DUNMORE ELEMENTARY CENTER

DUNMORE BUCKS

300 W. Warren St. - Dunmore, PA 18512
(570) 207-9572 - FAX (570) 207-6765

Matt Quinn
Principal

Michelle Kokindo
Assistant Principal

To: Parents of Incoming Kindergarten Students 2024/2025 school year
From: Matthew Quinn, Principal
Date: January 2024
Subject: **Kindergarten Registration**

The Dunmore Elementary Center will conduct Kindergarten registration for the students who will be entering our Kindergarten for the 2024/2025 school year on Thursday, March 21st and Friday, March 22nd 2024.

All children registering for Kindergarten must be 5 years of age by September 1, 2019.

In order to facilitate the registration of students, the registration will be conducted according to the **last name of each child**. Please adhere to the following schedule:

	Thursday, March 21st	
Last Initial	A through F	9:00am – 11:00am
Last Initial	G through K	1:00pm – 2:30pm
	Friday, March 22nd	
Last Initial	L through Q	9:00am – 11:00am
Last Initial	R through Z	1:00pm – 2:30pm

Enrollment applications are on our district website www.dunmoreschooldistrict.net (PLEASE print one sided) or may be picked up at our Elementary Center office to be completed in advance.

The following documents MUST be presented at the time of registration in order for your child to be registered in the Dunmore School District:

1. **Original Birth Certificate**
2. **Immunization Records**
3. **Proof of Dunmore residency – lease agreement, tax bill, gas or electric bill**
4. **An IEP and/or Custody Papers (if applicable)**
   (Please bring the original and a copy of these records)

DUNMORE SCHOOL DISTRICT
DUNMORE ELEMENTARY CENTER

KINDERGARTEN Registration

BUS STOP_____ BUS # TO SCHOOL_____

BUS STOP_____ BUS # FROM SCHOOL_____

SCHOOL YEAR_____ DATE_____

CHILD'S NAME_____
(LAST) (FIRST) (MIDDLE) (SEX)

ADDRESS_____ PHONE #_____

PARENT EMAIL ADDRESS _____

PROOF OF DUNMORE RESIDENCY_____

DATE OF BIRTH_____ BIRTH CERTIFICATE_____

PLACE OF BIRTH_____
CITY STATE COUNTRY

RACE - PLEASE CHECK ALL THAT APPLY:

____American Indian/Alaskan Native _____Asian _____Black
_____Hawaiian/Pacific Islander _____Hispanic/Latino _____White

FATHER'S NAME_____ OCCUPATION_____

GRADE COMPLETED BY FATHER_____ EMPLOYED BY_____

MOTHER'S MAIDEN NAME_____ OCCUPATION_____

GRADE COMPLETED BY MOTHER_____ EMPLOYED BY_____

CHILD IS LIVING WITH_____ CHILD'S LEGAL NAME_____

HAS YOUR CHILD BEEN RECEIVING ANY EDUCATIONAL SERVICES/EARLY INTERVENTION FROM ANY PUBLIC OR PRIVATE AGENCY OR SCHOOL? ___YES ___NO
IF YES, PLEASE PROVIDE NAME AND ADDRESS:_____

OTHER CHILDREN IN FAMILY (LIST OLDEST TO YOUNGEST)
NAME AGE GRADE

ENTRY DATE STUDENT ENTERED STATE OF PENNSYLVANIA_____
ENTRY DATE STUDENT ENTERED THE UNITED STATES OF AMERICA_____
NUMBER OF YEARS IN U.S. SCHOOLS (INCLUDING KINDERGARTEN)_____

PLEASE NOTIFY OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE _____

Parents must present the following items at the time of registration:

1. Birth Certificate
2. Immunization Records
3. Proof of Dunmore Residency (lease agreement, tax bill, mortgage statement, or gas or electric bill)
4. Special Education Records (I.E.P., N.O.R.E.P., ETC.) if applicable
5. Custody Papers (if applicable)

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Matt Quinn
Principal

Michelle Kokindo
Dean of Students

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

Telephone Number _____

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 or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act of offense involving weapons, alcohol or drugs, or for the wilful infliction of 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 was ____ was not _____ previously suspended or expelled, or is _____ is not _____ presently 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 wilful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A.§4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

_____

Dates of suspension or expulsion: _____
(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) _____

_____
(Signature of Parent or Guardian)

Equal Opportunity Employer _____ (Date)

Any wilful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

24 P.S. §13-1317.2

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RESIDENCY REQUIREMENT

In order to have your son or daughter educated by the Dunmore School District, they, and you as a parent or legal guardian, must be full-time residents.

So as not to delay the registration process, we are accepting the information you are supplying at the time of registration. This information may or may not be sufficient for us to satisfy our residency requirements. This form, along with your registration form, will be forwarded to my office and given to an administrator for further research and verification, if necessary.

By signing this form, you are declaring that to the best of your knowledge the address you are supplying is within the Dunmore School District boundaries and you and the student you are registering are full-time residents at that address. If our verification reveals that the address you supplied is not within our boundaries, or you are not living full-time within this District, you understand that you will be notified, the student will be removed in an appropriate manner, and you will be directed to the proper school district, if known.

If, for any reason, you choose not to sign this form, your son or daughter will not be registered.

Thank you, and welcome to the Dunmore School District!

Signed: _____

Address: _____

_____

Date: _____

DUNMORE SCHOOL DISTRICT
300 WEST WARREN STREET
DUNMORE PA 18512

It is the intent of the Dunmore School District to remain neutral toward families split by divorce or separation, we do not want to take sides with one parent against the other where there may be possible conflict over children attending school in this district. If you have a court decree, which established you as a legal guardian, you will want to provide the district a copy of such document for attachment to your child's permanent record. We will use this as a legal base for working with the custodial parent.

In the absence of such a document, you must be aware that we cannot deny either parent access to his/her child. We cannot withhold information or refuse to see or work with the other parent. We cannot keep the other parent from picking up his/her child from school.

The Dunmore School District wants to protect all children from emotionally upsetting situations. Whatever the parents can settle outside the school to forestall any confrontations should be pursued.

I have read and discussed the above with a Representative of the Dunmore School District.

Parent: _____

Address: _____

Name of Student: _____

Date: _____

Office Use:
Legal Document on file
Yes _____
No _____
Date _____

PARENT NOTIFICATION

By law, if parents are legally separated or divorced, each parent has equal rights to the custody of the child/children UNLESS a parent has a court order that indicates which parent has custody of the child/children.

THE SCHOOL MUST HAVE A COPY OF THE COURT ORDER ON FILE.

Otherwise, either parent may check the child/children out of school with proper identification.

I HAVE READ THE ABOVE STATEMENT OF THE LAW.

_____ The above statement IS applicable for my child/children.

_____ The above statement IS NOT applicable for my child/children.

Father's Signature (Guardian) _____ Date:_____

Mother's Signature (Guardian)_____Date:_____

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Student
Name_____Date_____GradeEntering_____SchoolYear_____

Please list the schools that your child previously attended.
School_____Grades_____
_____
_____
_____
_____

Has your child ever repeated a grade? Yes_____ No_____ If yes, what grade (s)_____ _____
When:_____Where:_____

Has your child ever been in a transitional or readiness class? _____Grade (s)_____
When:_____Where:_____

Has your child ever been enrolled in a special education program?_____ Type of program_____
When:_____Where:_____

Is child currently enrolled in special education program?_____Please list primary disability_____

IEP status: Has IEP_____Exited IEP less than 2 years_____No IEP or exited IEP greater than 2 years_____

Has your child ever received any of the following services: Gifted Class_____Speech_____
Remedial Class_____Please list subjects_____

Has child ever been in ESL/ELL or LEP class? Yes_____ No_____

If yes, child: is currently in program_____ exited ELL and in 1st year of monitoring_____
exited ELL and in 2nd year of monitoring_____ former ELL and no longer monitored_____

Is child: Homeless_____ Immigrant_____ Migrant_____ 504 Student_____

Foster Child_____ Court/Agency Placed_____ Gifted_____

_____
Parent or Guardian's Signature _____Date

Equal Opportunity Employer

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

D.E.C. STUDENT RECORD

STUDENT ID NUMBER_____ DATE_____

STUDENT INFORMATION

LAST NAME_____GRADE_____HOSPITAL OF CHOICE_____

FIRST NAME_____SEX_____PHYSICIAN_____

BIRTHDATE_____/_____/_____MEDICAL COND. (ALLERGIES, ETC.)_____

MEDICATIONS_____

PARENT/GUARDIAN CONTACT

FIRST NAME_____LAST NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

EMAIL ADDRESS _____

PARENT/CONTACT PERSON #2

NAME_____RELATIONSHIP_____PHONE_____

EMAIL ADDRESS_____

CONTACT PERSON #3

NAME_____RELATIONSHIP_____PHONE_____

If at any time the above emergency contacts change please notify the office in writing.

Brief medical history if applies to your child:_____

Indicate by circle if any apply:

Asthma
Diabetes
ADHD
Seizures
Vision Deficit
Hearing Deficit
Surgeries
In Counseling
Had Chicken Pox
Other_____

Parent Signature_____

Date_____

Last School District Attended_____

_____I AGREE TO GIVE PERTINENT MEDICAL INFORMATION TO ALL APPROPRIATE STAFF.

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 NAME:

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 ☐

12

STUDENT NAME:

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)					

You must hand in to nurse before the first day of school

DUNMORE SCHOOL DISTRICT

State Required Physical Exam

As per Pennsylvania School Code all: New Entrants, **KG, First, Sixth and Eleventh** Grade Students are required to have a physical health exam. It is recommended that you have an examination done by your private physician. However, if you prefer, the school examiner, will perform an examination in the Health Suite free of charge.

Student Name:_____ Grade_____Section_____

Choose ONE only and Sign

- **I give my consent for my child to be examined by the school physician. I will complete the health history form attached and return it to the school.**
  (This will include a hernia check for all male students)
  I would like to be present for the school exam_____

  _____**Date:**_____
  Signature

- **I will have my private physician complete the physical form and return it to the medical room by May 1st of this school year.( )**

_____**Date:**_____
Signature

All forms are available on the school website or in the main office

12
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Dunmore School District

300 West Warren Streets
Dunmore, Pennsylvania 18512

DEC 207-9572
DMS/DHS 346- 2043

Mandated Dental Exam

Dear Parent/ Guardian:

In accordance with Pennsylvania School Code, dental examinations are required on all students in grades **Kg. or 1st, 3 and 7**. Parents are encouraged to have this examination done by their private dentist to provide continuity in dental care of your child. If you would prefer a school dental exam free of charge you may indicate so below. All forms must be completed and returned by May 1st of the school year.

Student_____Grade_____

Choose Only One and Sign and return this permission form, keep the attached private dental form if having a private dental exam.

_____I give consent for my child to be examined by the **school** dentist

Signature_____Date_____

_____I will have my private dentist complete the **private** dental form and return it by May 1St.

Signature_____Date_____

H514.027

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 or 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

Student Questionnaire

Has your child demonstrated academic difficulties in the past? □ no □yes (If yes, please describe)

_____

_____

_____

Has your child demonstrated behavioral difficulties in the home, school, or community setting? □ no □yes (If yes, please describe)

_____

_____

_____

Has your child demonstrated social or emotional difficulties in the home, school, or community setting? □ no □yes (If yes, please describe)

_____

_____

_____

Student's Name: _____

Completed by: _____ Date: _____

REGISTRATION CHECKLIST

_____Registration Form_____	_____PA State Law/Immuniz.
_____Parental Registration Statement	_____Health Services Form
_____Home Language Survey	_____Private Physician's Report
_____DEC Student Record	_____Private Dentist Report
_____Birth Certificate	_____Proof of Residency
_____Other (i.e. Custody Papers)	_____Special Ed Survey

STUDENT'S NAME_____DATE_____

Checked By_____