DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
Sure Start Medical / Dental Examination

OMB No.: 0704-0495
OMB approval expires:

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section, 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921 - 932 (Defense dependents' education system). **PRINCIPAL PURPOSE(S):** Obtain health related information about a student enrolling or enrolled in Department of Defense Education Activity schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education. **ROUTINE USE(S):** DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD. **DISCLOSURE:** Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

INSTRUCTIONS: Please read the Privacy Act Statement (above) and Agency Disclosure Notice (back) on the back prior to completing this form. Return completed form to the school in which the student is enrolling.

SECTION I - CHILD INFORMATION *(To be completed by Parent/Sponsor)*

1. NAME OF SCHOOL		2. ANTICIPATED ENROLLMENT DATE *(YYYYMMDD)*
3. CHILD'S NAME *(Last, First, Middle Initial)*		4. DATE OF BIRTH *(YYYYMMDD)*
5. SPONSOR'S NAME *(Last, First, Middle Initial)*	6. HOME/CELL PHONE *(Include area code)*	7. DUTY PHONE *(Include area code/DSN)*

SECTION II - MEDICAL EXAMINATION *(To be completed by Physician/Primary Care Manager)*

If a 4 year-old well-child check-up has been completed, the results may be used to complete this form. If there is no record of a 4 year-old well-child check-up, please complete the 4 year-old well-child check-up.

1. DATE OF EXAMINATION *(YYYYMMDD)*	2. NAME OF MEDICAL FACILITY OR CLINIC	3. TELEPHONE *(Include area code)*

☐ **4.** *(X if applicable)* The above named child was examined and found to be in satisfactory health for participation in the Sure Start School Program. Examination results indicate that the child is free of communicable disease at the time of the examination and able to participate in the Sure Start School Program.

☐ **5.** *(X if applicable)* The following medical conditions or restrictions apply to this child *(allergies, dietary restrictions, medications)*:

6. IMMUNIZATIONS *(X one)***.** Please attach a copy of the immunization record.

☐ a. Up-to-date, including 4 year-old vaccines.

☐ b. Incomplete. Refer to immunization clinic for the following vaccines: _____

7. EXAMINING PHYSICIAN/PRIMARY CARE MANAGER SIGNATURE AND STAMP

SECTION III - DENTAL EXAMINATION *(To be completed by Dentist)*

1. DATE OF EXAMINATION *(YYYYMMDD)*	2. NAME OF DENTAL FACILITY OR CLINIC	3. TELEPHONE *(Include area code)*

☐ **4.** *(X if applicable)* The above named child had a complete dental examination and was found to be in satisfactory health for participation in the Sure Start Program. Examination results indicate that the child is free from communicable disease and able to participate in all activities except as noted below.

☐ **5.** *(X if applicable)* The following limitations were found:

6. EXAMINING DENTIST SIGNATURE AND STAMP

SECTION IV - PARENT AUTHORIZATION *(To be completed by Parent/Guardian/Sponsor)*

I authorize my dependent's primary medical/dental care provider to release medical information from my child's medical records to complete this form. The Protected Health Information may be used or disclosed to better facilitate student academic performance. I understand that I have the right to revoke this authorization at any time in writing.

1. SIGNATURE OF PARENT/GUARDIAN/SPONSOR	2. DATE SIGNED

AGENCY DISCLOSURE NOTICE (ADN)

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, by emailing: whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. [OMB Control Number: 0704-0495]. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **RETURN COMPLETED FORM TO THE SCHOOL IN WHICH THE STUDENT IS ENROLLING.**