration
  - County Benefit Voucher

Please contact our office if you have any questions regarding the necessary documents prior to your appointment. This will avoid any delay in enrollment of your preschooler and risk of losing an available spot.
MAPLE HEIGHTS CITY SCHOOLS

In order to process this application, PART 1 MUST be completed

********************************************************************************

PART 1. INCOME DETERMINATION AND VERIFICATION

Proof of income MUST accompany this application. Proof of income is confidential information and is used only to verify eligibility and tuition.

PROF OR INCOME MAY INCLUDE ONE OF THE FOLLOWING FOR EACH WAGE EARNER IN THE FAMILY:

- Recent paycheck stub
- Employer statement as to individual’s earnings
- Copy of the most recent W-2 from your employer
- SSI or Disability statement of benefits
- Unemployment Benefits statement

CHECK ALL THAT APPLY:

- Employment: (list gross income amount) $ _________________
- Paycheck stub(s) __________________
- 2018 W-2 Wage and tax Statement(s)
- ADC: ADC Number ______________________________________
- Medical Card Number ___________________________________
- Other Assistance: (SSI, Worker’s Compensation, Child Support, Unemployment, etc.)

I certify that all of the above information is true and correct and that all income is reported. I understand that if my financial situation changes, I will notify the preschool and submit an updated income determination.

______________________________________________  ______________________________
Signature of Parent(s)/Guardian     Date

Weekly
Every 2 weeks
Monthly
United States Department of Health and Human Services

2019 FEDERAL POVERTY GUIDELINES*
INCOME BASED ON HOUSEHOLD, NOT INDIVIDUAL

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>100% Poverty Level</th>
<th>200% Poverty Level</th>
<th>300% Poverty Level</th>
<th>400% Poverty Level</th>
<th>450% Poverty Level</th>
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<tbody>
<tr>
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<td>$12,490</td>
<td>$24,980</td>
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<td>$120,680</td>
<td>$135,765</td>
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<tr>
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<td>$69,180</td>
<td>$103,770</td>
<td>$138,360</td>
<td>$155,655</td>
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<td>$43,430</td>
<td>$86,860</td>
<td>$130,290</td>
<td>$173,720</td>
<td>$195,435</td>
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* Annual Family Income

For family units with more than 8 members, add $4,420 for each additional member.

Updated 3/14/19
# MAPLE HEIGHTS CITY SCHOOL DISTRICT

## Student Registration Form

- **New** [ ]  
- **Re-entry** [ ]  

### Student Information

<table>
<thead>
<tr>
<th>Building</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

### Student Name

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Entry Grade</th>
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### Social Security # (optional)

<table>
<thead>
<tr>
<th>Social Security #</th>
<th>Birth Date</th>
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<tbody>
<tr>
<td></td>
<td>Month/Day/Year</td>
</tr>
</tbody>
</table>

### Student's Home Address

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Up</th>
<th>Down</th>
<th>Apt. #</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### Parent/Guardian

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Previous school attended

- Kindergarten include preschool if attended
- Include homeschooling

<table>
<thead>
<tr>
<th>Name of School</th>
<th>School District</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Is this student Hispanic/Latino?

- No, not Hispanic/Latino [ ]  
- Yes, Hispanic/Latino [ ]

### Race

- White [ ]  
- Black or African American [ ]  
- Asian [ ]  
- American Indian or Alaskan Native [ ]  
- Native Hawaiian or Other Pacific Islander [ ]  

### How Identified: ______________________

### Gender

- Male [ ]  
- Female [ ]

### Citizenship

- Dual National [ ]  
- Non-Resident Alien [ ]  
- Resident Alien [ ]  
- U.S. Citizen [ ]  
- Other please name: ______________________

### Birthplace

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Native / Primary Language

- English [ ]  
- Other please name: ______________________

### Student Lives With

- Mother [ ]  
- Father [ ]  
- Step-Parent [ ]  
- Other (explain): ______________________

### Legal Custody

- Mother [ ]  
- Father [ ]  
- Foster Parent [ ]  
- Other (explain): ______________________

<table>
<thead>
<tr>
<th>Court Journal Entry: (Month/Day/Year)</th>
<th>Probate Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>County: ______________________</td>
<td>Juvenile Court</td>
</tr>
</tbody>
</table>

### District Bearing Cost (for Foster Children only):

- Guardian [ ]  
- Spouse [ ]  
- Self [ ]  
- CCDCFS [ ]  
- Other (explain): ______________________

### Is the child in gifted or Advanced Placement?

- Yes [ ]  
- No [ ]

### Does the child have a 504 plan?

- Yes [ ]  
- No [ ]

### Has the child ever had an IEP?

- Yes [ ]  
- No [ ]

### Is the child suspended?

- Yes [ ]  
- No [ ]

### Is the child expelled?

- Yes [ ]  
- No [ ]

### End Date:

---

3/2018
### PARENT(S) / GUARDIAN INFORMATION

**Mother**
- Single
- Married
- Divorced
- Separated
- Remarried
- Deceased
- Residential
- Non-Residential
- Dual Mailing: Yes
- Last Name
- First Name
- Address
- Number
- Street
- City
- Zip Code
- Up
- Down
- Apt. #

**Father**
- Single
- Married
- Divorced
- Separated
- Remarried
- Deceased
- Residential
- Non-Residential
- Dual Mailing: Yes
- Last Name
- First Name
- Address
- Number
- Street
- City
- Zip Code
- Up
- Down
- Apt. #

**Legal Guardian**
- Step Parent
- Foster Parent
- Other:
- Last Name
- First Name
- Address
- Number
- Street
- City
- Zip Code
- Up
- Down
- Apt. #

**Social Worker (If Applicable):**
- Phone:

### EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td></td>
<td>Telephone</td>
<td></td>
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<tr>
<td>Address</td>
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<td>Address</td>
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<tr>
<td>Email</td>
<td></td>
<td>Email</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
</tr>
</tbody>
</table>

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date: ____________  Parent/Legal Guardian/Independent Student: ________________

Signature
MAPLE HEIGHTS CITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

Student Name______________________________________________Grade_________ DoB__________

Address _____________________________________________Telephone_____________________________

Email_____________________________________________________

Residential Parent or Guardian

Mother living with family?  Yes ☐  No ☐

Father living with family?  Yes ☐  No ☐

No

Purpose - To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Mother_________________________________________________Tel__________________

Father__________________________________________________Tel__________________

Other Name/Relationship____________________________________Tel__________________

Other Name/Relationship____________________________________Tel__________________

Other Name/Relationship____________________________________Tel__________________

Facts concerning the child’s medical history including allergies, medications being taken, and/or any physical impairments to which a physician should be alerted:

__________________________________________________________________________

__________________________________________________________________________

Part I OR Part II must be completed

Part I (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor________________________________________________________Tel_________________________

Dentist________________________________________________________Tel_________________________

Medical Specialist______________________________________________Tel_________________________

Local Hospital_________________________________________________Tel_________________________

In the event reasonable attempts to contact me at _______________ (tel #) or __________________________ (other parent) at _______________ (tel #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _________________________ (preferred doctor) or Dr. _________________________ (preferred dentist), or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _________________________ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

_________________________     _________________________________
Date                                                     Signature of Parent

Address

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (REFUSAL OF CONSENT)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_________________________     _________________________________
Date                                                     Signature of Parent

Address
MAPLE HEIGHTS CITY SCHOOL DISTRICT

Home Language Survey

Date:______________

Federal guidelines require that this form be completed for all enrolled students.

School:______________________________________________    Grade:___________    Gender: □ Male □ Female

Student Name:__________________________________________    Birthdate:______________    Country of Birth:__________________________

Home Address:_______________________________________________________________________________________________

(Street)  (City)   (Zip)

Parent/Guardian Name:_______________________________________________________________________________

Home Phone:_____________________    Cell Phone:_____________________    Work Phone:_____________________

Please answer the following questions:

1. What language did your child speak when first learning to talk? _____________________________________________
2. What language does your child speak most often at home? _______________________________________________
3. What language do you use most frequently when communicating with your child? _________________________
4. List the language(s), other than English, spoken by your child __________________________________________
5. List the language(s), other than English, spoken in the home. __________________________________________

PARENT/GUARDIAN SIGNATURE: ____________________________________________________________

If your answer was any language other than English to questions 1-5, please answer the following questions.

6. What is the Parent/Guardian’s native language?  Mother:_________  Father:_________  Guardian:_________

7. Does your child: □ speak English    □ read English    □ write English  (Check all that apply.)

8. Which adults in the home speak English? 🌐 Mother:_________  Father:_________  Guardian:_________

9. Which adults in the home read English? 🌐 Mother:_________  Father:_________  Guardian:_________

10. Do you need an interpreter? ☑ Yes ☐ No    If yes, do you have one available? ☑ Yes ☐ No

11. Interpreter’s Name (If available): __________________________________________  Phone #:__________________

12. When did your child first attend school in the United States?            Date:______________________

13. List the schools your child attended in the United States

<table>
<thead>
<tr>
<th>School Name</th>
<th>City/State</th>
<th>Grade</th>
<th>Dates Enrolled</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

14. List the schools your child attended in another country

<table>
<thead>
<tr>
<th>School Name</th>
<th>City/Country</th>
<th>Grade</th>
<th>Dates Enrolled</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
MAPLE HEIGHTS CITY SCHOOL DISTRICT
Residency and Custody Affidavit
For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I, ____________________________________________________certify that I am the custodial parent/legal guardian of
(Parent’s or Legal Guardian’s Full Name)
________________________________________________________________________________________________
(Students’ Names)

and that I have established residency at
(Street Number, Name, Apt. #)  (City)  (State) (Zip Code)

Date of Occupancy:        Lease End Date (if applicable):

I,      , certify that I am a resident of the above residence located within Maple Heights City School District. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the Maple Heights City School District address and also, that the residence where meals are taken, and where the resident parent sleeps must be at the Maple Heights City School District residence. This is the legal definition of residency for school purposes in Ohio. See Ohio Revised Code Sections 3301.121, 3313.66 through 3313.662.

List the names of ALL people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and “status” (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.). Attach a separate piece of paper, if needed.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>School (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>School (If Applicable)</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>School (If Applicable)</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>School (If Applicable)</td>
</tr>
</tbody>
</table>

Please read each statement and then place your initials to the left of the statement.

I/we certify that the information provided in this document and registration packet is true and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the Maple Heights City School District.

I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the Maple Heights City School District, I will immediately file another residency and custody affidavit with the enrollment office of the Maple Heights City School District. I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the Maple Heights City School District, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.
I/we are also responsible for informing school officials of any changes to the legal custody or guardianship of the child(ren).

I/we have provided the Maple Heights City School District with an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other court which has exercised jurisdiction over the custody or residency of the children being enrolled as per Ohio Revised Code 3313.672.

I/we acknowledge the student who is being registered has not been expelled or excluded from any other school pursuant to O.R.C. Sections 3301.121 and 3313.662.

I/we understand that if the student attends school while not being eligible to do so tuition free, the student and all responsible parties will be liable for tuition at a rate set by the Ohio Department of Education according to the Ohio Revised Code 3317.08 (the tuition rate of $3820.98 for the year) plus interest at a rate of 1.5% per month, administrative costs, court costs, and any attorney fees incurred in the collection of those sums and the student will immediately be withdrawn from the Maple Heights City School District.

I/we understand that the Maple Heights City School District may use whatever legal means it has at its disposal to verify my residency. I/we hereby waive my rights to confidentiality of information relative to my/our residence and give permission to the Maple Heights City School District, the City tax Administrator, and the Regional Income Tax Agency (RITA) to release selected information such as name, social security number, and current and former addresses to confirm or deny my residency for the current or prior years.

NOTE: Be sure you have read this statement carefully before you sign. Giving false information under oath is punishable as a criminal offense under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a maximum fine of $1,000 and/or a jail term of six months. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.

SIGNATURE(S)

Parent/Legal Guardian/Custodian: ____________________________________________

County of Cuyahoga ) ) SS:
State of Ohio )

Before me, a Notary Public of the State of Ohio, came the above-named who said that he/she/they did understand the statements set forth above and did adopt said statements and the information, herein as his/her/their own, as true to the best of his/her knowledge of the consequences and penalties of falsification, and did affix his/her signature in my presence,

This ____________________ day of _____________________________, 20_______________

__________________________________________________________________________ Notary Public
Child Medical Statement

Child’s Name ___________________________  Date of Birth ____________________________
Sex (circle one)  Male  Female  Height ____________________  Weight _________________________
BMI Percentile __________________________  BP ___________________________

**COMPLETELY FILL OUT ENTIRE FORM - REQUIRED**

*All “results” and “date completed” have to be within the year that this form is being filled out*

<table>
<thead>
<tr>
<th>Assessments/Screenings</th>
<th>Date Completed</th>
<th>Results: Please fill in (REQUIRED)</th>
<th>Explain why not assessed/screened</th>
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<tbody>
<tr>
<td><strong>Vision</strong></td>
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<td>No</td>
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<td>Distance Acuity:</td>
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<td>R  L</td>
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<td></td>
<td>Muscle Balance:</td>
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<td></td>
<td>Pass  Fail</td>
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<td>Stereopsis:</td>
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<td></td>
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<td>Pass  Fail</td>
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<td>Color:</td>
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<td></td>
<td></td>
<td>Pass  Fail</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Child wears glasses:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Yes  No</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Tested with glasses:</td>
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<td>Yes  No</td>
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<tr>
<td><strong>Hearing</strong></td>
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<td>No</td>
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<td>Pure Tone:</td>
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<td>Right Ear:</td>
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<td></td>
<td>Pass  Fail</td>
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<td></td>
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<td>Left Ear:</td>
<td></td>
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<td></td>
<td></td>
<td>Pass  Fail</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Child wears hearing aid?</td>
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<td></td>
<td></td>
<td>Pass  Fail</td>
<td></td>
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<tr>
<td><strong>Lead</strong></td>
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<tr>
<td><strong>Hemoglobin</strong></td>
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<td>No</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Please circle one</th>
<th>Exempt from Immunizations</th>
<th>Please circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete for age</td>
<td>Yes  No</td>
<td>Religious conviction</td>
<td>Yes  No</td>
</tr>
<tr>
<td>In Process</td>
<td>Yes  No</td>
<td>Health concern</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

**IMPORTANT: Please attach a copy of your child’s immunization records**

**Speech/Language**

<table>
<thead>
<tr>
<th>Speech assessment completed</th>
<th>Yes  No</th>
<th>Child has possible problem with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child has no discernible speech problem</td>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>Speech evaluation recommended</td>
<td>Yes  No</td>
<td></td>
</tr>
</tbody>
</table>

**Limitations or health conditions (including allergies, medications, and dietary restrictions):**

**Chronic Physical Problem(s):**

**History of Hospitalization:**

**Diseases this child has had:**

Signature of examining (Physician, Physician’s Assistant or Advanced Practice Nurse) ___________________________  Date of Exam ___________________________

Providers Address: ___________________________________________  Providers Phone: ___________________________

Print Providers Name: ___________________________  Providers Phone: ___________________________

Parent Signature: ___________________________________________  Date: ___________________________
DENTAL HEALTH RECORD
Maple Heights City Schools
Early Childhood Program – Public Preschool

CHILD'S NAME:
ADDRESS: ____________________________
SEX: ____________________________
BIRTHDATE: ____________________________
PHONE: ____________________________

Has child previously seen a dentist? ______ Yes ______ No
Dentist’s name ____________________________
Is child under a physician’s care? ______ Yes ______ No
Physician’s name ____________________________
Is child receiving medication? ______ Yes ______ No
If so, what type ____________________________
Child is reported to have

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Asthma</th>
<th>Bleeding</th>
<th>Diabetes</th>
<th>Epilepsy</th>
<th>Heart/Vascular Disease</th>
<th>Liver Disease</th>
<th>Rheumatic Fever</th>
<th>Sickle Cell Disease</th>
<th>Other</th>
</tr>
</thead>
</table>

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<tr>
<th>Yes</th>
<th>No</th>
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| Is the child now receiving topical fluoride application? ______ Yes ______ No Unknown |
|______________________________________________________________________________|
| If “yes” include length of time receiving fluoride ____________________________|
|_______ Yes ______ No Unknown |
|   Yes ______ No Unknown |

Is the child now receiving fluoridated water? ______ Yes ______ No Unknown
Is the child now receiving fluoride supplement diet? ____________________________
(tables ______, liquid ______)

Oral conditions before treatment

TO BE COMPLETED BY DENTIST

Missing X
Decayed ____________________________
Filled ____________________________

Does the child have any trouble with teeth, gums, or mouth other than the parent knows about? ____________________________

Examination and Treatment Record (list recommended services in order)

<table>
<thead>
<tr>
<th>Tooth # or Letter</th>
<th>Surfaces</th>
<th>Description of work</th>
<th>Treatment Approved</th>
<th>Date Services Performed</th>
<th>A.D.A. Procedure Number</th>
<th>Actual Charges</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

DENTAL NEEDS: Treatment (restoration, pulp therapy, extraction) ______ Fluoride ______ Other
Cleaning ______ No problems
Approximate number of visits ____________________________
Approximate cost ____________________________

CHILD ORAL HEALTH SUMMARY

All planned treatment(s) ______ is ______ is not complete. If not, explain here as well as items checked

___ Routine recall visits
___ Special home emphasis, oral hygiene
___ Dietary problem(s)
___ Developmental problem(s)
___ Harmful oral habits
___ Needs fluoride supplement

I certify that I have completed the service(s) recommended for the child

Signature: ____________________________ Date: ____________________________