W. R. Croman Primary School
KDG Registration Check List
March 20th and 21st, 2024

Dear Parents/Guardians:

To register for kindergarten, your child must be 5 years of age on or before August 31st. **Registrations will not be considered complete until all checklist items are turned in.**

Please use the main entrance for Registration. Do your best to be on time, as we will have several small groups throughout the two days. **Two adults (parents/guardians) with the registering child will be allowed to attend registration, at the scheduled time. (No siblings, or extra people)**

Your child will receive a vision, hearing, speech, and OT screening, along with meeting a Kindergarten teacher, who will do a Kindergarten readiness assessment of your child. While your child is busy, parents will meet with our principal, Mr. Wilcox, for a review of what to expect for the coming school year. Please plan on being here for about 45 minutes.

Bring these forms from this packet with you:

____ **Registration Form**
____ **Family Survey**
____ **Health History**
____ **Home Language Questionnaire**
____ **Kindergarten Parent Information Form**
____ **New Student Registration Addendum**
____ **Separation-Divorce Form (if applicable)**
____ **Vision Screening**

Bring these items with you: (we will make copies)

____ **Child's Official Birth Certificate**
____ **Two Proofs of Residency in the Troy Area School District** (utility bill, letter from landlord, and/or driver license with physical address within the district, etc.)
____ **Immunization Records** (Your doctor's office can fax these to 570-297-3260)
____ **Custody Papers (if applicable)**

Due before school starts:

____ **Any missing Immunizations**

Due during the school year:

____ **Private Physicians Report of Physical Examination**
____ **Private Dentist Report of Dental Examination**

Any questions, please call the office at 570-297-3145.

TROY AREA SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Please print all information

STUDENT INFORMATION

Effective Date

Student's Legal Name (Last) (First) (Middle) Name Used Other Than Legal Name

Street Address (Include Apartment Information) City and State of Birth

Mailing Address (If Different) Road Name Sex Date of Birth

Description of Residence for Transportation Boro/Twp Grade Entering

City State Zip Phone Cell Phone No.

Child Lives With:
____ Both Parents
____ Mother
____ Father
____ Step _____
____ Guardian

____ Affidavit
____ Custody Papers*

*Are there custody papers which limit the child from being picked up by the non-custodial parent? If yes, please furnish a copy of the custody papers to the school principal.

Race:
A - Asian ____
B - Black ____
S - Hispanic ____
W - White ____
Multi-Racial ____
I - American Indian/Alaskan ____

If child was placed in your custody by an agency, please give name and address of agency:

Previous Education:
Last School Attended with Address: _____

Classes Attended: _____

_____ I.E.P.: _____Yes _____No

PARENT OR GUARDIAN INFORMATION

Father's Name (Last, First, Middle) Address (if different from student) Marital Status
Married__ Separated__ Divorced__

Employer Employer Address & Phone Number Occupation

Mother's Name (Last, First, Middle) Address (if different from student) Marital Status
Married__ Separated__ Divorced__

Employer Employer Address & Phone Number Occupation

Please list additional residents at this address who are not listed above:

Name (Last, First, Middle)	Sex	Grade	School	Date of Birth

PARENT SIGNATURE / DATE

OFFICE USE ONLY: Student ID _____ Grade _____ Homeroom _____ Locker _____ Rec. Requested. _____

Attd. Code:
E _____
R _____

Residency
1 - District Resident _____
2 Tuition _____
4 1305 _____
5 1306 _____

Curriculum:
1 - Regular Education _____
2 District Spec. Ed. _____
3 Intermediate Unit _____
7 Vo-Tech _____
8 Spec. Ed.-Vo-Tech _____
9 Blended School _____

PA Secure ID Number

Copy Distribution: White, Building Copy
Canary, District Office Copy

12/09

H511.336 (Rev 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20_____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

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

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, and Year each immunization was given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other: _____					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
▪ Height (inches)				
▪ Weight (pounds) BMI				
▪ Pulse ( )				
▪ Blood Pressure				
▪ Hair/Scalp				
▪ Skin				
▪ Eyes/Vision				
▪ Ears/Hearing				
▪ Nose and Throat				
▪ Teeth and Gingiva				
▪ Lymph Glands				
▪ Heart – Murmur, etc				
▪ Lung – Adventitious Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
PRINT Name of Examiner

_____
Address

_____
Telephone Number

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

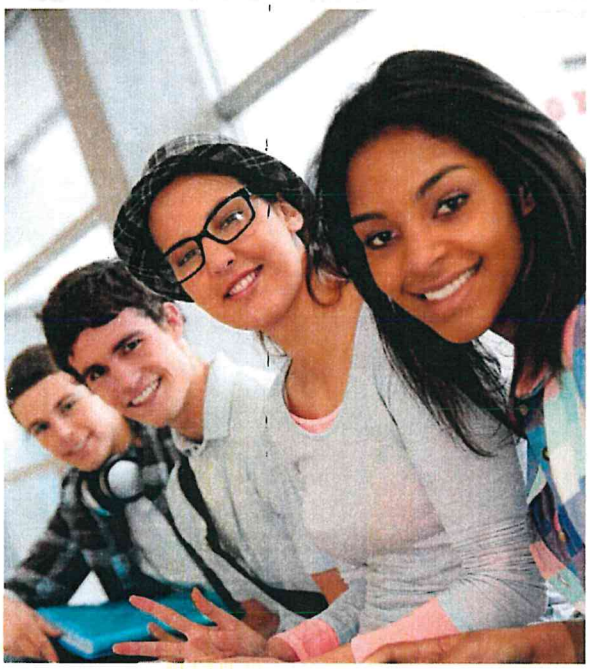
_____
Address

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*



ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.

- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

TROY AREA SCHOOL DISTRICT
68 Fenner Avenue
Troy, PA 16947

FAMILY SURVEY

Date _____

PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ SCHOOL Elementary Middle High

CHILDREN'S NAME (List all living in your household between ages 0-22)

_____

_____

Have you or any member of your household worked or looked for work in any of the following agricultural activities during the last 3 years? Check all activities that apply.

_____ Farming (Dairy, Veal, Horse, Poultry)

_____ Food Processing Plant (Milk, Beef, Pork, Poultry)

_____ Logging (Cutting, Thinning, Transporting)

_____ Christmas Tree Farm or Nursery

_____ Vegetable or Fruit Farm

_____ Crop Farm

What type of work are you doing now? _____

Your children may qualify for an educational program, which includes free year round educational support and receiving books from the Migrant Program. Someone will be contacting you to determine if your children qualify for the program.

All responses are **confidential** and will be used for educational purposes only.

Central Susquehanna Intermediate Unit, Northeast Migrant Education Program
PO Box 213, Lewisburg, PA 17837
570-523-1155

OFFICIAL USE-FAMILY CONTACT LOG	

TROY AREA SCHOOL DISTRICT HEALTH HISTORY (to be completed by parent/guardian)

STUDENT NAME_____sex_____Date of birth_____

Life Threatening Allergic Conditions: Check ALL that apply

( ) Severe allergic reactions to bee stings or other insects:_____
( ) Severe reaction to Nuts, Peanuts:_____
( ) Severe reaction to other food products_____

Please indicate any of your child's symptoms which would indicate a severe allergy:

( ) Itching and/or tightness in throat, hoarseness ( ) Itching or swelling of eyes, lips or tongue
( ) Shortness of breathe, coughing and/or wheezing ( ) Thready pulse, faintness/passing out
( ) Hives

Has your physician prescribed an Epi Pen or other medication for a life threatening allergy? ( )YES ( ) NO
Specify medication and dose_____

Health conditions: Has your child been diagnosed by a physician with any of the following? Check Yes or No. Provide dates and details for all items checked "Yes" on back side.

YES	NO	Condition
_____		Attention deficit ADD or ADHD
		Date diagnosed_____Medications_____
_____		Allergies to medications Names_____
_____		Allergies (environmental / seasonal)
_____		Asthma Use an inhaler? Yes_____ No_____
		Use a nebulizer? Yes_____ No_____
_____		Autism Spectrum Disorder_____ Aspergers_____
_____		Behavior problems
_____		Bleeding disorder
_____		Bowel or digestive problems
_____		Cancer Type_____Date diagnosed_____
_____		Cerebral Palsy
_____		Cystic Fibrosis
_____		Dental problems
_____		Depression
_____		Diabetes: Date diagnosed_____Insulin dependent ( ) YES ( ) NO
_____		Eating disorder Anorexia_____ Bulemia_____
_____		Emotional disorder
_____		Growth problems or developmental problems
_____		Heart/ blood pressure problems Specify_____
_____		Hepatitis Type and date diagnosed_____
_____		Hospitalizations: Specify_____
_____		Immunodeficiency disease
_____		Kidney or urinary problems or genital problems
_____		Lyme Disease
_____		Muscular disorder
_____		Migraine headaches
_____		Orthopedic (bone/joint) problems
_____		Pregnancy
_____		Scoliosis (curvature of the spine) date of diagnosis_____
_____		Seizure disorder Type_____
		Date of last seizure_____Medications_____
_____		Self harm/mutilation
_____		Sickle cell disease
_____		Spina Bifida
_____		Substance abuse (alcohol, drugs, tobacco)
_____		Suicide risk or attempt
_____		Surgeries: Specify_____
_____		Thyroid disorder
_____		Tourette's syndrome
_____		Other

Complete other side

DETAILS FOR ALL CONDITIONS MARKED "YES"

_____
_____
_____
_____
_____
_____
_____

SERIOUS ACCIDENTS _____
_____

HEARING

YES NO

Hearing loss:

_____
_____ (R)_____Mild _____Moderate_____Severe_____
_____ (L)_____Mild_____Moderate_____Severe_____
_____ Hearing aid ( ) Right ( ) Left

VISION

_____ Color deficiency
_____ Legally blind
_____ Vision problem / Eye defect_____
_____ Wears glasses ( ) all the time ( ) distance only ( ) reading
_____ Wears contact lens

MEDICATION

NAME OF ALL MEDICATIONS TAKEN: include all prescriptions and over the courter meds taken regularly

_____
_____
_____

NAME OF FAMILY DOCTOR_____Phone_____

Pennsylvania School Health mandates that annual screenings be done on all students.

YES NO

_____
_____ **Height and Weight** all grades
_____ **Vision Exam** all grades
_____ **Hearing exams** grades: kindergarten, 1,2,3,7, 11
_____ **Scoliosis** (spine curvature) grade 7
_____ **Physical exams** grades: kdg, 6 and 11 grades. You will be notified when they will be offered and have the option of having your family doctor complete this exam.
_____ **Dental exams** grades kdg, 3 and 7 if not completed by your family dentist

I give my permission for my child to have the mandated screening.

*** Parent/guardian signature**_____

Do you have any concerns about your child's health that were not included above that you want the school nurse to be aware of?

Do you give the school nurse permission to share this medical information with your child's teachers and/or coaches if the need arises?
YES_____NO_____

***Parent/guardian signature**_____Date_____

HOME LANGUAGE QUESTIONNAIRE FORM

68 Fenner Avenue
Troy, PA 16947
Phone: 570-297-4391
www.troyareasd.org

INSTRUCTIONS: Complete this form for each child to be registered. In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English as well as prior school and personal history. **PLEASE PRINT CLEARLY**

A. STUDENT INFORMATION			
Student's Name			
	FIRST	MIDDLE	LAST
Was the student born in the United States?		Country of Birth	
		Country of Origin	
❍ Yes – skip to Section B		Date entered USA	
❍ No – complete the questions as right		Date of Entry to US School	
		Years in the USA	

B. LANGUAGE BACKGROUND			
Check all boxes below that apply			
1. What language(s) is spoken in the student's home or residence?	❍ English ❍ Other Specify:		
2. What language(s) is spoken most of the time to the student in home of residence?	❍ English ❍ Other Specify:		
3. What language(s) does the student understand?	❍ English ❍ Other Specify:		
4. What language(s) does the student read?	❍ English ❍ Other Specify:		
5. What language(s) does the student write?	❍ English ❍ Other Specify:		
6. What language(s) does the student speak?	❍ English ❍ Other Specify:		
In your opinion, how well does the student understand, speak, read and write English?			
Understands English	❍ Very Well	❍ Only a Little	❍ Not at All
Speaks English	❍ Very Well	❍ Only a Little	❍ Not at All
Reads English	❍ Very Well	❍ Only a Little	❍ Not at All
Writes English	❍ Very Well	❍ Only a Little	❍ Not at All

C. PARENT/GUARDIAN SIGNATURE	
	DATE:
SIGNATURE OF PARENT OR OF PERSON IN PARENTAL RELATION	
Relationship to student: ❍ Mother ❍ Father ❍ Other:	

TROY AREA SCHOOL DISTRICT

KINDERGARTEN REGISTRATION PARENT INFORMATION SHEET

1. Child's Name: _____ Date of Birth:_____
2. Mother's Name: _____Father's Name: _____
3. Name(s) and age/grade of any sibling(s): _____
4. Other students attending Croman that are a relation to your child? _____
5. Can your child use the bathroom independently? Yes _____ No _____
   Can your child tie his/her own shoes independently? Yes _____ No _____
   Can your child zip or button his/her own coat independently? Yes _____ No _____

6. Did your child attend a daycare or preschools in the past couple years:
   Stepping Stones Daycare: _____ How many days a week attended: _____
   Leaps and Bounds Daycare: _____ How many days a week attended: _____
   Spire Nursery School: _____ How many days a week attended: _____
   Headstart: _____ How many days a week attended: _____
   Other day care _____ How many days a week attended: _____

7. Does your child have any allergies: _____

8. Please write a brief statement about your child's behavior in preschool: _____

   _____

9. Please write a brief statement about your child's behavior at home: _____

   _____

10. Can your child follow simple directions? _____

    _____

11. Is your child cooperative and helpful? _____
12. Does your child have any behaviors or medical concerns that might interfere with learning? _____

    If yes, please specify. _____

    _____

13. Does your child currently have an IEP for academics, speech or behavior? _____

    If yes, which are? _____

14. How often do you read to your child? _____
15. Does your child have a favorite book they like to read or hear you read to them? _____

    If yes, what is the name of the book? _____

16. What are your child's favorite things to do? _____
17. Other areas of concern we should be aware of? _____

    _____

TROY AREA SCHOOL DISTRICT
68 Fenner Avenue
Troy, PA 16947
New Student Registration: Addendum

Student Name:_____ **Date:** _____

1. If born outside of the US, what country was the child born in? ❍ YES ❍ NO
   What is the child's initial US entry date? _____(leave blank if born in US)
2. If born in a state other than PA, what is the date of when the child took residency in PA? _____
3. How many years total has the child attended any school in the US? _____
4. If the child is a grade 9, 10, 11, or 12 student, what date did they enter 9th grade? _____
5. If the child has a name suffix (Jr., II, III, etc) please list: _____
6. Please list any additional siblings who are or will be attending school in this District:

   Name _____ Grade _____ Building WRC TIS JSHS

   Name _____ Grade _____ Building WRC TIS JSHS

   Name _____ Grade _____ Building WRC TIS JSHS

7. Is the child residing in a single parent household: ❍ YES ❍ NO
8. Is the child attending Troy Area School District as a result of the School Choice Provision? ❍ YES ❍ NO
9. Parent/Guardian Email address: _____
10. Where are the student(s) currently living? (please check only one)

    ❍ In Permanent Housing
    ❍ In a shelter
    ❍ In a hotel/motel
    ❍ With another family due to loss of housing (double up)
    ❍ In a car, park, bus, train or campsite
    ❍ Other temporary living situation (Please describe): _____

_____ _____

Print name of Parent, Guardian or Student if unaccompanied youth

Signature of Parent, Guardian or Student if unaccompanied youth

The answers you gave above will help the District determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitle to free transportation and other services.

FOR OFFICE USE ONLY:
District Entry Date (date the student began attending in TASD): _____
School Entry Date (the date the student started attending school in the current building): _____
City and State of birth: _____

If there is a Guardian, according to Court documentation, the Guardian is registered to receive:
Summary of current grades & attendance
Detailed report showing all assignment scores for each class
Balance Alert (note: will only be sent when a student is low on funds)
Detail report of attendance
School announcements

TROY AREA SCHOOL DISTRICT
TROY, PA 16947

SEPARATIONS – DIVORCES

The Troy Area School District is neutral toward parents in families split by divorce or separation. We do not take sides with one parent against the other where there may be possible conflict or issues involving children attending school in this district. If there is a court order which establishes legal guardianship or primary physical and legal custody, it should be provided to the district for attachment to your child's permanent record. We will use this as a legal base for working with the parents.

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

The Troy Area School District wants to protect all children from emotionally upsetting situations. Parents are encouraged to cooperate in order to resolve custodial conflicts, to forestall confrontations and to foster the best interests of the child or children.

I have read and discussed the above with a representative of the Troy Area School District.

_____
Parent/Guardian Signature

_____
Address

_____
Name of Student

_____
Date

Office Use Only

Legal Document on File

Yes ____
No ____
Date _____

THIS FORM MUST ACCOMPANY YOUR CHILD TO THE FREE VISION SCREENING

NORTH CENTRAL SIGHT SERVICES INC.

Member of Pennsylvania Association for the Blind

ROBERT B. GARRETT PRESIDENT/C.E.O.

W AA A H NA O UK

DATE: _____

SITE: _____

SCR: _____ REFERRED: ☐

FREE CHILDREN'S VISION SCREENING!

North Central Sight Services is pleased to inform you that we are scheduled to perform FREE Vision Screenings at your child's Day Care, Preschool, Head Start, or Kindergarten Registration. Young children do not always realize that they are having vision problems and don't always know how they are supposed to be seeing the world around them. Most eye problems do not go away as a child grows. Early detection and treatment of a diagnosed condition can yield the best results. Along with vision screenings, parents should also be alert for signs of vision problems that include frequent rubbing of the eyes, holding books and papers close to the face, squinting, excessive blinking, or tilting of the head from one side to the other. Covering one eye to favor the other, frequent appearance of sties or redness, and even watery eyes can also be signs of a vision problem.

NCSS takes pride in being able to provide the highest level of quality by using the latest technology in vision impairment detection equipment. The screening will be conducted by our highly trained staff using the Welch Allyn SPOT Screener, a camera like device that scans the eye for evidence of refraction errors and the presence of astigmatism. The scan is quick, non-invasive, stress free, and highly accurate at detecting vision problems in young children. Please fill out the attached consent form and return to your child's preschool as soon as possible. Only children with signed consent forms will be able to participate.

VISION SCREENING CONSENT AND REGISTRATION FORM

PLEASE COMPLETE IN FULL (PLEASE PRINT)

Child's Name: _____ **Age:** _____ **Date of Birth:** _____ **Gender:** M F

Parent/Guardian Name: _____ **Phone:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email (optional): _____ **County of Residence:** _____ **School Dist:** _____

Known Vision Issues/Concerns: _____

Date of child's last eye exam: _____ **(Circle One): Pediatrician or Optometrist/Ophthalmologist**

As the undersigning parent/guardian, I hereby grant permission to North Central Sight Services, Inc. to screen the vision of the above named child. If a professional eye exam is recommended, I give my consent to permit North Central Sight Services, Inc to obtain information from the examining eye specialist regarding my child's eye examination and recommended treatment and to furnish such information, as needed, to the appropriate school/agency. I also understand that follow-up is required and that I may be contacted by the agency for further information. In addition, I understand that this procedure is a limited vision screening, designed only to detect certain symptoms of potential vision problems in children. It is not an eye exam and is not intended to take the place of a professional eye exam performed by an optometrist or ophthalmologist.

Parent/Guardian Signature: _____ **DATE:** _____

Occasionally, North Central Sight Services will use pictures taken during screenings and events for marketing purposes. If you wish for your child's picture not to be used in our non-profit marketing material, please initial here. _____

Office Use Only

OD		OS	
SE	_____	SE	_____
DS	_____	DS	_____
DC	_____	DC	_____

North Central Sight Services, Inc.
2121 Reach Road PO Box 3292 Williamsport, PA 17701-0292
Phone (570) 323-9401 Toll Free 1-866-320-2580 Fax (570) 323-8194

Our Prevention of Blindness and Social Services Programs are funded in part through grants from the PA Dept. of Labor and Industry, Bureau of Blindness & Visual Services, Office of Vocational Rehabilitation, and the United Way.