

## **REGISTRATION INSTRUCTIONS**

***STUDENTS WILL NOT BE ENROLLED UNTIL REQUIREMENTS ARE MET AND PAPERWORK IS COMPLETE.***

### **DOCUMENTS AND INFORMATION NEEDED FOR ENROLLMENT:**

1. Student's original Birth Certificate or Passport.
2. Copy of the driver's license of the student's parent/legal custodian (for photo identification purposes).
3. Proof of residency (see other side for requirement details). If your residency changes, inform the school district and provide the required proof. Please be aware that the school district has the right to investigate residency and act accordingly.
4. Custody: When applicable, the custodial parent/legal guardian must provide the certified/court stamped copy of the custody order or decree which shows that he/she is the "residential" custodian or legal guardian. Please bring the entire document. Also, a marriage license may be required in some circumstances. Students are eligible to attend school in the district where the custodial parent, or legal guardian, resides.
5. In the event a biological parent is deceased, provide a copy of the death certificate.
6. Proof of immunizations.

### **IMPORTANT**

If your child currently receives special services (has an I.E.P. - Individual Education Plan - or Section 504 Plan), please bring your copy with you at time of registration.

**NOTE:** Although a registration may be for a former Oak Hills student, we follow the entire procedure as if it is a new registration. Please provide the required documents.

Thank you for your cooperation. For questions, please call District Office at 513-574-3200.

## PROOF OF RESIDENCY

### ACCEPTABLE PROOF OF RESIDENCY:

1. Copy of deed, current mortgage statement, recent settlement statement, current 1098 form, or the most recent property tax bill (no print-outs from the auditor's website please). If property is only in the name of your spouse, your marriage certificate is also required. OR
2. Current rental or lease agreement: provide full document, signed and dated. It must contain the name, address, and phone number of the landlord. OR
3. Parent(s) and student(s) living with another person: Parent must obtain affidavits from the Oak Hills District Office at 6325 Rapid Run Road PRIOR to registration. You will need to provide the homeowner's name, address, and phone number. The affidavits must be fully completed (including the required attachments as listed on the forms), and notarized. This only applies if the current occupant is the homeowner. If moving in with someone who is renting (sharing an apartment or rental house), you need to have your name added to the rental/lease agreement, or have the landlord or apartment manager provide an addendum to the current lease which states you and your family also live there.

### House Under Construction/Purchase:

If a person has a contract to build, parent(s) must submit, at registration, a copy of the contract, PLUS a letter from the builder stating that he does have a firm contract and giving an estimate of the time of completion (not to exceed 90 days from the day school starts or from the time the child starts school). The letter should contain the builder's name, address, and phone number. After closing, a copy of the settlement statement must be submitted to the school district within 10 days.

If a person has a signed a contract to purchase an existing home, a copy of the Contract to Purchase which shows the closing date must be submitted at time of registration. The occupancy date must be within 60 days from the day school starts or the first day the child attends school. After closing, a copy of the settlement statement must be submitted to the school district within 10 days.

**The school district has the right to investigate residency. Parents are required to inform the district of any change of residence and/or custody status.**

*These instructions also apply to address changes for current students. For enrolled students – we will accept a current utility bill, i.e. Duke Energy, to "change" an address. If renting, the landlord's name and phone number is still required with the new utility bill. Thank you.*

In determining "residency" for school purposes, the State of Ohio examines criteria such as where the parent sleeps and eats the majority of time, where mail is received, and where the parent is registered to vote. One cannot establish a residence merely by purchasing a house or apartment building or even by furnishing such a house or apartment so that it is suitable for the owner's use. "Residence" involves something more. It must be a place where important family activity takes place during significant parts of each day; a place where the family eats, sleeps, works, relaxes, and plays. It must be a place, in short, which can be called "home."

**STUDENT REGISTRATION – OAK HILLS LOCAL SCHOOL DISTRICT 2023-2024**

student ID # \_\_\_\_\_

PLEASE PRINT FRONT AND BACK CUSTODIAL PARENT MUST COMPLETE THIS FORM

STUDENT'S NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
(Name must be as it appears on birth certificate)Is Student called by first Name? ☐ Yes ☐ No If not: \_\_\_\_\_

Student's Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Location of Birth: City \_\_\_\_\_ State \_\_\_\_\_

Grade \_\_\_\_\_ ☐ Male ☐ Female Current Age: \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ PREVIOUS ADDRESS (within 5 years) \_\_\_\_\_

Mother's Cell Phone Number \_\_\_\_\_ Mother's E-Mail Address \_\_\_\_\_

Father's Cell Phone Number \_\_\_\_\_ Father's E-Mail Address \_\_\_\_\_

Brothers' Names \_\_\_\_\_ Age(s) \_\_\_\_\_ School(s) \_\_\_\_\_

Sisters' Names \_\_\_\_\_ Age(s) \_\_\_\_\_ School(s) \_\_\_\_\_

**STUDENT'S RACE AND ETHNICITY**Is the student Hispanic, Latino or of Spanish origin (regardless of race)? ☐ Yes ☐ No*Note: Hispanic or Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*What race is the student (Choose all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American  
☐ Native Hawaiian or Pacific Islander ☐ White*If you choose not to indicate your child's race, the Oak Hills Local School District is required by Federal law, to identify your child by observation***PARENT/LEGAL CUSTODIAN INFORMATION**☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed ☐ Court Order\*\*

Name and relationship of custodial parent(s): \_\_\_\_\_

\*\*Evidence of legal custody must be presented and filed with the school.

**MOTHER'S NAME:** \_\_\_\_\_ Maiden Name \_\_\_\_\_Is mother living? ☐ Yes ☐ No Mother's Date of Birth \_\_\_\_\_ Does student live with mother? ☐ Yes ☐ No

Address (if not same as student's) \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Place of employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work No. \_\_\_\_\_

If remarried, husband's name \_\_\_\_\_ Phone No. \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_Is father living? ☐ Yes ☐ No Father's Date of Birth \_\_\_\_\_ Does student live with father? ☐ Yes ☐ No

Address (if not same as student's) \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Place of employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work No. \_\_\_\_\_

If remarried, wife's name \_\_\_\_\_ Phone No. \_\_\_\_\_

**LEGAL CUSTODIAN (if different than above):** \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**MILITARY STATUS**

Please select the option that best describes your family's military status:

- ☐ Active Duty: student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marines or Coast Guard)
- ☐ National Guard: student is a dependent of a member of the National Guard (Army or Air)
- ☐ Reserve Duty
- ☐ Not Applicable

## OCCUPATIONAL SURVEY

Has anyone in your immediate family been involved in one of the following occupations, whether full time or part-time or temporarily during the last 36 months? ☐ Yes ☐ No

Agriculture: planting/picking of fruits or vegetables

Packing/Canning: fruits or vegetables

Meat or seafood packing/meat or seafood processing

Fishing or fish farms

Nursery work: preparing soil, planting seedlings or other activities related to the production of flowers and/or other greenhouse commodities OR timber work: planting, growing or cutting trees

Dairy/Poultry/Livestock

## EDUCATIONAL BACKGROUND

Has this student attended any Oak Hills School prior to this enrollment (including an OHLSD preschool?) ☐ Yes ☐ No

If Yes: Date: \_\_\_\_\_ School(s) \_\_\_\_\_ Grade(s) \_\_\_\_\_

NAME OF LAST SCHOOL ATTENDED \_\_\_\_\_

Address of former school \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is student currently expelled? ☐ No ☐ Yes If yes, what dates \_\_\_\_\_

### IEP – Individual Education Plan

Is the student on an IEP (Individual Education Plan) and currently receiving special education services? ☐ Yes ☐ No

**Disability Category:**

<input type="checkbox"/> Specific Learning Disability	<input type="checkbox"/> Orthopedically/Health	<input type="checkbox"/> Emotional Disturbance
<input type="checkbox"/> OHI (Other Health Impaired)	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Speech/Language Impaired
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Autism	<input type="checkbox"/> Visually Impaired
<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Deaf/Blindness

**SECTION 504 PLAN:** Is the student on a 504 Plan and currently receiving educational services? ☐ Yes ☐ No

Retention: Has your student ever been retained? ☐ Yes ☐ No If yes, what grade? \_\_\_\_\_

Is student enrolled in a Gifted Program? ☐ Yes ☐ No

## IF PARENTS CANNOT BE REACHED, WHO SHOULD BE CALLED

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No. \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No. \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Is the student on any medication? ☐ Yes ☐ No If yes, name \_\_\_\_\_

Does the student have any of the following conditions: ☐ Diabetes ☐ Epilepsy ☐ Asthma ☐ Bleeder ☐ Heart Condition

Allergy (Specify) \_\_\_\_\_ Other: \_\_\_\_\_

**My signature below certifies that I am a current resident of the Oak Hills Local School District and that I have supplied the school district with the proper proof of residency. I agree to immediately inform the school district if my residence changes. I understand that the school district has the right to investigate my claims of residency and act accordingly. The information on this form is true and accurate to the best of my knowledge.**

\_\_\_\_\_  
Signature of Parent or Legal Custodian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Printed Name

COMPLETING AND RETURNING THIS FORM TO A SCHOOL BUILDING DOES NOT GUARANTEE PLACEMENT AT THAT SCHOOL.

## Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

<b>Student Name:</b> <i>(First Name and Last Name)</i> _____		<b>Student Date of Birth:</b> <i>(mm/dd/yyyy)</i> _____	
<b>Communication Preferences</b> Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.		1. In what language(s) would your family prefer to communicate with the school? _____	
<b>Language Background</b> Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.		2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____	
<b>Prior Education</b> Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.		5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month                  Day                  Year	
<b>Additional Information</b> Please share additional information to help us understand your child's language experiences and educational background.			
Parent/Guardian First Name: _____		Parent/Guardian Last Name: _____	
Parent/Guardian Signature: _____		Today's Date: <i>(mm/dd/yyyy)</i> _____	

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>



## Pre-Kindergarten Experience Survey

Dear Parent/Guardian: We are requesting that families complete and return the survey below. Your responses to this survey will help us learn more about your child's diverse early learning experiences. All the information on this survey will be kept secure and confidential. Thank you in advance for your assistance.

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: ☐ Male ☐ Female

Home School: ☐ CO Harrison ☐ Delshire ☐ J.F. Dulles ☐ Oakdale ☐ Springmyer

Does your child qualify for free/reduced lunch or any other government assistance program? ☐ Yes ☐ No

Primary language spoken at home: ☐ English ☐ Spanish Other: \_\_\_\_\_

From the age of 3 until the time he/she entered Kindergarten...

1. Did your child attend a part-day preschool or childcare program?

☐ Never ☐ 1 year or less ☐ more than 1 year

2. Did your child attend a full-day preschool or childcare program?

☐ Never ☐ 1 year or less ☐ more than 1 year

3. Did your child participate in a Head Start program?

☐ Never ☐ 1 year or less ☐ more than 1 year

4. What is the name of the preschool, Head Start, or child care program your child attended the longest?

\_\_\_\_\_

5. How many times have you moved before your child entered kindergarten?

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 or more times

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent Printed Name: \_\_\_\_\_

Parent Phone Numbers: \_\_\_\_\_

Parent Email: \_\_\_\_\_

**OAK HILLS LOCAL SCHOOL DISTRICT  
6325 RAPID RUN ROAD  
CINCINNATI, OHIO 45233**

**Instructions to Parents Filling Out “School Health Examination Record”**

Complete forms and give as much information as possible.

\*\*\*\*The State of Ohio Compulsory Immunization Law states that all children who enter Ohio Schools **MUST** have received the following immunizations:

- a. 5 doses of DPT (Diphtheria, Pertussis and Tetanus) for Kindergarten  
1 dose of Tdap or Td vaccine on entry to 7<sup>th</sup> grade
- b. 4 doses of Polio Vaccine (OPV/IPV)
- c. 2 doses of Rubeola, Rubella, and Mumps (MMR) must be administered after 12 months of age.
- d. 3 doses of Hepatitis B Vaccine
- e. 2 dose Varicella Vaccine must be administered prior to entry of kindergarten.

**NOTE:** Your child **MAY NOT ENTER** school unless he/she has received the above listed immunizations. The attached form **must be completed** by your physician and returned to your child’s school by July 31. The oral assessment/Dental form is highly recommended but is not a requirement.

Revised 1/2012

## Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /	
Height	Weight	BMI percentile		BP	

## Screening Tests

Vision		Hearing		Postural	
Date performed / /		Date performed / /		Date performed / /	
Distance Acuity	<input type="checkbox"/> R <input type="checkbox"/> L	Pure Tone		<input type="checkbox"/> No abnormality noted	
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done	
Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made	
Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments	
Child wears glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care of a hearing specialist	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tested with glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

## Speech/Language

Speech assessment completed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child has no discernible speech problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech evaluation recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child has possible problem with	

## Lead Poisoning

<input type="checkbox"/> Date _____	Type	<input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL
<input type="checkbox"/> Date _____	Type	<input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL
<b>Tuberculin Test</b>			
Date _____	Type _____	Results _____	

## Health History (Serious or chronic illnesses/injuries/surgeries)

_____
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## Physical Examination Date of most recent examination / /

<input type="checkbox"/> Essentially normal <input type="checkbox"/> Abnormalities as follows	
_____	
_____	
Is this child able to participate fully in:	
Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
If limitations are advised, please specify	
_____	
_____	
Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?	
_____	
_____	

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

# Ohio Department of Health • School and Adolescent Health

## Immunization Report

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /      /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).  
 A copy of the child's immunization record may be attached or dates may be entered below.  
 Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by    ☐ Health Care Provider    ☐ Parent/Guardian    ☐ Other \_\_\_\_\_

Signature	Print name	Date /      /
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# Ohio Department of Health • School and Adolescent Health

## Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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### Family Health History

Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

### Birth and Developmental History

☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. _____	
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

### Student Health Conditions

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:			<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia	
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions	
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems	
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury	
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)	
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____	
Please explain any conditions above or any reasons for hospitalizations. _____			
Please indicate any allergies your child may have.			
<b>Allergy type</b>	<b>Reaction</b>	<b>School restrictions or recommended actions</b>	
<input type="checkbox"/> Bee/Insect			
<input type="checkbox"/> Food			
<input type="checkbox"/> Medication			
<input type="checkbox"/> Other			

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.		
Medication and dose	Time	Reason
Do any health and/or medical conditions require school restrictions, modifications, and/or intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, please explain.		
Does the student require any special procedures and/or treatments for their health condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, please explain.		
Please indicate any other information about your child's health or development that you think would be helpful for the school to know.		
Form completed by	Relationship to student	Date / /

**Ohio Department of Health • School and Adolescent Health**  
**Oral Assessment**

Student's name	Date of birth / /
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**The following services have been performed** (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

**The following oral hygiene instruction was provided** (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

**The following statements are applicable** (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis) <input type="checkbox"/> No restorative services are required at this time. <input type="checkbox"/> Further treatment is indicated.(See comments) <input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative) <input type="checkbox"/> Routine recall visits recommended.	
Comments  _____  _____  _____  _____	

Dentist's signature	Print name	Phone (      )
Address		Date / /
City	State	ZIP