ENROLLMENT APPLICATION

REQUIRED REGISTRATION FORMS

1st – 12th GRADE

9th – 12th grade – 2019 - 2020 registration appointments begin on Monday, April 15, 2019

1st – 8th grade – 2019 – 2020 registration appointments begin on Monday, June 3, 2019
NON-RESIDENT STUDENTS

Penn-Delco School District does not accept tuition students. If you do not live within the boundaries of the District, we cannot register your child. If you would like to know if your residence falls within the District's boundaries please contact the Office of Student Residency at (610) 497-6300 extension 1308.

REGISTRATION INFORMATION

If you are looking to enroll a new student into the District, have a student who is registered with a private school and are requesting testing, or if you have a student who has been withdrawn from Penn-Delco and you wish to return to them to our schools, the parent or legal guardian will be required to complete the forms attached to this packet and follow the registration procedure.

AGE REQUIREMENTS

There are no exceptions to the policy for age requirements

All students entering Kindergarten must be five (5) years old by September 1st of the upcoming school year.

All students entering 1st grade must be six (6) years old by September 1st of the upcoming school year.

ALL REGISTRATIONS ARE BY PRE-SCHEDULED APPOINTMENT ONLY

All registrations are completed at the Administration Building located at 2821 Concord Road Aston, PA 19014. Please make sure that prior to scheduling your appointment you have all of the required documents on the attached checklist completed and gathered together. If you are missing any paperwork we will not be able to schedule you for an appointment. To schedule an appointment, please call the Office of Student Residency at (610) 497-6300 extension 1308. Registration Office hours are Monday – Friday, 8:00 a.m. to 4:00 p.m. (Hours may change during the summer months)

REGISTRATION PROCEDURE

If for any reason you are not able to attend your pre-scheduled appointment, please call (610) 497-6300 extension 1308 to reschedule as soon as possible.

At the appointment copies will be made of your residency documentation, birth certificates, immunization records and we will collect the completed forms from your application packet. If any forms are missing, the application for enrollment will be placed on hold until the forms are received by the Office of Student Residency. The parent/guardian is responsible for obtaining all of the required documents listed on the attached checklist. We do not allow faxing of documents from third parties. ~ Please provide transcripts if available ~

Review and approval of the completed application may take up to three (3) business days. Once the application and forms have been reviewed and approved by the Office of Student Residency the student will be enrolled and the file will be forwarded to the District designated school building.

The school will then contact you at the phone number provided on the Student Information Form to schedule placement testing and the student’s first day of attendance. The entire process may take up to five (5) business days. If you have questions pertaining to one of our school buildings, please contact them directly at the following extensions:

Aston Elementary                     Extension 4500  Coebourn Elementary                     Extension 5500
Parkside Elementary                  Extension 6500  Pennell Elementary                    Extension 7500
Northley Middle School               Extension 3337  Sun Valley High School                 Extension 2400
REQUIRED DOCUMENTS CHECKLIST

(All items below MUST be presented at the time of your appointment)

☐ 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 documents are not acceptable for proof of ownership/rental)

☐ 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 (Credit card and insurance bills are not acceptable forms of utilities)

☐ Valid Pennsylvania Driver’s License or Pennsylvania State ID Card
License/ID Card must reflect the current property address within Penn-Delco

* 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 as well. These affidavits are available at the Administration Building and on our website under the Student Registration link (located 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

☐ Completed Student Information Page

☐ Completed Home Language Survey

☐ Completed and Notarized Parental Registration Statement

☐ 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 Fact Sheet

☐ Completed Health History Form

☐ Completed Special Education Form

☐ Completed Release of Records Authorization Form

☐ Report Cards/Transcripts and IEP/504 (if applicable) from previous school if possible
## PENN-DELC0 SCHOOL DISTRICT REGISTRATION PACKET

<table>
<thead>
<tr>
<th><strong>Student’s Legal Name:</strong></th>
<th><strong>Date of Birth:</strong></th>
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<tr>
<th><strong>Student’s Legal Address:</strong></th>
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</table>

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

### Office use only
- Mortgage
- Deed
- Tax Bill
- Current Utility Bill
- Valid PA License or ID

### 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

<table>
<thead>
<tr>
<th><strong>Need the following from District resident</strong></th>
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<tr>
<td><img src="#/ckoxes" alt="checkboxes" /> Mortgage <img src="#/ckoxes" alt="checkboxes" /> Deed <img src="#/ckoxes" alt="checkboxes" /> Tax Bill <img src="#/ckoxes" alt="checkboxes" /> Current Utility Bill <img src="#/ckoxes" alt="checkboxes" /> Valid PA License or ID</td>
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<tr>
<th><strong>Need the following from the parents</strong></th>
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<tr>
<td><img src="#/ckoxes" alt="checkboxes" /> Valid PA License or ID <img src="#/ckoxes" alt="checkboxes" /> W-2 <img src="#/ckoxes" alt="checkboxes" /> Pub. Asst. Ltr. <img src="#/ckoxes" alt="checkboxes" /> PayStub <img src="#/ckoxes" alt="checkboxes" /> Veh. Reg. <img src="#/ckoxes" alt="checkboxes" /> Utility Bill</td>
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<tr>
<th><strong>Notarized documents for both resident and parents</strong></th>
</tr>
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<tbody>
<tr>
<td><img src="#/ckoxes" alt="checkboxes" /> Multiple Occupancy Form <img src="#/ckoxes" alt="checkboxes" /> Letter from Landlord/Owner granting permission of all parties to reside at property</td>
</tr>
</tbody>
</table>

### 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 and Notarized Parental Registration Statement
### Completed Food Allergy Factsheet
### Completed Health History Form
### Completed Special Education Page
### Release of Records Authorization
### Multiple Occupancy Forms (if applicable)

<table>
<thead>
<tr>
<th><strong>Date of registration:</strong></th>
<th><strong>School of Residence:</strong></th>
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<th><strong>ID Number:</strong></th>
<th><strong>IEP/ER:</strong></th>
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<th><strong>Grade:</strong></th>
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<tr>
<th><strong>Residency Office Signature:</strong></th>
<th><strong>Date Entered:</strong></th>
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</tbody>
</table>
STUDENT INFORMATION PAGE

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

Student’s City of Birth: __________________________ State of Birth _____________ Country of Birth_____

Signature of Parent/Legal Guardian: __________________________________ Date _________________
Student Information Page 2

Please print clearly in blue or black ink

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:** ___________________________
PENN-DELCO SCHOOL DISTRICT

HOME LANGUAGE SURVEY

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 ______ NO
   If yes, complete the following:

   Name of School_________________________ State____________ Dates Attended___________________________

   ________________________________ State____________ Dates Attended___________________________

   ________________________________ 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.
PENN-DELCO SCHOOL DISTRICT
Parental Registration Statement
MUST BE NOTARIZED PRIOR TO YOUR APPOINTMENT

Student Name:__________________________________________
Date of Birth:__________________________________________
Grade Entering:________________________________________
Parent or Guardian Name:________________________________
Address:_______________________________________________
Primary Telephone Number:_______________________________

Pennsylvania School Code § 13-1304-A states in part “Prior to admissions to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any state for an act of offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property.”

Please complete the following:

I hereby swear that my child was_____ was not _____ previously suspended or expelled, or is _____ is not_____ presently suspended or expelled from any public or private school of this Commonwealth or any state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. § 13-1304-A (b) and 18 Pa. C.S.A § 4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If the student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

________________________________________________________

Dates of suspension or expulsion:

________________________________________________________

(Please provide additional schools and dates of expulsion on the back of this sheet)

Reason for suspension or expulsion:

________________________________________________________

________________________________________________________

Sworn to and subscribed before me on this

_____________ day of ____________, A.D. ____________.

(Signature of Parent or Guardian)

(Date) ___________________________

Notary Public

This form shall be maintained as part of the student’s disciplinary record

24 P.S. § 13-1317.2
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 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>
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|                     |        |                      |

|                     |        |                      |

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: ________________________________ 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 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>
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<tbody>
<tr>
<td>Early Intervention</td>
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<tr>
<td>Life Steps (Easter Seals)</td>
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<tr>
<td>Special Education (Learning Support)</td>
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<tr>
<td>Special Education (Gifted)</td>
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<tr>
<td>Instructional Support (IST)</td>
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<td>Title III</td>
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<tr>
<td>Speech Therapy</td>
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</tbody>
</table>

OT          Yes No
PT          Yes No
Headstart   Yes No
Title I Reading        Yes No
Title 1 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.
I hereby authorize the release of information for the following child to the Penn-Delco School District:

Name of Student: ________________________________________________
Date of Birth: ________________________________________________
Present Address: ________________________________________________

Former Address: ________________________________________________

Student’s Previous School Information
Name of School: ________________________________________________
Address: ________________________________________________
Phone Number: ________________________________________________
Fax Number: ________________________________________________

Information for release includes the following:

Grades
Report Cards
Standardized Test Results
Health/Immunization Records
Attendance Records
Transcripts/Credit Data
Discipline Records
Psychological Evaluations
Psychiatric Evaluations
Special Education Data (ER, IEP)
Gifted Education Data (if separate from special education

Please send Records to: (Circle Requesting School Below)
Aston Elementary
900 Tryens Rd
Aston, PA 19014
Coebourn Elementary
1 Coebourn Blvd
Brookhaven, PA 19015
Parkside Elementary
2 E Forestview Rd
Brookhaven, PA 19015
Pennell Elementary
3300 Richard Rd
Aston, PA 19014
Northley Middle
2801 Concord Rd
Aston, PA 19014
Fax: 610-485-5557
Sun Valley High School
2881 Pancoast Ave
Aston, PA 19014
Fax: 610-497-4610

It is understood that this information will be used to assist the Penn-Delco School District in offering appropriate services and will not be released or discussed with outside parties unless subpoenaed for Court proceedings or with the specific written consent of the student’s parent or legal guardian.

______________________________________________________________
Signature of Parent/Guardian
______________________________________________________________
Date

Form Faxed on: ____________________________ Form Mailed on: ____________________________
Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

<table>
<thead>
<tr>
<th>Section</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td><strong>GENERAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Any ongoing medical conditions? If so, please identify:</td>
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<tr>
<td>- Asthma [ ]</td>
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<td>- Anemia [ ]</td>
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<tr>
<td>- Diabetes [ ]</td>
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<td>- Infection [ ]</td>
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<tr>
<td>- Other [ ]</td>
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<tr>
<td>2. Ever stayed more than one night in the hospital?</td>
<td>No</td>
<td></td>
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<tr>
<td>3. Ever had surgery?</td>
<td>No</td>
<td></td>
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<tr>
<td>4. Ever had a seizure?</td>
<td>No</td>
<td></td>
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<tr>
<td>5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?</td>
<td>No</td>
<td></td>
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<tr>
<td>6. Ever become ill while exercising in the heat?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7. Had frequent muscle cramps when exercising?</td>
<td>No</td>
<td></td>
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<tr>
<td><strong>HEAD/NECK/SPINE</strong></td>
<td></td>
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<tr>
<td>8. Had headaches with exercise?</td>
<td>No</td>
<td></td>
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<tr>
<td>9. Ever had a head injury or concussion?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12. Ever been unable to move arms or legs after being hit or falling?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>13. Noticed or been told he/she has a curved spine or scoliosis?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14. Had any problem with his/her eyes (vision) or had a history of an eye injury?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>15. Been prescribed glasses or contact lenses?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>HEART/LUNGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Ever used an inhaler or taken asthma medicine?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Asthma/heart murmur or heart infection [ ]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- High blood pressure [ ]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- High cholesterol [ ]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Other [ ]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded during or after exercise?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>20. Had discomfort, pain, tightness or chest pressure during exercise?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>21. Felt his/her heart race or skip beats during exercise?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>BONE/JOINT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Had a broken or fractured bone, stress fracture, or dislocated joint?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>23. Had an injury to a muscle, ligament, or tendon?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>24. Had an injury that required a brace, cast, crutches, or orthotics?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>26. Had joints that become painful, swollen, feel warm, or look red?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>SKIN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Had any rashes, pressure sores, or other skin problems?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>28. Ever had herpes or a MRSA skin infection?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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 ____________
STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes □  No □

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>K/1 6 11 Other</td>
<td>NORMAL *ABNORMAL DEFER</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>
<tbody>
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</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____________________________________________________________________  Phone________________________
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>
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</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>
</table>
| Diphtheria/Tetanus/Pertussis (child)  
Type: DTaP, DTP or DT | 1  2  3  4  5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)  
Type: Tdap or Td | 1  2  3  4  5 |
| Polio  
Type: OPV or IPV | 1  2  3  4  5 |
| Hepatitis B (HepB) | 1  2  3  4  5 |
| Measles/Mumps/Rubella (MMR) | 1  2  3  4  5 |
| Mumps disease diagnosed by physician | Date: |
| Varicella: Vaccine | Disease | 1  2  3  4  5 |
| Serology: (Identify Antigen/Date/POS or NEG)  
i.e. Hep B, Measles, Rubella, Varicella | 1  2  3  4  5 |
| Meningococcal Conjugate Vaccine (MCV4) | 1  2  3  4  5 |
| Human Papilloma Virus (HPV)  
Type: HPV2 or HPV4 | 1  2  3  4  5 |
| Influenza  
Type: TIV (injected)  
LAIV (nasal) | 1  2  3  4  5  6  7  8  9  10  11  12  13  14  15 |
| Haemophilus Influenzae Type b (Hib) | 1  2  3  4  5 |
| Pneumococcal Conjugate Vaccine (PCV)  
Type: 7 or 13 | 1  2  3  4  5 |
| Hepatitis A (HepA) | 1  2  3  4  5 |
| Rotavirus | 1  2  3  4  5 |
| **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

TOOTH CHART

RIGHT LEFT

UPPER 1 2 3 4 A 5 B 6 C 7 D 8 E 9 F 10 G 11 H 12 I 13 J 14 15 16 Upper

LOWER 32 31 30 29 T 28 S 27 R 26 Q 25 P 24 O 23 N 22 M 21 L 20 K 19 18 17 Lower

UPPER

LOWER

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