



Butler Area School District

110 Campus Lane Butler PA 16001 724-287-8721

KINDERGARTEN ENROLLMENT PACKET/FORM CHECKLIST



Student's Legal Name: _____
Please PRINT First Middle Last

Date of Birth: ____/____/____ Place of Birth: _____
MM DD YYYY County, State

Parent's Bring:

- _____ Original Birth Certificate
- _____ Residency I.D.
- _____ Parent/Guardian Driver's License _____ Utility bill, Lease, etc.
- _____ **Must Show Current Address**
- _____ Immunization Records
- _____ Affidavit of Legal Guardianship (if necessary)
- _____ Current Custody Order (If applicable)
- _____ This Packet Including:
 - ☐ Student Enrollment Form – Signed
 - ☐ Emergency Data information Form – Signed
 - ☐ Kindergarten Information Sheet – Completed
 - ☐ Consent for Release of Preschool Records – Signed
 - ☐ Computer & Digital Technology Form – Signed
 - ☐ Home Language Survey – Signed
 - ☐ Preschool Transition Form - *to be completed by preschool teacher if attended*
 - ☐ Student Program Information - Completed
 - ☐ Health History – Complete
 - ☐ Physician's Physical Examination Form – Completed by doctor's office
 - ☐ Dental Examination Form – Completed by dentist's office

FOR OFFICE USE ONLY:

Completed Forms Received

- _____ Birth Certificate
- _____ Residency
- _____ Guardianship/ Custody Court Order
- _____ Enrollment Form
- _____ Parent Email
- _____ Emergency Form
- _____ Kdg Information Form
- _____ Release of Records
- _____ Technology Form
- _____ Language Survey
- _____ Preschool Transition Form
- _____ Program Services Form
- _____ Health History
- _____ Immunizations
- _____ Doctor Exam Form
- _____ Dental Exam Form

Make Copies of:

- _____ Birth Certificate
- _____ Residency (both)
- _____ Immunizations
- _____ Guardianship
- _____ Custody Court Order

Copy to Nurse:

- _____ Enrollment Form
- _____ Health/Medical History
- _____ Immunizations
- _____ Doctor Exam Form
- _____ Dental Exam Form

Fax to Special Ed:

- _____ Enrollment Form
- _____ Program Services Form
- _____ Guardianship Form
- _____ Custody Court Order

Fax to Transportation:

- _____ Enrollment Form

At Building:

- _____ Entered into Student Database
- _____ Records Request Sent
- _____ Records Received

**STUDENT ENROLLMENT FORM**

Date: _____

___ Non-Resident ___ Emancipated

STUDENT INFORMATION

Last Name		First Name		Middle Name		Sex ○ Male ○ Female	
Street Address (House #, Street Name)		City, State, Zip Code		Ethnicity ○ Hispanic ○ Non-Hispanic ○ American Indian/Alaskan Native ○ Asian ○ Black/African American ○ Native Hawaiian/Pacific Islander ○ White			
Mailing Address (If P.O. Box)		Phone Number		Grade			
Date of Birth		Place of Birth		Birth Date Authority			
Month	Day	Year	City of Birth	State of Birth	Country Birth	Birth Certificate #	Other

In the following fields, place the date the CHILD moved into PA and the U.S. respectively.

* If child resided in PA since birth, place child's birth date in "Date Move to PA" and "Date Moved into U.S."

* If child resided in U.S. since birth, place child's birth date in "Date moved into U.S."

* If child move multiple times in/out of PA and/or U.S., use MOST CURRENT move dates.

Date Moved into PA

Date Moved into U.S.

Total Years in
U.S. Schools

Date Child Entered 9 th Grade			Previous School Attended		Address of School		Dates Attended	
Month	Day	Year	○ Child has not entered Grade 9.					

NATURAL PARENT/LEGAL GUARDIAN INFORMATION

Relationship to Student: ☐ FATHER ☐ MOTHER ☐ STEP-PARENT ☐ FOSTER PARENT ☐ OTHER (SPECIFY) _____								
Last Name			First Name			Home Phone Number		
Street Address (House Number, Street Name) <i>If different than student</i>						City, State, Zip Code		
Email Address			Employer Name			Employer Phone Number		
Relationship to Student: ☐ FATHER ☐ MOTHER ☐ STEP-PARENT ☐ FOSTER PARENT ☐ OTHER (SPECIFY) _____								
Last Name			First Name			Home Phone Number		
Street Address (House Number, Street Name) <i>If different than student</i>						City, State, Zip Code		
Email Address			Employer Name			Employer Phone Number		

CHILDREN IN HOUSEHOLD NOT LISTED ABOVE

Last Name	First Name	*REL	Sex	Birthdate			School	Grade
				Mo	Day	Yr		

Relationship: B-Brother S-Sister A-Aunt U-Uncle C-Cousin N-No Relationship O-Other

OFFICIAL USE ONLY

TRANSPORTATION			ASSIGNMENT			
BUS #	BUS STOP LOCATION	PICK-UP TIME	BUILDING	GRADE	HOMEROOM	START DATE
		AM PM				

Emergency Data Information

Please print clearly all data requested below. Please list emergency contact person(s) who live near the school, have transportation, and have a local phone number. The safety of your child may depend on the accuracy of this data.

STUDENT INFORMATION				
Last Name	First Name	Middle Name	Grade	Homeroom

EMERGENCY DATA CONTACT(S): <i>(Must live locally)</i>	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): <i>(Must live locally)</i>	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): <i>(Must live locally)</i>	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): <i>(Must live locally)</i>	
Full Name	Phone #
Address	Relationship to Student

In case of an emergency requiring immediate medical treatment, if I cannot be reached by phone, I give my permission to transport this student (by ambulance if necessary) to the Butler Memorial Hospital, and I will assume responsibility for the expenses incurred.

Parent/Guardian Signature: _____ Date: _____



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KINDERGARTEN INFORMATION SHEET

Child's Name _____
Last First Nickname

❖ Please list the names and ages of any brothers or sisters: _____

❖ Is there a custody order in effect? ☐ No ☐ Yes (If yes, please provide a copy to the office.)

❖ Does your child go to a babysitter or daycare before or after school? ☐ No ☐ Yes

If yes, babysitter/daycare name: _____

Phone number(s): _____

❖ Has your child attended preschool? ☐ No ☐ Yes

If yes, where? _____ Dates of Attendance: _____

May we have your permission to obtain academic records from the preschool? ☐ No ☐ Yes

(If yes, please sign the Kindergarten Information Release form contained in the registration packet.)

❖ Is your child potty trained? ☐ No ☐ Yes If no, please schedule a meeting with your principal to develop a plan.

❖ Does your child have an IEP (Individualized Educational Plan), special needs, or receive Early Intervention? ☐ No ☐ Yes

If yes, what is your child's disability or special needs(s)? _____

❖ Do you have any concerns about your child (fears, speech, ability to learn, making friends, etc.)? ☐ No ☐ Yes

If yes, please describe _____

❖ Have there been any family events that might affect your child's learning or behavior in school (such as the loss of a family member, serious illness in the family, fire, etc.)? ☐ No ☐ Yes

If yes, please describe _____

❖ Do you have any special talents or abilities that you would like to share with the kindergarten class?

☐ No ☐ Yes If yes, please describe: _____

❖ Is there anything else you would like us to know about your child? _____

Form completed by: _____
Name Date



Butler Area School District

Harriger Educational Services Center • 110 Campus Lane • Butler, PA 16001

Consent for Release of Pre-School Information Form

Our goal is to provide a positive transition from preschool into Kindergarten. Please complete the form below for school staff to contact preschool staff regarding your child's needs, behaviors, strategies that worked and services received in preschool.

Student Name: _____ DOB: _____

Parent's Name: _____

I hereby authorize Butler Area School District to obtain and/or release information on my child to/from:

Name of Preschool: _____

Teacher's Name (if available): _____

Address: _____

Phone: _____

Records to be shared may include but are not limited to:

- | | |
|--|--|
| ✓ Administrative records (birth certificate, attendance, etc.) | ✓ Psychological records (please sign another release for the doctor's office.) |
| ✓ Academic records | ✓ Disciplinary records |
| ✓ Health records (including immunizations) | ✓ Special education records |

Send records to:

- ☐ **Broad St. Elementary School:** 200 Broad Street, Butler, PA 16001 PH 724-214-3630 FAX 724-282-2673
- ☐ **Center Avenue Community School:** 102 Lincoln Ave, Butler PA 16001 PH 724-214-3960 FAX 724-287-0263
- ☐ **Center Twp Elementary:** 950 Mercer Road, Butler PA 16001 PH 724-214-3800 FAX 724-282-3503
- ☐ **Connoquenessing Elementary:** 102 Connoquenessing School Rd, Renfrew PA 16053 PH 724-214-4040 FAX 724-789-7478
- ☐ **Emily Brittain Elementary:** 338 N Washington Str, Butler PA 16001 PH 724-214-4200 FAX 724-282-1013
- ☐ **McQuiston Elementary:** 210 Mechling Drive, Butler PA 16001 PH 724-214-3900 FAX 724-287-1119
- ☐ **Northwest Elementary:** 124 Staley Avenue, Butler PA 16001 PH 724-214-4100 FAX 724-287-2516
- ☐ **Summit Elementary:** 351 Brinker Road, Butler PA 16002 PH 724-214-3880 FAX 724-287-2734

Parent's Signature: _____ Date: _____



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ACCEPTABLE USE OF COMPUTER & DIGITAL TECHNOLOGY AGREEMENT FORM

Please return this signed Acceptable Use of Computers and other Digital Technology Agreement Form as soon as possible. Students are NOT permitted to use computers, the computer network or other digital technology at the school until this form has been properly signed and returned to the Principal's Office.



Student Name: _____

School Name: _____

Homeroom: _____

Parent Agreement

By signing this form, I acknowledge that I have read the Butler Area School District's Policies 815 and 815.1 and have reviewed the content of those policies and guidelines with my student. I understand that a violation of the policies and guidelines by my student may result in disciplinary action and/or revocation of the student's permission to use the Butler Area School District computers, the computer network, or other digital technology.

Parent Signature: _____ Date: _____

Student Agreement

By signing this form, I acknowledge that I have read the Butler Area School District's Policies 815, Acceptable Use of Computer Networks/Digital Technology/Internet and Internet Safety, and Policy 815.1 Computers/Computer Software/Other Digital Technology. I understand that a violation of the policies and guidelines by me may result in disciplinary action and/or revocation of my permission to use the Butler Area School District computers, the computer network, or other digital technology.

Student Signature: _____ Date: _____



HOME LANGUAGE SURVEY

The Civil Rights Act of 1964, Title VI – Language Minority Compliance Procedures, requires that school districts/charter schools identify limited English Proficient (LEP) students. The Pennsylvania Department of Education has selected the Home Language Survey as a method for the identification.

SCHOOL: _____ GRADE: _____

STUDENT NAME: _____ DATE OF BIRTH: _____

SEX: M F CELL PHONE: _____ HOME PHONE: _____

ADDRESS: _____

WHAT WAS THE STUDENT'S FIRST LANGUAGE?

DOES THE STUDENT SPEAK A LANGUAGE OTHER THAN ENGLISH? (Do not include languages learned in school).

WHAT LANGUAGE(S) IS/ARE SPOKEN IN YOUR HOME?

NAME OF PERSON COMPLETING THIS FORM (if other than parent/guardian):

SIGNATURE: _____ DATE: _____

(Parent/Guardian)

The school district/charter school 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 has the right to ask for the information it needs to identify English Learners (ELs). As part of the responsibility to locate and identify ELs, the school district/charter school may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enroll in the school district/charter school in the future.

This form will be placed in the student's cumulative records folder.



BUTLER AREA SCHOOL DISTRICT

110 Campus Lane Butler, PA 16001 724-287-8721

PRESCHOOL TRANSITION FORM

TO BE COMPLETED BY PARENT:

Child's Last Name:	First:
Preschool Program Attended:	
Teacher Name:	Teacher Email/Phone:

TO BE COMPLETED BY PRESCHOOL TEACHER:

Special Services child receives or received in the past year (check all that apply):							
☐	Speech/Language	☐	OT/PT	☐	Early Intervention	☐	Counseling

Agency/agencies providing special services:

Health or development concerns (that might limit participation in program activities):

Please circle YES or NO:

YES	NO	Transitions from one activity to another
YES	NO	Follows simple directions
YES	NO	Understands personal space – keeps hands and feet to oneself
YES	NO	Can play/work in a group – shares, takes turns and uses self-control
YES	NO	Can appropriately express a range of emotions, needs, wants, and feelings
YES	NO	Can stay focused on a task (not easily distracted)
YES	NO	Stays in assigned or designated area
YES	NO	Has independent restroom and hygiene skills – wipes, and washes hands
		If no, please explain:
YES	NO	Can maintain appropriate frustration levels
YES	NO	Accepts redirection from adults

Does this student have any problems with other student(s) or should this student be separated from another student:

Areas needing more development or any other concerns:

FOR BASD OFFICE USE ONLY: PLEASE CIRCLE SCHOOL STUDENT WILL ATTEND

CENTER TOWNSHIP	CONNOQUENESSING	EMILY BRITTAIN
MCQUISTION	NORTHWEST	SUMMIT



Butler Area School District

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STUDENT PROGRAM INFORMATION

Student Name: _____

School: _____ Grade: _____

Check **ALL** that apply to your child:

☐ Individual Education Plan	☐ Gifted Individualized Education Plan
☐ Section 504 / Chapter 15 Service	☐ Early Intervention Program
☐ Preschool Program	☐ Speech / Language Support
☐ ESL (English as Second Language)	☐ IST (Instructional Support Team
☐ Remedial Math (Extra Help)	☐ Remedial Reading (Extra Help)
☐ None	☐ Custody Agreement / Guardianship Paperwork



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

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 HEALTH: <i>Has the student...</i>	YES	NO
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?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had 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?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
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 lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
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:	YES	NO
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: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
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:	YES	NO
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	YES	NO
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 _____

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

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
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				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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 ☐

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

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
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)					

SCHOOL HEALTH PROGRAM

Healthy children are generally more eager to participate in all the activities that are part of a normal school day. They are also more likely to benefit from these activities.

It is important for you to inform the school if your child has allergies, physical defects not easily recognized, or other unusual illnesses or conditions that may require special attention by the classroom teacher or school nurse.

A child who has any of the following symptoms should be kept home. They are often forerunners of many different diseases:

Diarrhea Vomiting Fever Rash anywhere on the body

Children who do have communicable diseases should remain at home for the recommended periods of time. The term onset refers to the date that the first symptom(s) appear:

Chicken Pox - Five (5) days from the appearance of the first crop of vesicles, or when all lesions have dried and crusted, whichever is sooner.

Infectious Conjunctivitis (Pink Eye) – Until judged not infective; that is, without drainage

Impetigo Contagiosa - Until judged not infective by the nurse in school or child's physician.

Pediculosis Capitis (Lice) - Until judged not infective by the nurse in school or child's physician.

Ringworm - All Types - Until judged not infective by the nurse in school or child's physician.

Scabies - Until judged not infective by the nurse in school or child's physician.

Respiratory Streptococcal Infections (Strep Throat) Including Scarlet Fever - No less than seven (7) days from the onset if no physician is in attendance or twenty-four (24) hours from institution of appropriate antimicrobial therapy.

The following examinations and screenings are included in the school health program. Since kindergarten is not yet compulsory in Pennsylvania, the term original entry can refer to either kindergarten or first grade.

PHYSICAL EXAM - Required by state law for students on original entry (kindergarten or first grade), sixth (6th) and eleventh (11th) grades. May be given by family physician or at school by physician.

DENTAL EXAM - Required by state law for students on original entry (kindergarten or first grade), third (3rd) and seventh (7th) grades. May be given by family dentist or at school by dentist.

HEARING SCREENING – Given to students with an IEP, students upon original entry, students in grades 1, 2, 3, 7 and 11 and to any student with hearing problems using an audiometer.

VISION SCREENING – Given annually to every child by school nurse using a portable Titmus machine or Snellen chart.

HEIGHT and WEIGHT – annually to every child.

SCOLIOSIS SCREENING – Done in sixth (6th) and seventh (7th) grade.

**The school nurse will notify you if she detects any problems during these screenings.



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HEALTH HISTORY

Confidential

TO THE PARENT OR GUARDIAN:

The information requested on this form will be of help to the school personnel in determining the health status of your child and in assisting him/her to receive maximum benefits from his/her educational experience.

Student full name _____ Male _____ Female _____ Birthdate _____

Address _____ Phone _____

Place of birth _____

Father's Name (first, middle, last) _____

Mother's Name (first, middle, maiden, last) _____

With whom does child live? _____

List names of siblings:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL

Name of child's doctor or nurse practitioner _____ Phone number _____

In the past 12 months, did you have problems obtaining medical care for your child? Yes _____ No _____

DENTAL

Name of child's dentist _____ phone number _____

Did your child receive a dental exam in the last 12 months? Yes _____ No _____

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes _____ No _____

Do others have difficulty understanding your child? Yes _____ No _____

If yes, please explain _____

Does student have Individualized Education Plan (IEP)? Yes _____ No _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes* _____ No _____

Describe: _____

*If yes, a meeting with the school nurse is required. Medication or treatment orders will need to be completed.

Check next to any condition or illness that applies to your child.

Note: For medication questions, mark the “yes” box only if child is taking medication now.

STUDENT FULL NAME _____

1. ☐ **Allergies** Food _____ Medicine _____

☐ Ants ☐ Wasps ☐ Bee stings

☐ Environmental allergies List _____ ☐ Other allergies List _____

Specify reaction to allergy or allergen: ☐ Rash ☐ Swelling ☐ Hives ☐ Trouble Breathing ☐ Vomiting

☐ Diarrhea ☐ Local Reaction

☐ **Takes medication for any allergies** List medication(s) _____

Does child need a special diet? ☐ Yes ☐ No (If yes, school requires a prescription from a doctor)

2. ☐ **Arthritis** Describe _____

3. ☐ **Asthma** List triggers _____ Diagnosed at age _____

☐ Takes medication List medication(s) _____

Under doctor's care now ☐ Yes ☐ No

4. ☐ Other frequent **Respiratory Conditions** Describe _____

5. ☐ **Attention Deficit/Hyperactivity Disorder (ADD/ADHD)** Medically Diagnosed? _____

☐ Takes medication List medication(s) _____

6. ☐ **Blood disorder** ☐ **Sickle cell anemia** ☐ **Anemia** Specify _____

7. ☐ **Cancer** Explain _____

8. ☐ **Chickenpox-illness** At age _____

9. ☐ **Cystic Fibrosis** ☐ Takes medication List medication(s) _____

10. ☐ **Dermatological/Skin Condition** Describe _____

11. ☐ **Developmental Delay** Explain _____

12. ☐ **Diabetes** (high blood sugar) ☐ Type 1 ☐ Type 2 ☐ Hypoglycemia (low blood sugar)

13. ☐ **Digestive/Gastrointestinal disorders** Explain _____

14. ☐ **Eating Disorder** Explain _____

15. ☐ **Endocrine** Explain _____

16. ☐ **Gynecological Problems** Explain _____

17. ☐ **Headaches** ☐ **Migraines** Under doctor's care for this condition ☐ Yes ☐ No

☐ Takes medication List medication(s) _____

18. ☐ **Head injury/Concussion** Month/Year _____ Explain _____

19. ☐ **Hearing Problems** ☐ Tubes ☐ Uses hearing aid

20. ☐ **Heart condition** Explain _____ Under doctor's care for this condition ☐ Yes ☐ No

Physical restrictions ☐ Yes ☐ No If yes, explain _____

21. ☐ **High blood pressure** (Hypertension)

22. ☐ **Kidney or bladder disorder** Explain _____

23. ☐ **Muscle/bone/mobility disorder** Explain _____

Physical restrictions ☐ Yes ☐ No Explain _____ Need a doctor note yearly!

24. ☐ **Neurological Condition** ☐ **Cerebral Palsy** Explain _____

25. ☐ **Nosebleeds**

26. ☐ **Psychiatric diagnosis** _____

☐ Takes medication List medication(s) _____

27. ☐ **Seizure Disorder** Type _____ How long ago was the last one? _____

☐ Takes medication List medication(s) _____

28. ☐ **Sinus Problems** Explain _____

29. ☐ **Surgery** Explain _____ Date _____

30. ☐ **Vision problems** ☐ **Glasses** ☐ **Contacts** Explain _____

31. ☐ **Other** Explain _____

32. My child does not have any of the listed conditions or illnesses.

Parent/Guardian Signature _____ **Date** _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH**PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD			AGE	SEX		GRADE	SECTION/ROOM
_____ _____ _____ LastFirstMiddle				☐ ☐ M F			

ADDRESS

No. and StreetCity or Post OfficeBorough or TownshipCountyStateZip

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																	Upper
	LOWER																	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

Send only enough medication to be taken at school for the duration of the need. Your pharmacist, upon request, will divide the prescription medication into two separate labeled containers-one for use at home, the second for use at school.

4. The following guidelines control the administration of the medication:
 - A. The medication shall be locked in a cabinet or other secure container.
 - B. School personnel will keep a record of the administration of medication and destroy unused medication or have it picked up by the parent or guardian.
 - C. All medication is to be taken in the presence of the school nurse or health technician/the principal or his/her designee.
 - D. Students may self-administer rescue medications i.e., asthma inhalers and epinephrine auto-injectors. A Rescue Medication Self-Administration Authorization Form must be completed. Parents should review School District Policy #210.1, *Possession/Use of Asthma Inhalers/Epinephrine Auto-injectors* for procedures governing this policy. The policy is posted on the District website.
5. The parent or guardian of the child must assume responsibility for informing the school of any changes in the child's health or change in medication. Newly completed Medication Authorization Form(s) will be required with each change in medication and at the beginning of each school year.

Based upon the recommendation of legal counsel, the direction of professional health organizations, and a research of best practices, our policies require doctor's written authorization for both prescriptions and over-the-counter medications. We believe that such a stipulation provides for ensuring the proper administration of medication to our students.

If you have any questions regarding this policy, please call your school nurse:

Center Avenue	Michele Smith, 724-214-3965
Center Township	Lynn Zidek, 724-214-3806
Connoquenessing	Debra Bowser, 724-214-4043
Emily Brittain	Tracy Futscher, 724-214-4204
McQuiston	Michele Harold, 724-214-3903
Northwest	Kathryn Marik, 724-214-4104
Summit	Tracy Futscher, 724-214-3883
Middle School	Janet Kraus, 724-214-3620
Intermediate High	Kimberly Halter, 724-214-3430
Senior High	Judy Zarnick/Ashely Miller, 724-214-3227

Sincerely,



Brian White Jr.,
Ed.D.Superintendent



BUTLER AREA SCHOOL DISTRICT

MEDICATION IN SCHOOLS

Dear Parent(s) or Guardian(s):

According to School District Policy #210, Use of Medication, the Butler Area School District shall not be responsible for the administration of any medication unless there is written authorization by a physician and a signed parent consent form. **Please note: this applies to both prescribed and over-the-counter medications.**

Due to the demands made upon our health room personnel, requests for administration of medication during school hours should only be made when failure to take such medicine would jeopardize the health of the student or the student would not be able to attend school if the medicine were not made available during school hours. It is the parent's responsibility to supply all medications to be taken at school.

PROCEDURES:

Under these conditions, the school district will cooperate with parents and their medical practitioners in giving medications. The following procedures should be followed when making a request for administration of either prescribed or over-the-counter medications:

1. Complete the appropriate Medication Authorization Form(s). Forms are available in the nurse's office in each building and/or on the BASD Website (Click on Department Tab on home page, scroll down to Health Services section, under Health Services, Click on Health Services Forms, choose the Authorization for Medication Form).
2. When possible, the parent or guardian should bring the completed Medication Authorization Form(s) and the medication to the school and give it to the appropriate personnel.
3. The container for the medication, either prescription or over-the-counter, shall be in the original container from the pharmacy. The container for the prescription medication must carry the following information:
 - A. Name of student
 - B. Name of physician
 - C. Name of medication
 - D. Dosage amount
 - E. Time to be given

SCHOOL VACCINATION REQUIREMENTS FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:



- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*

*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*

****Usually given as MMR*



ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.



pennsylvania
DEPARTMENT OF HEALTH