

INDIAN BOARD OF EDUCATION
for the
PIERRE INDIAN LEARNING CENTER



Enclosed is a student application for admission to the Pierre Indian Learning Center. Please complete ALL of the requested information. It is ABSOLUTELY NECESSARY to have the following documents included with the application. **Incomplete applications will be returned; this will delay the student's acceptance.**

- ✓ Copy of last report card showing student passed or was retained (**report card must be included with this application**)
- ✓ **Copy of most recent IEP (Individualized Education Plan), if applicable** (**must be included with this application**)
- ✓ Social Summary (if your child has received specialized counseling, a report of services must be submitted with application)
- ✓ Degree of Indian Blood Certification (copy)
- ✓ Birth certificate (copy)
- ✓ Social Security Card (copy)
- ✓ Custody Order (copy), where applicable. If you are not the legal parent of the student, we require an Order showing you have legal guardianship. Only parents or **LEGAL** guardians (accompanied by the Custody Order) shall sign the application
- ✓ **Complete** medical information requested on health section of application
- ✓ **Medical Physical must be included with the application**
- ✓ **Medicaid card (copy) or personal insurance information which includes the name and complete address of the insurance company and your policy number (copy). We require all students to be covered either by Medicaid, CHIPS or personal insurance**
- ✓ **Any student with a history of psychiatric hospitalization or who is on medication(s) must submit full reports from the physician/psychologist and/or hospital before the application will be considered.**

All current medical, dental and vision needs must be completed and on file before the student arrives on campus. (Send the completed application in and the medical/dental/vision exams can be faxed upon completion to 605/224-8465 or sent via email to renee.bearstops@k12.sd.us)

If you have any questions or need further information, please call us at (605) 224-8661, ext. 110, or email renee.bearstops@k12.sd.us

Renee Bear Stops, Registrar

Signature of Parent/Legal Guardian

Date

INDIAN BOARD OF EDUCATION
for the
PIERRE INDIAN LEARNING CENTER

Cheyenne River Sioux Tribe
Crow Creek Sioux Tribe
Flandreau-Santee Sioux Tribe
Lower Brule Sioux Tribe
Oglala Lakota Nation
Omaha Tribe of Nebraska
Rosebud Sioux Tribe
Santee Sioux Tribe of Nebraska



Sisseton-Wahpeton Oyate
Spirit Lake Nation
Standing Rock Sioux Tribe
Mandan, Hidatsa & Arikara Nation
Turtle Mountain Band of Chippewa Indians
Winnebago Tribe of Nebraska
Yankton Sioux Tribe

STUDENT ENROLLMENT APPLICATION

Social Security Number _____
(required)

Student Name _____
Last First Middle

Address: P.O. Box _____ Street _____
(Physical location is required)

City _____ County _____ State _____ Zip _____

Date of Birth _____
Month Day Year

Place of Birth _____ Sex: Male () Female ()

Tribal Affiliation _____ Degree of Indian Blood _____

Enrollment Number _____ Home Agency _____

Religious Affiliation (optional) _____

Signature of Parent/Legal Guardian

Date

FAMILY AND BACKGROUND INFORMATION

Father: _____

Mother: _____

Address: _____

Address: _____

Tribal Affiliation: _____

Tribal Affiliation: _____

Home Agency: _____

Home Agency: _____

Enrollment Number: _____

Enrollment Number: _____

Living () Deceased ()

Living () Deceased ()

Employer: _____

Employer: _____

Telephone: Home _____

Telephone: Home _____

Work _____

Work _____

Emergency _____

Emergency _____

Other (specify) _____

Other (specify) _____

EMAIL _____

EMAIL _____

Social Media handle _____

(if we are unable to reach you via phone or email, we would like to be able to reach our via Social Media)

IF YOU HAVE A CHANGE OF ADDRESS/PHONE NOTIFY ADMINISTRATION ASAP!

This section must be complete if legal guardian is not parent(s), a copy of the Custody Order/Guardianship is required.

LEGAL GUARDIAN: _____ **Relationship:** _____

Physical Address: _____

Mailing Address: _____

Telephone: Home _____ Cell: _____ Work: _____

Emergency contact: _____

EMAIL address: _____

Social Media handle: _____

Employer: _____

Signature of Parent/Legal Guardian

Date

RELEASE/TRANSFER OF EDUCATIONAL RECORD(S) FORM

RELEASE TO**PIERRE INDIAN LEARNING CENTER**

3001 E Sully Avenue

Pierre, SD 57501-4419

Phone: (605)224-8661 or Fax: (605)224-8465

REQUESTED FROM

(Previous School Name)

(Mailing Address)

(City/State/Zip)

STUDENT'S NAME _____ **2024-25 Grade** _____☐ General Education (report card)☐ Special Education - include the following for Special Education records:
Referral/Parental Permission to test – Parental Consent for Placement-Educational Testing –
I.E.P. – Team Notes – Psychological Evaluations (Clinical or otherwise) – other relevant
information you may have.

This is to certify that I do hereby agree to the release of medical, psychological and education records (defined as any information used to make a decision regarding special education for my child) with the understanding that they will be released only for the purpose stated above and only to the person/institution stated above. If there are no specific educational needs for these records, the records will be destroyed or returned to parents upon written request.

Signature of Parent/Legal Guardian

The undersigned releases these records with the understanding that they are being released only for the purpose stated above and only to the person/institution stated above.

Signature of Parent/Legal Guardian



Student and Family Language Survey

Student Name: _____

Gender: **Female** _____ **Male** _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Name: _____

Select all that apply to the student:

Native American _____ **Caucasian** _____ **Hispanic** _____ **Asian** _____

Native Hawaiian/Pacific Islander _____

Tribal Membership: _____

Other Tribes: _____

Which language did your child learn when they first began to talk? _____

Which language does your child most frequently speak at home? _____

Which language do you (the parents/guardians) use more often when speaking with your child?

If English is not my child's first language, I give my permission for Pierre Indian Learning Center to administer the WIDA ELL Assessment for evaluation and possible placement in the school's ELL program.

Signature of Parent/Legal Guardian

Date

PERMISSION SLIP

Students who are permanently released during the school year will not be accepted for re-admission at a future date. I/we have read and understand this action and hereby agree that this student will remain at the Pierre Indian Learning Center until the completion of the school term.

Parent/Legal Guardian

Date

I, _____, hereby authorize the following persons to temporarily
Print name of parent/legal guardian
check out my child _____. (Please include your name(s) on the list.)
Print student's name

Must be at least 18 years of age (proof required) to check out students. PILC staff members may not check students out for anything other than school/church activities.

NON OVERNIGHT LIST

1. _____
2. _____
3. _____
4. _____
5. _____

OVERNIGHT LIST

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE CHECK APPLICABLE BOX:

I/we grant the **Pierre Indian Learning Center** permission to utilize the above-referenced student's photographs, writings or illustrations for information and educational purposes only.

☐ Yes ☐ No

I/we give permission for the above-named student to participate in on/off campus sporting events and other extra-curricular activities conducted/represented and supervised by staff members of the **Pierre Indian Learning Center**.

☐ Yes ☐ No

I/we give permission for the above-named student to participate in **Sweat Ceremonies** at the **Pierre Indian Learning Center**.

☐ Yes ☐ No

Signature of Parent/Legal Guardian

Date

*Students will be allowed to make their own decisions concerning haircuts, trims or permanents
unless we receive written instructions from parents/guardians stating otherwise*



GIFTED AND TALENTED PROGRAM

Parent Consent – Assessment/Evaluation

This is to certify that I consent for my child, _____ to be evaluated,
(Print Student's Name)
tested and data collected, to determine whether he/she is eligible for special services as provided by the Gifted and Talented Program. These evaluations are performed by persons with special training to evaluate and identify student needs. I also give permission for my child to participate in the Gifted and Talented Program, if qualified. As, a parent, I have the right to access, to inspect, to question, to obtain copies of all relevant documentation pertaining to my student's file and to remove my child from the program upon written request.

_____ **I consent to have my child individually evaluated**

Signature of Parent/Legal Guardian

Date

_____ **I do not consent to have my child individually evaluated**

Signature of Parent/Legal Guardian

Date

It is the mission of Pierre Indian Learning Center, in partnership with parents and communities, to empower each child to achieve his or her fullest potential to become a lifelong learner and responsible citizen. We are committed to foster high expectations and promote positive attitudes to achieve equity and excellence in a safe and nurturing environment.

**Community, Parents, Schools, and Students
Partners in Each Child's Education • Success for All**

As a parent/guardian, I will strive to:

- Believe my child, _____ can learn;
- Show respect and support for my child, the staff, and the school;
- Explain to my child the importance of doing his/her best;
- Encourage my child to complete all homework assignments;
- Attend parent-teacher conferences when possible;
- Support the school in developing positive behaviors in my child;
- Talk with my child about his or her school and dormitory activities; and
- Encourage my child to read at home and apply all their learning to daily life.

As a student, I will strive to:

- Believe that I can learn;
- Show respect for myself, my school, and other people;
- Always try to do my best in my work and my behavior;
- Work cooperatively with students and staff;
- Obey the student expectations in the classroom and throughout the school; and
- Come to school prepared with my homework and supplies.

As a teacher I will strive to:

- Believe that each child can learn;
- Respect and value the uniqueness of each child and his or her family;
- Provide an environment that promotes active learning;
- Enforce student expectations in the classroom and throughout the school in a fair and consistent manner;
- Assist each child in achieving the essential academic learning requirements;
- Document ongoing assessment of each child's academic progress;
- Maintain open lines of communication with students and parents;
- Seek ways to involve parents in the school program; and
- Demonstrate professional behavior and a positive attitude.

As a dormitory staff, I will strive to:

- Communicate and work with families to enhance students' learning.
- Respect the cultural differences of students and their families.
- Continue efforts to develop professionally.
- Provide a safe, pleasant, and caring atmosphere.
- Provide resources to help all children be successful in their school experience.
- Maintain high expectations for myself, students, and other staff.
- Assist students in the development of a sense of personal and civic responsibility.
- Help students learn to resolve conflicts in an appropriate and positive manner.

Members of the Pierre Indian Learning Center educational community, together as partners in your child's education, uphold the intent of this compact.

Signature Student

Date

Signature of Parent/Legal Guardian

Date



PIERRE INDIAN LEARNING CENTER

3001 E. Sully Avenue
Pierre, SD 57501
Phone: (605-224-8661
Fax: (605-224-8465

McKinney-Vento Residency Form

Student Name _____ Gender: Male / Female Grade _____

Date of Birth _____ Parent/Guardian Name _____

The McKinney-Vento Homeless Assistance Act (Title X, Part C, of the No Child Left Behind Act) defines “homeless” as “individuals who lack a fixed, regular, and adequate nighttime residence.” This includes children who “are temporarily sharing the housing of other persons due to the loss of housing or economic hardship.”

_____ Does not apply; student is not homeless.

Please check one of the following statements if your family is experiencing temporary homelessness:

_____ Living in a shelter, including transitional housing shelters; awaiting foster care, etc.

_____ Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, housing not fit for habitation.

_____ Living in hotels/motels for lack of other suitable housing – Please list name and address of hotel/motel.

_____ Doubled-up; Temporarily living with family or friends due to lack of adequate housing or financial conditions.

The undersigned certifies that the information provided above is accurate.

Signature of Parent/Guardian/Unaccompanied Youth

Relationship

Date

Office Use Only:

_____ Does Qualify under McKinney-Vento Act

_____ Does NOT Qualify

McKinney-Vento Liaison Signature

Date



**Pierre Indian Learning Center
Cell Phone and Electronics Program**

In the past, the Pierre Indian Learning Center has forbidden students to bring cell phones or Mp3 players/iPods to campus for fear of loss, damage, or theft. After much consideration, administration has drafted the following pilot program policy regarding these items:

1. In an effort to improve communication between parents/families and students attending the PILC, students will be permitted to bring cell phones with them to campus. Upon arrival at the dorms, students will be required to check their cell phones in, where the items will be kept secure in a locked room on each wing. Students will be permitted to “check out” their phones at a specified time each evening to make phone calls/answer texts, etc. Parents will be informed via letter of the time on each wing when cell phones may be checked out by students. Cell phones may NOT be brought to school during the academic day. Phones must be clearly labeled with the child’s name.
2. Students will be permitted to bring their personal Mp3 players/iPods/iPads to campus. These items will need to be labeled with the child’s name. Students may NOT bring these items to school during the academic day, and will only be permitted to use them during non-instructional time in the residential department.
3. The PILC assumes NO LIABILITY for the theft, loss, or misuse of these items (e.g. a student allows another child to use his cell phone, using the student’s prepaid minutes).
4. The PILC will not replace any student cell phone or Mp3 player/iPod/iPad. It is the responsibility of the student to manage the devices properly and according to the regulations established on each wing.

I acknowledge that I have read and agree to the Pierre Indian Learning Center cell phone and electronics policy. Should I choose to send electronic devices to the PILC campus with my child, I understand that the PILC assumes no liability for these items. I also understand that should my child violate these policies, he or she may lose electronics privileges temporarily or in severe cases the items may be sent home to the parents/guardian.

Signature of Parent/Legal Guardian

Date



TEMPORARY RELEASE PROCEDURE

ACADEMIC POLICY:

Consistent and punctual attendance is required of students each and every day while enrolled at the Pierre Indian Learning Center.

- **NO STUDENTS MAY BE CHECKED OUT DURING THE SCHOOL DAY FROM 8:00 AM UNTIL 3:30 PM.**

RESIDENTIAL POLICY:

- No student may be checked out between the hours of 8:30pm to 7:30am.
- Students are to be returned to the dormitory by 8:30 pm Sunday through Thursday. AND by 9:45 pm Friday and Saturday.

WEEKEND POLICY:

- Students may be checked out overnight on weekends or non-school days by individuals authorized on the student's check-out sheet for overnight check-out.
- When checking out a student overnight, please indicate when the student will be returned to the PILC campus.
- Overnight checkouts may NOT take place Monday through Thursday, unless there is no school.
- Students may NOT be checked out overnight on a Friday until after 3:30 pm.
- Students who are checked out overnight MUST be returned to the dormitory by 8:30pm.

All gates will be locked at 8:45pm. No one will be admitted after that time.

My signature indicates that I have read and understand this procedure.

Signature of Parent/Legal Guardian

Date

Pierre Indian Learning Center
3001 E. Sully Avenue
Pierre, South Dakota 57501-4419
Phone: (605) 224-8661 Fax: (605) 224-8465

Dear Parent/Guardian:

Health care is a very important part of the program we provide to children while they are in attendance at Pierre Indian Learning Center. Our services include an on-site health clinic for injuries, illnesses, medications and health education, working closely with family physicians and specialists in the Pierre area.

If you don't have personal health insurance for your child, please seek coverage by Medicaid or through CHIP (a federally funded health insurance for children). **This coverage must be in place before you send your child to Pierre Indian Learning Center. Please contact a social worker in your area for medical coverage.**

The following must be completed and on file at Pierre Indian Learning Center **before** child arrives at our school:

- 1) **Proof of current health insurance and/or Medicaid coverage; we require a copy of the open and active card that includes name, policy/ID number.**
- 2) **A complete physical exam**
- 3) **A complete dental exam**
- 4) **A complete vision exam. If glasses are recommended, they must accompany the student to school.**
- 5) **Immunization Records**

Due to the high cost of medical care, it is important that these items are covered through your Indian Health Service Unit or through the clinic of your choice, **BEFORE** your child comes to school.

We look forward to working with your child.

Sincerely,



Mitchell Kleinsasser, RN
PILC School Nurse

Cheyenne River Sioux Tribe
Crow Creek Sioux Tribe
Flandreau-Santee Sioux Tribe
Lower Brule Sioux Tribe
Oglala Lakota Nation
Omaha Nation
Rosebud Sioux Tribe
Santee Sioux Tribe of Nebraska
Sisseton-Wahpeton Oyate
Spirit Lake Nation
Standing Rock Sioux Tribe
Mandan, Hidatsa & Arikara Nation
Turtle Mountain Band
of Chippewa Indians
Winnebago Tribe of Nebraska
Yankton Sioux Tribe

HEALTH CARE INFORMATION

The following must be completed prior to admission to PILC

Student Name _____

P.O. Box _____ Physical Address _____

City _____ County _____ State _____ Zip Code _____

The student resides with _____

Relationship to the student _____

Home Phone _____ Work Phone _____

Social Security Number (student) _____ Sex (student) _____ Birth Date (student) _____

Does your family have a state or tribal social worker who assists you? () Yes () No

If yes, name: _____ Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Previous School _____ Last grade completed _____

Mailing Address _____ City _____ State _____ Zip _____

Medicaid Number _____ or

Insurance Company Name _____ Policy Number _____

Indian Health Service Unit address where current information can be requested

Current Immunizations must accompany this application (see enclosed physical form)

Does the student have **allergies** to medications? () Yes () No

If yes, which medication(s) _____

Reaction(s)? _____

Does the student have **allergies** to foods? () Yes () No

If yes, which food(s) _____

Reaction(s)? _____

Is the student disabled physically or mentally? () Yes () No

If yes, in what way? _____

When/where was the disability identified _____

Parent/Guardian Signature _____

Date _____

RELEASE OF INFORMATION CONSENT

This is to certify that I, _____, do hereby agree to the release of
(PRINT: Parent/Legal Guardian)

medical and psychological/psychiatric report, evaluation or hospitalization records for:

_____/_____/_____
(PRINT: Student's Name) (Student's Date of Birth) (Student's Social Security Number)

This release should include immunization records, medical records, hospital stays, and psychiatric or other treatment records. All this information will be filed in the student's health records with other confidential information.

REQUESTOR **Pierre Indian Learning Center**
3001 E Sully Avenue
Pierre, SD 57501-4419

FACILITY WHERE STUDENT'S MEDICAL RECORDS ARE:
(Please Print)

NAME: _____

ATTN: _____

FAX NUMBER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Parent/Guardian Signature _____

Date _____

**CONSENT OF PARENT OR LEGAL GUARDIAN WHO HAS PRIMARY RESPONSIBILITY
FOR THE CARE OF THE CHILD**

Student Name (please print) _____ DOB _____

I/We, _____
being the parent(s) or legal guardian(s) of the above-named student have read and understand the consent and give my (our) consent for the Pierre Indian Learning Center (PILC) to provide the following health services for this student **during the time he/she is enrolled at PILC:**

1. Health care including, but not limited to, medical and nursing examinations and treatments, laboratory studies, x-ray procedures, immunizations and blood draws ordered by the physician. The treatment may include medication.
2. Health education and instruction including, but not limited to, AIDS education, self-examination, routine health maintenance, age and gender appropriate sexuality education, and sexually transmitted infection (STI) education, and access to SD Family Planning Clinic.
3. Emergency Optometry care.
4. Emergency care.
5. Emergency health care for accidents and/or illness, which may include surgery if indicated.
6. Transportation of the child to and from health facilities for these services.
7. Emergency mental health care.
8. Dental exams, follow up and emergency dental care.

Parent/Guardian Signature _____

Date _____

I. **CHILD'S HEALTH HISTORY – IMPORTANT**, the listed below item needs to be completed.

If YES, an explanation needs to be included.

Has your child had:

Describe

Suicidal Ideation	() Yes	() No	Currently	_____
Previous diagnosis of ADHD/ADD	() Yes	() No	Currently	_____
Chickenpox	() Yes	() No	Currently	_____
Ear infections	() Yes	() No	Currently	_____
Pneumonia	() Yes	() No	Currently	_____
Bronchitis	() Yes	() No	Currently	_____
Asthma	() Yes	() No	Currently	_____
Urinary infection	() Yes	() No	Currently	_____
Diabetes	() Yes	() No	Currently	_____
Hepatitis	() Yes	() No	Currently	_____
Seizures	() Yes	() No	Currently	_____
Bedwetting problems	() Yes	() No	Currently	_____
Sleeping problems	() Yes	() No	Currently	_____
Eating problems	() Yes	() No	Currently	_____
Hyperactivity	() Yes	() No	Currently	_____
Stammering/lisping	() Yes	() No	Currently	_____
Accident prone	() Yes	() No	Currently	_____
Depressed/withdrawn	() Yes	() No	Currently	_____
Nervousness	() Yes	() No	Currently	_____
Constipation and/or bowel accidents	() Yes	() No	Currently	_____
Injuries	() Yes	() No	Currently	_____
(burns, broken bones, knocked unconscious, etc.)				
Cardiac Defect/History of Cardiac Problems	() Yes	() No	Currently	_____
MRSA (Methicillin-resistant Staphylococcus Aureus)	() Yes	() No	Currently	_____
Fainting with exertion or activity	() Yes	() No	Currently	_____

Explanation _____

Any serious sickness, hospitalization or surgeries? () Yes () No
If yes, please state date, type of sickness/surgery, hospital, and physician's name who treated the child.

Does your child wear glasses for vision problems? () Yes () No

Has your child ever seen a doctor for hearing problems () Yes () No

When did your child last see a medical doctor or a physician's assistant? _____

For what? _____

Parent/Guardian Signature _____ Date _____

NOTE: If the student is or has taken medication for psychological problems, (example: hyperactivity and/or depression), the doctor's records must accompany this application.

ADDITIONALLY: in the case of psychiatric hospitalization, a discharge summary must accompany this application!

PRESENT MEDICATIONS

If the applicant is receiving any medications at the present time, please list name of drug, dosage, date started, purpose and any adverse reactions to the drug. (Please include oral and topical medications.)

1. Drug: _____ Dosage: _____ Date Started: _____
Purpose: _____
2. Drug: _____ Dosage: _____ Date Started: _____
Purpose: _____

PAST MEDICATIONS

If the applicant has received any other medication in the past, please list name of drug, dosage, date started, purpose, date discontinued and reason(s) for discontinuing.

1. Drug: _____ Dosage: _____ Date Discontinued: _____
Purpose: _____
2. Drug: _____ Dosage: _____ Date Discontinued: _____
Purpose: _____

Has this child been in treatment for Emotional, Alcohol/Drug or Behavior issues?

Explain, Date(s)

Other problems or additional information helpful to the care of your child.

Parent/Guardian Signature _____

Date _____

II. FAMILY HEALTH HISTORY

Please check any of the following diseases or health problems that have affected your family.
(Example: mother, father, grandparents, etc.)

DISEASE OR PROBLEM	STUDENT	RELATIVE (adult's only)	EXPLAIN
Diabetes _____			
Epilepsy _____			
Cancer _____			
High Blood Pressure _____			
Heart Attacks _____			
Urinary/Kidney problems _____			
Pneumonia _____			
Tuberculosis _____			
Hearing problems _____			
Smoking/Alcohol _____			
Drug addiction _____			
Nervous/Mental disorders _____			
Hepatitis _____			
Family history of sudden unexplained death under age 50.			

Parent/Guardian Signature _____

Date _____

BEHAVIORAL

Is there a behavioral plan in place for your child at school? (IEP or academic file)? Yes _____ No _____

Behavioral Concerns (if applicable)

<input type="checkbox"/> Hitting	<input type="checkbox"/> Kicking
<input type="checkbox"/> Spitting	<input type="checkbox"/> Swearing
<input type="checkbox"/> Hair Pulling	<input type="checkbox"/> Running Away
<input type="checkbox"/> Fire Starting	<input type="checkbox"/> Inappropriate Sexual Behavior
<input type="checkbox"/> Cruelty to animals	<input type="checkbox"/> Criminal Activity

☐ Inappropriate touching (describe) _____

☐ Self Abusive (describe) _____

☐ Other(s) _____

1. What does your child do when angry or frustrated?

2. What typically will calm or stop your child from being angry or frustrated?

3. Does your child display physically aggressive behaviors to him/herself or other(s)?

If so, how often and what is the duration of the behavior? _____

4. Please list any other behavior concerns that you have for your child:

5. Is your child presently, or in the past, on Probation? Yes _____ No _____

If YES, please explain _____

Name of Court Services/Probation Officer: _____

Parent/Guardian Signature _____ Date _____

PHYSICAL HEALTH EXAM

Pg. 1 of 2

Date of Exam _____

STUDENTS NAME _____

Date of Birth _____

HISTORY or PRESENT

Allergies _____

Medications _____

Medical Conditions _____

Emotional/Psychiatric Conditions _____

SCREENINGS/ASSESSMENTS (Please enter dates if done previously)

Measurements _____ Height _____ Weight _____

Blood Pressure _____ Results _____ / _____

Tuberculosis: Assess the individual's personal & environmental risk factors & perform tests as needed.

_____ Low Risk: No testing recommended at this time

_____ At Risk: Test performed

Date _____ Type _____ Results _____

Recommendations _____

IMMUNIZATIONS (Please review record & provide update as appropriate for age).

WE REQUIRE A COPY OF ALL IMMUNIZATIONS.

Immunizations reviewed and up to date for age () Yes () No

Immunizations given today _____

OTHER TESTS (Need determined by provider)

Urinalysis Date _____ Results _____

_____ Results _____

Other (specify): Date _____

NAME _____

PHYSICAL EXAM/ASSESSMENTS

	Normal	Abnormal	Referred	Not Evaluated	Comments/Treatment Plan
General Appearance _____					
Speech _____					
Head _____					
Skin _____					
Eyes External Aspects _____					
Optic Fundoscopic _____					
Cover Test _____					
Ears External Canal _____					
Nose, Mouth, Pharynx _____					
Teeth _____					
Heart _____					
Lungs _____					
Abdomen _____					
Genitalia _____					
Bones, Joints, Muscles _____					
Neurological/Social _____					
Fine Motor _____					
Communication Skills _____					
Cognitive _____					
Self-Help Skills _____					
Social Skills _____					
Glands (lymph/thyroid) _____					
Muscular Coordination _____					
Other _____					

COMMENTS/RECOMMENDATIONS _____

Provider Signature _____	Date _____
Print Name _____	
Clinic/Agency (Please Print) _____	