CLINTON SCHOOL DISTRICT #32

20397 East Mullan Road
PO Box 250
Clinton, MT 59825-0250

Date: ________________________________

Parent Release:

I do hereby authorize the ____
Former School

____
Address

____
City State Zip

to release all health, scholastic and psychological records accumulated including Special Education or Title 1 files, for:

____
Pupil's Name

presently in grade ____ to:

Clinton Elementary School
P.O. Box 250
Clinton, MT 59825

____
Signature of Parent or Guardian

CLINTON SCHOOL DISTRICT #32

20397 East Mullan Road
PO Box 250
Clinton, MT 59825-0250
Phone (406) 825-3113
Fax (406) 825-3114

Date ____________________

Student Registration

Name of Pupil ____________________________________ Grade ___________________

Date of Birth _____________ Place of Birth ____________________________________

Social Security Number ____

Parent or Guardian ____

Address ___________________________________ E-mail ________________________

Occupation ____

Home Phone ________________________________ Work Phone ___________________

Name of school last attended ____

Address of school last attended ____

____

Family Physician ____
(Used only in emergency)

In case of emergency, who to contact if you cannot be reached:

Name _____________________________________ Phone _________________________

HAS YOUR CHILD BEEN RECEIVING ANY EXTRA HELP IN ANY SUBJECTS? ________

What subjects ____

Resource Room ___________ Self Contained ____________ Chapter One _______

CLINTON SCHOOL DISTRICT #32

20397 East Mullan Road
PO Box 250
Clinton, MT 59825-0250
Phone (406) 825-3113
Fax (406) 825-3114

CUMULATIVE HEALTH RECORD

Pupil's Name ______________________________ Sex ________ Birth Date ________

Physician ______________________________ Dentist ______________________________

Pupil's Health History (Give Approximate Age)

Allergy, specify ______________________

Under MD treatment? ______________________

Asthma ______________________

Congenital defects (cleft lip, or palate, hip dysplasia

____

Diabetes (date of onset) ______________________

Epilepsy or Seizure Disorder (date of onset)

____

Ear Infections ______________________

Ear Tubes (year inserted) ______________________

Heart Condition, specify ______________________

____

Injuries ______________________

Surgery ______________________

Other ______________________

Significant family history (diabetes, hypertension, etc.) ______________________

____

Physical restrictions or health problems that may require special seating, bathroom privileges, etc.

____

Special diet or food restrictions ______________________

Current medications (name of medication and how often) ______________________

____

Date	Nurse/Teacher Comments

Name

Year

Grade

Height	Fall								
	Spring								
Weight	Fall								
	Spring								
Vision Screening	Date								
	Corrective Lenses								
	Right Eye								
	Left Eye								
	Near Point								
	Muscle Balance								
	Color Vision								
Hearing Screening	Date								
	Right Ear Pure Tone								
	Right Ear Impedance								
	Left Ear Pure Tone								
	Left Ear Impedance								
Dental	Screening Class I, II, or III								
	Fluoride Mouth Rinse								
S.S.	Scoliosis Screening								
B.P.	Blood Pressure								
T.B.	Tuberculosis Tine Test								
Etc.	Other (Specify)								

Please note: If this sheet was completed recently for new registration, another is not needed. Thank you.

EMERGENCY CARE IN CASE OF ILLNESS OR INJURY DURING SCHOOL

Student ____________________ Teacher ______________ Grade ____________

Special Health Problems _________________________ Allergy _________________

Parents Name ______________________________ Phone ________________

Phone at Work – Mother ___________________________________

Phone at Work – Father ___________________________________

Mailing Address ____

E-Mail Address ____

Alternate Person to notify if you cannot be reached:

Contact #1 Name ____

Phone ____

Contact #2 Name ____

Phone ____

Please inform these people that they are your choice. I suggest you choose something that is local and that may be home when you are gone.

I hereby voluntarily consent to emergency treatment and first-aid screening examinations and minor treatment as may be deemed necessary. I also voluntarily consent to preventive health screenings including vision, hearing, scoliosis and others as may be deemed necessary by the school nurse. When unable to contact parent or friend, I hereby give my permission to the school to authorize treatment needed, until the parent can be notified.

_____________ Yes _____________ Exception _____________ No

Parent Signature ______________________________ Date _____________

Physician to Notify ____

Please return by 9/15/05
A renewal is necessary each year.

SEE REVERSE SIDE

Lauretta Ekstrom, R.N.
School Nurse

PLEASE SEE REVERSE SIDE ALSO

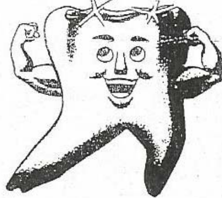
MONTANA

Department of Public Health & Human Services

Family & Community Health Bureau

School Based Fluoride Mouthrinse Program

Tooth decay is the most common, long-term disease of childhood, however, it can be prevented by the use of fluoride, regular dental check-ups, and good daily oral hygiene habits.



Fluoride is a mineral found naturally in soil, plants, animals and water which makes bones and teeth strong. Fluoride prevents tooth decay two ways: through direct contact with teeth and when people drink it in the water supply during the tooth forming years and later.

Many Montana communities do not have access to fluoridated community water systems or the fluoride in the water is too low to provide the best protection from decay. A dentist or physician can write a prescription for fluoride vitamin drops or tablets for children 6 months to 14 years of age to supplement low fluoride levels in drinking water. Fluoride mouthrinse use in schools is also effective in preventing decay.

The fluoride mouthrinse is swished for one minute with a .2% solution of sodium fluoride. <u>Research shows participation in this program can reduce decay by 35%.</u> The program is:

- well accepted by parents and teachers all across Montana.
- a simple procedure which utilizes approximately 5 minutes per week of classroom time.
- easy for students to learn.
- cost effective (supplied to schools at less than 50 cents per child per school year).

Parental Consent Form

(Please return this form at the beginning of the school year to ensure participation)

Child's Name____________________________________ Grade____________

School________________________________ Teacher __________________

______I would like my child to participate in the weekly fluoride mouthrinse program at school.

______________________________ (Parent Signature)

____/____/____ (Date)