PENN-DELCO SCHOOL DISTRICT
ENROLLMENT APPLICATION
2019 – 2020 KINDERGARTEN REGISTRATION

REQUIRED REGISTRATION FORMS
Kindergarten Registration will take place at your school of residence at the times and locations listed below. Please be sure to have all of your completed forms and required registration documentation with you. Please note, if you do not have a completed packet prior to registration, you will not be able to register your child. If you have any questions please contact the Office of Student Residency at (610) 497-6300 extension 1308 or via e-mail at mowens@pdsd.org.

After the dates listed below, registration will be completed by appointments only at the Administration Building, please contact the Office of Student Residency to arrange an individual appointment.

**Parents may report to the following locations to register their child on the following dates:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 18, 2019 (Monday)</td>
<td>9:00 am-11:00 am</td>
<td>Aston Elementary Students 900 Tryens Rd. Aston, Pa 19014</td>
</tr>
<tr>
<td></td>
<td>&amp; 1:00 pm-3:00 pm</td>
<td></td>
</tr>
<tr>
<td>March 19, 2019 (Tuesday)</td>
<td>9:00 am-11:00 am</td>
<td>Parkside Elementary Students 2 East Forestview Rd. Parkside, Pa 19015</td>
</tr>
<tr>
<td>March 19, 2019 (Tuesday)</td>
<td>5:00 pm-7:00 pm</td>
<td>Aston &amp; Parkside Elementary Students Administration Building 2821 Concord Rd. Aston, Pa 19014</td>
</tr>
<tr>
<td>March 20, 2019 (Wednesday)</td>
<td>9:00 am-11:00 am</td>
<td>Pennell Elementary Students 3300 Richard Rd. Aston, Pa 19014</td>
</tr>
<tr>
<td></td>
<td>1:00 pm- 3:00 pm</td>
<td></td>
</tr>
<tr>
<td>March 21, 2019 (Thursday)</td>
<td>9:00 am-11:00 am</td>
<td>Coebourn Elementary Students 1 Coebourn Blvd Brookhaven, Pa 19015</td>
</tr>
<tr>
<td>March 21, 2019 (Thursday)</td>
<td>5:00 pm-7:00 pm</td>
<td>Pennell &amp; Coebourn Elementary Students Administration Building 2821 Concord Rd. Aston, Pa 19014</td>
</tr>
</tbody>
</table>

In the event school is delayed or closed due to weather, registration will be canceled and the makeup day will take place March 22, 2019.
GENERAL INFORMATION ABOUT REGISTRATION

- All children entering kindergarten for the 2019 – 2020 school year must be five (5) by September 1, 2019.

- Penn-Delco School District offers a half day program for kindergarten. AM Kindergarten is from 8:50 am – 11:30 am. PM Kindergarten is from 12:40 pm–3:10 pm. We do not bus kindergarten students. Transportation is the responsibility of each parent.

- Students shall attend the school in their assigned attendance areas unless enrollment quotas are met; after enrollment quotas are reached, the Administration will assign students to another school in the District where a vacancy exists.

- If you are not sure which school zone you fall within, please contact the Office of Student Residency at (610) 497-6300 extension 1308, or by e-mail at mowens@pdsd.org.

- Screenings are required for all students. Screenings take place in the spring. The process includes literacy skills, speech & language and a health screening. You will be given a screening date and time at registration.

- Please indicate your preference of morning or afternoon session on your Student Information page. The District will make every attempt to accommodate the requests of each parent, however, please note that final placement determinations are made by the Administration.

- Once the student has been registered, the process of placement begins. This process has many steps and will not be finished until mid summer. Once determinations have been made, assignments will be mailed to your home directly. Again, please note that while we will make every attempt to accommodate each family’s wish, we cannot grant every request. Due to a variety of circumstances, no promise of morning or afternoon assignment can be made when registering. If you are assigned to a placement that you did not request, you may be added to a wait list.

- While we include Physical and Dental forms in this packet, these completed forms are not due back to the School Nurse until October 1, 2019. Please have the Physician and Dentist complete these forms when your child has their annual physical exam and dental check up.

- Even though the Physical and Dental forms are not required to be completed at the time of registration, we will need to see a complete immunization record for your child at the time of registration. Please note this record can either be a print out from your child’s physician’s office, a record you as the parent kept showing the type of immunization and date given, or the enclosed physical form. As maintaining a record of immunizations is a requirement that the State of Pennsylvania sets for all schools, we are not permitted to register any child without these records. If you are missing immunization records for your child when you report for registration, we will not be able to process your paperwork.

- You are permitted to make copies of your documentation, however if you make copies please be sure to bring the originals with you in the event that something was missed or needs further review.

- If you have a question or concern about the registration process, please contact the Office of Student Residency at (610) 497-6300 extension 1308, or by e-mail at mowens@pdsd.org.

- The District is unable to process any registration without a complete packet. If you are missing any of the required items on the checklist, you will not be able to register until all together. This may mean you will have to set up an individual registration appointment with the Office of Student Residency.
REQUIRED DOCUMENTS CHECKLIST

☑ One Current Month Utility Bill for the Property
* Acceptable Bills: Electric Bill, Home phone bill, Heating bill, Cable bill, Water bill, Sewer bill, or a notice for the initiation of service to the location for a home owned or rented less than 1 month.

☑ Valid PA Driver’s License or State ID card
* License/ID Card must reflect the current property address

☑ Current Proof of Ownership or Rental of the Property
* Acceptable Documents include: Deed to the Property, Current month mortgage bill or statement, Settlement papers for a home owned less than 1 month, Current year County, Borough, Township, or School District Tax Bill, or Current and Valid Residential Lease Agreement (Income tax and homeowner’s insurance documents are not acceptable for proof of ownership/rental)

* Please note that if Proof of Ownership or Rental of the property is not in the Parent/Legal Guardian’s name, Multiple Occupancy Affidavits will need to be completed. These affidavits are available at the Administration Building or on our website under Information, in the Student Registration section at the bottom of the page.

☑ Birth certificate for the student
* Acceptable certificates include: State certificate, Hospital certificate, or baptismal certificate

☑ Most recent immunization record for the student
* Acceptable documents include, print out from the physician’s office, immunization card, or completed physical form

☑ Completed Student Information Page

☑ Completed Home Language Survey

☑ Completed Custody Agreement/Court Order Registration Form
* Please note: If parents are not living together, a document establishing custody must be provided. If there is no court order or custody agreement, a notarized letter stating the custody arrangements (i.e. “with Mom Monday – Thursday and with Dad Friday – Sunday”) and signed by both parents is acceptable. A Child must be living and spending his/her nights in the Penn-Delco School District not less than 50% of the time throughout the calendar year.

☑ Completed Photo/Media Release Form

☑ Completed Food Allergy Factsheet

☑ Completed Health History Form

☑ Completed Special Education Page

☑ Multiple Occupancy Forms (if applicable)

Please do not attempt to register if you do not have all of the required paperwork. We do not want you to have to wait in line unnecessarily. If you are missing any of the 12 required items from the checklist above, we will not be able to begin the registration process for you. You will have to schedule an individual registration appointment with the Office of Student Residency once all of the items are available to you. If you have questions about the required documentation please contact the Office of Student Residency at (610) 497-6300 extension 1308 or by e-mail at mkrauss@pdsd.org.
PENN-DELCO SCHOOL DISTRICT  
KINDERGARTEN REGISTRATION PACKET

Student’s Legal Name: ___________________________  Student’s Date of Birth ___________________________

Student’s Legal Address: ___________________________

DO NOT WRITE ANYTHING BELOW THIS LINE ~ DO NOT WRITE ANYTHING BELOW THIS LINE DO NOT WRITE ANYTHING BELOW THIS LINE

Office use only  Office use only  Office use only  Office use only

Parents own property:
☐ Mortgage  ☐ Deed  ☐ Tax Bill  ☐ Current Utility Bill  ☐ Valid PA License or ID

Parents rent property:
☐ Valid/current lease  ☐ Current Utility Bill  ☐ Valid PA License or ID

Parents Live with District Resident: All this information is required

Need the following from District resident
☐ Mortgage  ☐ Deed  ☐ Tax Bill  ☐ Lease  ☐ Current Utility Bill  ☐ Valid PA License or ID

Need the following from the parents

Notarized documents for both resident and parents
☐ Multiple Occupancy Form  ☐ Letter from Landlord/Owner granting permission of all parties to reside at property

Birth certificate for the student
Most recent immunization record for the student
Completed Student Information Page
Completed Home Language Survey
Completed Custody Agreement/Court Order Registration Form
Completed Photo/Media Release Form
Completed Food Allergy Factsheet
Completed Health History Form
Completed Special Education Page
Multiple Occupancy Forms (if applicable)

Date of registration: ___________________________  School of Residence: ___________________________

ID Number: ___________________________  IEP/ER: ___________________________

Grade: ___________________________

Residency Office Signature: ___________________________  Date Entered: ___________________________
PENN-DELCO SCHOOL DISTRICT
STUDENT INFORMATION PAGE 1

Please print clearly in blue or black ink.

Student’s Full Legal Name: ________________________________________________________

Student’s Address: ______________________________________________________________

Student’s Primary Number: (______) __________________________ Gender (Circle): Male Female

Social Security Number for Student: _______________________________ Student’s Date of Birth:__________

Mother’s Name:______________________________________________________________

Mother’s Address:____________________________________________________________

How Long Have You Lived at the Address Above:____________________________________

Previous Address:____________________________________________________________

Mother’s Home Phone Number: (______) Cell # (______) ________________________________

Mother’s Employer’s Name:_______________________________________________________

Mother Work Phone: (______) E-Mail: _____________________________________________

Father’s Name:______________________________________________________________

Father’s Address:____________________________________________________________

How Long Have You Lived at the Address Above:____________________________________

Previous Address:____________________________________________________________

Father’s Home Phone: (______) Cell # (______) ________________________________

Father’s Employer’s Name:_______________________________________________________

Father’s Work Phone: (______) E-Mail: _____________________________________________

Student’s Ethnicity (Circle all that apply): American Indian/Alaskan Native Asian

Native Hawaiian/Pacific Islander White/Caucasian Black/African American Hispanic Multi-Racial

Student’s City of Birth: __________________________ State of Birth __________ Country of Birth ________

Signature of Parent/Legal Guardian: __________________________________________ Date ____________________

Kindergarten Preference: AM or PM
Student’s Full Legal Name: ____________________________________________________________

Grade ___________ School ___________________________ Student ID ________________

Student’s Primary Phone Number: (________) _______________________________________

Is the Student Residing with the Legal Parent or Guardian: ______ YES or ______ NO

Student Lives with: Mother & Father    Mother Only    Father Only    Other

If Other or a Blended Household, Explain: __________________________________________

Parent or Guardian (1) Name: ____________________________ Relationship: ____________

Address: _______________________________________________________________________

Home Phone Number: (________)    Cell # (_______)

Work Phone: (________)    E-Mail: ____________________________________________

Parent or Guardian (2) Name: ____________________________ Relationship: ____________

Address: _______________________________________________________________________

Home Phone Number: (________)    Cell # (_______)

Work Phone: (________)    E-Mail: ____________________________________________

Names and Ages of Siblings: ______________________________________________________
_____________________________________________________________________________
If the school is unable to reach the parent or guardian for any reason (example: in the event of an emergency or early dismissal) the following people may be contacted:

**Emergency Contact (1) Name:** __________________________  
**Relationship:** __________

**Address:** __________________________________________

**Home Phone Number:** (______)  
**Cell #:** (______)  

**Work Phone:** (______)  
**E-Mail:** __________________________

**Emergency Contact (2) Name:** __________________________  
**Relationship:** __________

**Address:** __________________________________________

**Home Phone Number:** (______)  
**Cell #:** (______)  

**Work Phone:** (______)  
**E-Mail:** __________________________

**Emergency Contact (3) Name:** __________________________  
**Relationship:** __________

**Address:** __________________________________________

**Home Phone Number:** (______)  
**Cell #:** (______)  

**Work Phone:** (______)  
**E-Mail:** __________________________

**Physician:** __________________________  
**Physician Phone #:** __________________________

**Hospital:** __________________________________________

**Insurance Company:** __________________________________

**Insurance ID Number:** __________________________  
**Group Number:** __________________________

**Group Name:** __________________________  
**Subscriber’s Name:** __________________________

**Signature of Parent/Legal Guardian:** __________________________________________
The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

DATE: _____/_____/_______  SCHOOL: _____________________________  GRADE: ________

STUDENT’S NAME: ___________________________________________________________________________

STUDENT’S ADDRESS: __________________________________________________________________________

1. What is the student’s first language? ______________________________________________________

2. What languages are spoken in your home? _________________________________________________

3. Not including languages learned in school, does the student speak a language other than English?
   ________ YES  ________ NO
   If yes, please list the language(s): _______________________________________________________

4. Has the student attended school in the United States for 3 or more years?
   ________ YES  If yes, complete the following  ________ NO
   Name of School  State  Dates Attended
   ___________________________________________  ________  __________________________
   ___________________________________________  ________  __________________________
   ___________________________________________  ________  __________________________

5. How many years has the student been attending United States schools? _________________________

6. Was the student born in the United States?  ________ YES  ________ NO
   If no, in what country was the student born? _____________________________________________
   If no, when did the student enter the United States for the first time? _______________________

7. Was the student born in Pennsylvania?  ________ YES  ________ NO
   If no, please list when the student moved to the State of Pennsylvania? ____________________

Parent or Guardian’s Signature: __________________________________________________________________ DATE: _____/_____/_______

If this form was completed by someone other than the Parent or Guardian, please complete the information below:

PRINTED NAME: ___________________________  SIGNATURE: ___________________________

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.
The Commonwealth of Pennsylvania requires this information for newly registered students:

1. Student’s Name:

2. Is the student a:  
   - Minor
   - Adult
   - Emancipated Minor

3. Is the student a single parent?  
   - Yes
   - No

4. Who has physical custody of the student?  
   - Both parents
   - Mother
   - Father

5. Who has legal custody of the student?  
   - Both parents
   - Mother
   - Father

6. Is there a custody agreement or court order?  
   - Yes
   - No

7. Does the child reside in Penn-Delco School District seven (7) days per week?  
   - Yes
   - No

   If not, please explain:__________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

Please note: If parents are not living together, a document establishing custody must be provided. If there is no court order or custody agreement, a notarized letter stating the custody arrangements (i.e. “with Mom Monday – Thursday and with Dad Friday – Sunday”) and signed by both parents is acceptable. A Child must be living and spending his/her nights in the Penn-Delco School District not less than 50% of the time throughout the calendar year.

Parent/Legal Guardian Signature: ____________________________ Date: ______________

Person completing this form (If other than parent/legal guardian): ____________________________
PHOTO/MEDIA RELEASE

I hereby give the Penn-Delco School District the unqualified right and permission to reproduce, copyright, publish, circulate or otherwise use my child’s distinguishable image in educational multimedia productions, including:

- The Penn-Delco School District Web Site or other official Penn-Delco School District Digital and Social Media Sites.
- Programming for the Penn-Delco local access television channel
- District & community newsletters
- Promotional brochures & other print materials
- Local, regional and/or national newsprint and television programming

_____ Yes  ____ No

Student’s name:_____________________________________________________________

Student’s grade:________________________

Parent’s name:_____________________________________________________________

Parent’s signature:__________________________________________________________
Food/Allergy Fact Sheet

Please complete this form, and return it with your registration packet. This information will be shared with appropriate school staff to help minimize and manage a food allergy attack at school. **If your child requires medication, please have your physician sign below.**

CHILD’S NAME: ____________________________ GRADE: ____________ HOME PHONE: ____________________________
PARENT/GUARDIAN: _____________________ CELL PHONE: ____________________________
HEALTH CARE PROVIDER: __________________________ PHONE: ____________________________

PLEASE INDICATE IF YOUR CHILD HAS FOOD ALLERGIES BY CHECKING YES OR NO: YES _____ NO _____

IF YOU HAVE MARKED YES, PLEASE COMPLETE THE REST OF THIS FORM:

1. Briefly describe what causes your child’s food allergy symptoms. My child is allergic to:
   ____________________________________________________________________________________________

2. What sort of food allergy reaction has your child had in the past?
   ____________________________________________________________________________________________

3. Has your child had allergy testing done by a physician specialist?
   ____________________________________________________________________________________________

4. Has your child ever had an anaphylactic reaction? Yes____ No _____
   Please describe in detail ________________________________________________________________
   __________________________________________________________________________________________

5. Is your child’s reaction triggered by ingestion alone? Yes_____ No _____

6. Does your child have a reaction when the food in question is touched? Yes_____ No _____

7. Do you have a food allergy plan from your Doctor? If yes, please give a copy to your school nurse as soon as possible. Yes__ No __

8. If applicable, does your child know how to administer an epi-pen? Yes_____ No _____

9. Does your child understand their food allergy and know enough to avoid obvious sources of the allergen? Yes ____ No____
   Please explain ________________________________________________________________
   __________________________________________________________________________________________

10. Does your child know of products with likely hidden sources of the allergen?
   __________________________________________________________________________________________

11. Will your child, most likely, avoid eating foods not provided by home, or labeled with the offending allergen?
   __________________________________________________________________________________________

**EMERGENCY MEDICATION PLAN:**

<table>
<thead>
<tr>
<th>NAME OF MEDICATION</th>
<th>DOSAGE</th>
<th>INSTRUCTIONS FOR USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>_______</td>
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<td>__________________</td>
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<tr>
<td>__________________</td>
<td>_______</td>
<td>______________________</td>
</tr>
</tbody>
</table>

HEALTH CARE PROVIDER SIGNATURE          DATE  PARENT/GUARDIAN SIGNATURE          DATE

Penn Delco School Nurses are experienced at identifying signs of anaphylaxis and fully understand the danger of hidden food allergen sources. Penn Delco School Nurses will follow your physician’s orders regarding the medication protocol. In the event that epinephrine is administered, we will make every attempt to notify parents and the student will rapidly be transported via ambulance to the nearest hospital for further monitoring. To better help your child, please let the school nurse know of changes in your child’s food allergy or medication schedules.
HEALTH HISTORY FORM

To Parent/Guardian:

The information requested on this form will assist the district to evaluate the health status of your child. Please note that children entering Kindergarten and 1st grade must have both a physical and a dental examination completed. All children entering 6th and 11th grade must have a physical exam, and all children entering 3rd and 7th grade must have a dental exam. We strongly encourage you to have these examinations done by your own physician and dentist. However, the District does provide a physician and dentist, if necessary. If you plan to have your child seen by your own physician and dentist, signed physical and dental forms are due to the school nurse by October 15th. These exams must be done within one year of the start of the school term, to be considered acceptable.

Student’s Name: ____________________________________________
Student’s Date of Birth: __________________________
Name of Mother/Legal Guardian: ____________________________
Mother/Legal Guardian’s Address: ____________________________
Mother/Legal Guardian’s Telephone Number: __________________
Name of Father/Legal Guardian: ______________________________
Father/Legal Guardian’s Address: ______________________________
Father/Legal Guardian’s Telephone Number: ______________________
Name of Child’s Physician: _________________________________
Physician’s Address: _________________________________________
Physician’s Phone Number: ________________________________
Has your child had any of the following: Yes: __________ No: __________ If yes, give details.
Food Allergies: ____________________________________________
Environmental Allergies: ____________________________________
Other Allergies: __________________________________________
Operations (note type): ______________________________________
Emotional Problems: ________________________________________
Serious Accidents __________________________________________
Childhood Diseases: ________________________________________
Other: ___________________________________________________

If your child at present under medical treatment? Yes: ______ No: ______

List any illnesses or health problems which you or your family physician feel should be made known to the school personnel:
_________________________________________________________
_________________________________________________________
_________________________________________________________

_________________________________________________________

Signature of Parent/Legal Guardian ___________________________________ Date ___________________________
I certify that my child ____________________________________________

(Print Student’s Name)

______  Is not now, nor has previously been identified as a Special Education Student.

______  Has been previously identified as a Special Education student with an IEP*, but is no longer classified as a Special Education student.

______  Has been identified as a Special Education student and is currently or was receiving services through an IEP at their previous placement.

Date of current IEP* __________________________

Date of Evaluation Report ________________

(Please provide a copy of the current ER/IEP/NOREP and any outside agency reports that will assist the District in providing an appropriate program to your child)

______  Is currently or has been receiving services through a 504 Agreement

(Please provide a copy of the 504 Agreement)

Has Student received any of the following special services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Steps (Easter Seals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Education (Learning Support)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Special Education (Gifted)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Instructional Support (IST)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Title III</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

OT  Yes  No
PT  Yes  No
Headstart  Yes  No
Title I Reading  Yes  No
Title I Math  Yes  No
504 Service Plan  Yes  No
Other ________________

_________________________________________  ____________________________
(Signature of Parent/Guardian)  (Date)

*IEP – An IEP is an Individualized Education Program and is the written plan for the education of a student who has a disability or is gifted.
Please Note

Even though Physical and Dental forms are not required to be completed at the time of registration, **we will need to see a complete immunization record for your child at the time of registration.** Please note this record can either be a print out from your child’s physician’s office, a record you as the parent kept showing the type of immunization and date given, or the enclosed physical form. **As maintaining a record of immunizations is a requirement that the State of Pennsylvania sets for all schools, we are not permitted to register any child without these records.** If you are missing immunization records for your child when you report for registration, we will not be able to process your paperwork.

Does the student have any allergies? □ No □ Yes (If yes, list specific allergy and reaction.)

- □ Medicines
- □ Pollens
- □ Food
- □ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

**GENERAL:** Has the student...

1. Any ongoing medical conditions? If so, please identify: □ Asthma □ Anemia □ Diabetes □ Infection □ Other
2. Ever stayed more than one night in the hospital?
3. Ever had surgery?
4. Ever had a seizure?
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?
6. Ever become ill while exercising in the heat?
7. Had frequent muscle cramps when exercising?
8. Has headaches with exercise?
9. Ever had a head injury or concussion?
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?
12. Ever been unable to move arms or legs after being hit or falling?
13. Noticed or been told he/she has a curved spine or scoliosis?
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?
15. Been prescribed glasses or contact lenses?

**HEAD/NECK/SPINE:** Has the student...

16. Ever used an inhaler or taken asthma medicine?
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: □ Heart murmur or heart infection □ High blood pressure □ Kawasaki disease □ High cholesterol □ Other:
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt light-headed during or after exercise?
20. Had discomfort, pain, tightness or chest pressure during exercise?
21. Felt his/her heart rate or skip beats during exercise?

**BONE/JOINT:** Has the student...

22. Had a broken or fractured bone, stress fracture, or dislocated joint?
23. Had an injury to a muscle, ligament, or tendon?
24. Had an injury that required a brace, cast, crutches, or orthotics?
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?
26. Had joints that become painful, swollen, feel warm, or look red?

**SKIN:** Has the student...

27. Had any rashes, pressure sores, or other skin problems?
28. Ever had herpes or a MRSA skin infection?

**GENITOURINARY:** Has the student...

29. Had groin pain or a painful bulge or hernia in the groin area?
30. Had a history of urinary tract infections or bedwetting?
31. FEMALES ONLY: Had a menstrual period? □ Yes □ No
   If yes: At what age was her first menstrual period?
   How many periods has she had in the last 12 months?
   Date of last period:

**DENTAL:**

32. Has the student had any pain or problems with his/her gums or teeth?
33. Name of student’s dentist:
   Last dental visit: □ less than 1 year □ 1-2 years □ greater than 2 years

**SOCIAL/LEARNING:** Has the student...

34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?  □ Yes □ No
35. Been bullied or experienced bullying behavior?
36. Experienced major grief, trauma, or other significant life event?
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?
38. Been worried, sad, upset, or angry much of the time?
39. Shown a general loss of energy, motivation, interest or enthusiasm?
40. Had concerns about weight/ been trying to gain or lose weight or received a recommendation to gain or lose weight?
41. Used (or currently uses) tobacco, alcohol, or drugs?

**FAMILY HEALTH:**

42. Is there a family history of the following? If so, check all that apply: □ Anemia/blood disorders □ Inherited disease/syndrome □ Asthma/lung problems □ Kidney problems □ Behavioral health issue □ Seizure disorder □ Diabetes □ Sickle cell trait or disease □ Other:
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: □ Brugada syndrome □ QT syndrome □ Cardiomyopathy □ Marfan syndrome □ High blood pressure □ Ventricular tachycardia □ High cholesterol □ Other:
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?
45. Has any family member / relative died of heart problems before age 50 or had an unexpected/unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?

**QUESTIONS or CONCERNS**

46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider?  (If yes, write them on page 4 of this form.)

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student __________________________ Date ____________

Adapted in part from the Pre-participation Physical Evaluation History Form; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.
**STUDENT’S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION:**  Yes ☐  No ☐

<table>
<thead>
<tr>
<th>Physical exam for grade:</th>
<th>CHECK ONE</th>
<th>*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>K/1 ☐ 6 ☐ 11 ☐ Other ☐</td>
<td>NORMAL</td>
<td>*ABNORMAL</td>
</tr>
</tbody>
</table>

- **Height:** ( ) inches
- **Weight:** ( ) pounds
- **BMI:** ( )
- **BMI-for-Age Percentile:** ( )%
- **Pulse:** ( )
- **Blood Pressure:** ( )/
- **Hair/Scalp**
- **Skin**
- **Eyes/Vision** Corrected ☐
- **Ears/Hearing**
- **Nose and Throat**
- **Teeth and Gingiva**
- **Lymph Glands**
- **Heart**
- **Lungs**
- **Abdomen**
- **Genitourinary**
- **Neuromuscular System**
- **Extremities**
- **Spine (Scoliosis)**
- **Other**

<table>
<thead>
<tr>
<th>TUBERCULIN TEST</th>
<th>DATE APPLIED</th>
<th>DATE READ</th>
<th>RESULT/FOLLOW-UP</th>
</tr>
</thead>
</table>

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**

(Additional space on page 4)

**Parent/guardian present during exam:**  Yes ☐  No ☐

**Physical exam performed at:**  Personal Health Care Provider’s Office ☐  School ☐  Date of exam ___________20_________

**Print name of examiner**

**Print examiner’s office address**

**Signature of examiner**  MD ☐  DO ☐  PAC ☐  CRNP ☐
**IMMUNIZATION HISTORY**

**HEALTH CARE PROVIDERS**: Please photocopy immunization history from student’s record – OR – insert information below.

**IMMUNIZATION EXEMPTION(S):**

<table>
<thead>
<tr>
<th>Medical</th>
<th>Date Issued:</th>
<th>Reason:</th>
<th>Date Rescinded:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**NOTE**: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

### VACCINE DOCUMENT:

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT</td>
<td>1</td>
</tr>
<tr>
<td>Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td</td>
<td>1</td>
</tr>
<tr>
<td>Polio Type: OPV or IPV</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>1</td>
</tr>
<tr>
<td>Mumps disease diagnosed by physician</td>
<td></td>
</tr>
<tr>
<td>Varicella: Vaccine Disease</td>
<td>1</td>
</tr>
<tr>
<td>Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella</td>
<td>1</td>
</tr>
<tr>
<td>Meningococcal Conjugate Vaccine (MCV4)</td>
<td>1</td>
</tr>
<tr>
<td>Human Papilloma Virus (HPV) Type: HPV2 or HPV4</td>
<td>1</td>
</tr>
<tr>
<td>Influenza Type: TIV (injected) LAIV (nasal)</td>
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</tr>
<tr>
<td>Haemophilus Influenzae Type b (Hib)</td>
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</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>1</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1</td>
</tr>
</tbody>
</table>

**Other Vaccines: (Type and Date)**
PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL________________________________________________ DATE ____________________ 20 ___

NAME OF CHILD ___________________________________________________________________________

Last First Middle

AGE SEX GRADE SECTION/ROOM

☐ ☐ ☐

M F

ADDRESS __________________________________________________________________________________

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

REPORT OF EXAMINATION

<table>
<thead>
<tr>
<th>TOOTH CHART</th>
<th>RIGHT</th>
<th>LEFT</th>
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</thead>
<tbody>
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<td>4 A</td>
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<tr>
<td></td>
<td>5 B</td>
<td>6 C</td>
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<tr>
<td></td>
<td>7 D</td>
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<td>9 F</td>
<td>10 G</td>
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<td>11 H</td>
<td>12 I</td>
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<tr>
<td></td>
<td>13 J</td>
<td>14 15</td>
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<tr>
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<td>Upper</td>
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<td></td>
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<td>30 29</td>
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<td></td>
<td>28 T</td>
<td>27 S</td>
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<td></td>
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<td>25 P</td>
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<td>24 O</td>
<td>23 N</td>
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<td></td>
<td>22 M</td>
<td>21 L</td>
</tr>
<tr>
<td></td>
<td>20 K</td>
<td>19 18</td>
</tr>
<tr>
<td>LOWER</td>
<td>17</td>
<td>Lower</td>
</tr>
</tbody>
</table>

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