# Karns City Area School District

1446 Kittanning Pike
Karns City, PA 16041

P: 724-756-2030
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Eric D. Ritzert, Ed.D.
Superintendent of Schools


Dear Parents/Guardians,

Welcome to the Karns City Area School District!

At Karns City, we are committed to preparing students to be successful. We look forward to supporting you through your child's educational journey. If you have any questions or concerns throughout the school year, I encourage you to contact your child's teacher or principal. We hope you quickly feel at home and become involved in some of the many activities available to you.

At the time of registration, you will need to present the following documents:

- Copy of your child's proof of age (example: birth certificate)
- Copy of your child's immunization records (must meet PA immunization requirements)
- Two current proofs of residency (examples: mortgage statement, rental agreement, utility bill, etc.)
- Custody agreement (if applicable)

During registration, you will need the following documents to be completed prior to enrollment completion:

- Admission Form
- Transportation Form
- Home Language Survey Form
- Emergency and Health Information Form
- Health History
- Physical Examination - PA required upon original entry, 6th, 11th, and non-Pennsylvania residents
- Dental Examination - PA required upon original entry, 3rd, 7th, and non-Pennsylvania residents

Again, we are happy to have you with us this year, and we want to assure you that we will do our best to help your child experience academic, social, and emotional achievement.

Sincerely,

Eric D. Ritzert

Eric D. Ritzert, Ed.D.
Superintendent of Schools

Karns City Area School District **Admission Form**

***Student Information*** (please print) (*) required fields

*Name: _____ _____ _____ Grade: _____
Last First Middle

*Date of Birth:_____/_____/_____ Age:_____ Gender: _ *State of Birth: _____

*Physical Address:_____/ _____/ PA / _____
Street Number Street Name City Zip Code

Ethnicity/Race: The district is required to collect ethnicity/race data in order to satisfy US Department of Education audit requirements.

☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Non Resident Alien ☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Asian ☐ Multi-Racial/Ethnic ☐ American Indian/Alaskan Native ☐ Unknown

Student Resides with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other_____
☐ Sharing housing of others due to loss of housing, economic hardship or similar reason

***Guardian Information*** (please print) (*) required fields

*Parent/Legal Guardian 1:_____
Last, First

Parent/Legal Guardian 2: _____
Last, First

*Physical Address:_____

_____ / PA /_____
City Zip Code

Address: _____

_____/_____/_____
City State Zip Code

Home Phone: _____
Cell Phone: _____
Email Address: _____
Work Phone: _____

Home Phone: _____
Cell Phone: _____
Email Address: _____
Work Phone: _____

If your child is absent how would you like to be contacted? (Please check mark above. Limit to one phone number and two email addresses)
Is the parent/guardian an active duty member of a branch of the United States Armed Forces? ☐ Yes ☐ No
Are there custody issues concerning this child?
☐ No
☐ Yes explain _____
☐ Court documents enclosed

***Previous School Information*** (please print)

Name of last school attended:_____Last date attended:_____/_____/_____Last grade completed: _____

Last school attended address:_____/_____/_____/ _____
Street Number Street Name City State Zip Code

Phone:_____ Fax:_____ Counselor: _____

Reason for withdrawal from previous school: _____

I hereby give permission to the previous school or agency listed to release all available information identifying official administrative records (name, address, birth date, grade level completed, grades, class standing, attendance record); standardized achievement, intelligence and aptitude test scores; record of extracurricular activities; and health records for the student named above.

Signature of Parent/Guardian Date

Student Name: _____ _____ _____
Last First Middle

***Special Services*** *Does your child currently receive any Special Services listed below? (please check mark)*

☐ Has IEP ☐ Has GIEP ☐ Remedial Reading ☐ Early Intervention ☐ Speech ☐ Physically Handicapped ☐ Other _____

***Policy Information***

The Pennsylvania School Code requires that prior to admission 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 suspended or expelled from any public or private school of this commonwealth or any other 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. The registration shall be maintained as part of the student's disciplinary record. It also requires the transfer of pupil records concerning these disciplinary actions and this information be released with student records to the receiving school at the time of transfer. **Any willful false statement made under this section shall be a misdemeanor of the third degree.**

My son/daughter ☐ has not been ☐ has been involved in a previous expulsion/disciplinary action.

Signature of Parent/Guardian Date

***Food Services*** Do you have a free or reduced eligibility for the National School Lunch Program determined by your previous district/state?

☐ Yes
☐ No

***Immunizations Records***

All students are required by the state of Pennsylvania to submit proof of immunization or exemption from immunization prior to entry to school. Copies of immunization records for students are usually available from the transferring school. Immunization regulations are cited in 28 Pa. Code §23.83 (c), revised March 2016. State law requires that in order to attend schools, a child must receive all immunizations as mandated by the Department of Health unless a medical or religious exemption is provided to the school districts.

Does your child have a life threatening condition? ☐ No ☐ Yes Explain: _____

********** School Use Only **********

Student ID:_____ School:_____ Grade:_____Registration Date:_____Tentative Start Date: _____

☐ Admission Form
  ☐ Custody Documentation
  ☐ Expulsion/Disciplinary
  ☐ Request for Special Services
☐ Proof of Age
☐ Immunization Records
  ☐ Exemption
☐ Acceptable Use of the Internet Form
☐ Transportation Form
☐ Home Language Survey Form
  ☐ Request for ESL Services
☐ Emergency and Health Information Form
☐ Two Proofs of Residency

☐ Health History Form
☐ Transcript/Report Card/Grades/TestScores
☐ Lunch Application
☐ PA Private Physician's Report of Physician Examination (original entry into PA, grades 6 & 11)
☐ PA Private Dental Report of Dental Examination (original entry into PA, grades 3 & 7)

☐ Tyler Enrollment
☐ PIMS Enrollment
☐ PIMS Programs
☐ Email enrollment to school
☐ Enrollment filed
☐ Originals to school
☐
☐
☐ Forward Admission form to:

  ☐ Food Service Department
  ☐ Special Ed Department
  ☐ ESL Department
  ☐ IT Department
  ☐ Nurse (w/health forms K-12 grades only)
  ☐

_____

Reviewed and processed: _____

August 2016

# KARNS CITY AREA SCHOOL DISTRICT

## *Request for Student Transportation*

**Type of Request** ☐ **New** ☐ **Change**

**If this is a change, please state the reason** _____
**(Ex. Moved, change from home to sitter, etc.)**

**Date of Request:**_____ **School:**_____ **Gender:** ☐ **M** ☐ **or F**

**Student's Last Name:**_____ **First:**_____ **M I:**_____

**Parent or Guardian's Name:**_____ **Phone:**_____

**Student Date of Birth:**_____ **Student Grade:**_____

**This Section Must Be Completed: Exact Physical Address for Pick-up and Drop-off:**

**Physical Address:**_____

**Municipality/Township/Borough:**_____

**City:**_____ **Zip Code:**_____

**Please Identify Exact Location of Residence: Please do not use Rural Route or PO Box Numbers in this section- Use Street Names and House Numbers above.**
**List information below to identify exact location at which your child resides.**
**(use nearest intersections, landmarks, house style and color, etc.)**

_____
_____
_____

**Mailing Address: (This might be PO box or RR number -If same as above "write same")**

**Street Address**_____

**PO Box No.** **City:** **Zip Code:**_____

**School Use Only ---**
**Student Number Assigned:**_____

**Bus Number** _____ **Pick –Up Time**_____

**Return completed form to a School Office; it will be forwarded to the Transportation Department. You will then be contacted with transportation arrangements.**

**Karns City High School 724-756-2030 • Chicora Elementary 724-445-3680 • Sugarcreek Elementary 724-545-2409**

# Karns City Area School District

## HOME LANGUAGE SURVEY[1]

The Office of Civil Rights (OCR) requires that all Local Education Agencies (LEA's) 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 initial step in the identification process.

School District: _____ Date: _____

School: _____

Student's Name: _____ Grade: _____

**1.** What is/was the student's first language? _____

**2.** Does the student speak a language(s) other than English? ☐ Yes ☐ No

*(Do not include languages learned in school.)*

If yes, specify the language(s): _____

**3.** What language(s) is/are spoken in your home? _____

**4.** Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No

If yes, complete the following:

| Name of School | State | Dates Attended |
|---|---|---|
| | | |
| | | |
| | | |

Person completing this form: _____

*(if other than parent/guardian)*

Parent/Guardian signature: _____

**Please disregard English as a Second Language Student Background Questionaire if questions 1-3 state English only.**

[1] The local education agency (LEA) has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the LEA 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 LEA 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 LEA in the future.

Karns City Area School District

**The School Health Program and Your Child**

Immunizations required by Pennsylvania law:

| | ALL STUDENTS | 7TH GRADE | 12TH GRADE |
|---|---|---|---|
| Diphtheria-Tetanus-Pertussis (DTP) | 4 doses(1 dose must be after 4th birthday) | | |
| Polio | 4 doses(4th dose must be after the 4th birthday) | | |
| Measles, Mumps and Rubella (MMR) | 2 doses(1st dose must be after the 1st birthday) | | |
| Hepatitis B | 3 doses | | |
| Varicella (chickenpox) [1] | 2 doses of varicella vaccine (1st dose must be after the 1st birthday) or history of disease | | |
| Tetanus, diphtheria, acellular pertussis (Tdap) if 5 years have elapsed since last tetanus immunization | | 1 dose | |
| Meningococcal conjugate vaccine (MCV) | | 1 dose | 1 dose |

[1] If your child has had the chickenpox disease, the vaccine is not required. A signed statement from the parent or physician with the date or age of the child when chickenpox occurred is acceptable.

Screenings as required by Pennsylvania law:

A physical examination upon original entry to school and in grades 6 and 11. *
A dental examination upon original entry to school and in grades 3 and 7. *

> * *Students who do not turn in a completed, private physical or dental exam form will be scheduled for an exam with the school doctor or dentist. Exams dated up to one year before the start of the school year in which the exam is required will be accepted.*

Height and weight measurement and determination of Body Mass Index-for-Age percentile annually.
A vision test annually.
A hearing test in grades K, 1, 2, 3, 7, and 11.
Scoliosis screening in grades 6 and 7.
Screening for pediculosis (head lice) where indicated.

The purpose of the screening program is to identify possible health problems that may require further evaluation and/or treatment. School screenings are not intended to replace periodic examinations by your family health practitioners. It is recommended that physical and dental examinations be conducted by your family physician or dentist, with payment being the responsibility of the parent. You can request a screening at any time if you suspect that your child may have a problem.

Parents may assist in maintaining students' good health by:

Providing proper meals at regular times. Insist that your child eat breakfast every day.
Have a regular bedtime. *School aged children need 9 – 12 hours of uninterrupted sleep every night.*
Dress young children according to weather conditions.
Keep a sick child home from school.
Please follow these guidelines for keeping your child home from school.

- A fever of 100 or greater. A child must stay home until free of fever for 24 hours without the use of medication.
- Red eyes with drainage or that are "stuck together" upon awakening. Consult a health careprovider.
- Vomiting the night before. Must tolerate a light diet before returning to school.
- Excessive coughing or nasaldrainage

**KARNS CITY AREA SCHOOL DISTRICT**
**HEALTH HISTORY**

The information requested on this form will be of help to school personnel in determining the health status of your student and in assisting them to receive the maximum benefits from their education.

Full name of child_____ Date of Birth_____

Address_____Phone_____
Street City Zip

Parent/Guardian's Name:_____

Parent/Guardian's Name:_____

Student lives with (Please circle): Mother Father Legal Guardian Foster Parents Group Home

Brothers:_____ Age/Grade:_____ Sisters:_____ Age/Grade:_____
_____ _____ _____ _____

**Allergies: No☐ Yes☐ (please list the allergen)**
Foods:_____ Insects:_____ Medications:_____
Plants/animals:_____Other:_____
Please describe the allergic reaction and treatment: _____
_____

**Does the student take any medication regularly? No☐ Yes☐ (please list below)**

Name: _____Dose: _____Time: _____Reason:_____
Name: _____Dose: _____Time: _____Reason:_____
Name: _____Dose: _____Time: _____Reason:_____

**STUDENT HEALTH HISTORY (please check any conditions that apply and note year dx)**

☐ Anxiety
☐ Attention Deficit/ADHD
☐ Arthritis
☐ Asthma triggers:
- ☐ allergies
- ☐ exercise
- ☐ illness
- ☐ weather

☐ Autoimmune Deficiency
☐ Bladder Control
☐ Bleeding Disorder /Anemia
☐ Bowel Control
☐ Chickenpox (disease only)
☐ Cystic Fibrosis
☐ Color Blindness
☐ Connective Tissue Disorder
☐ Dental Condition
☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ Dietary Restrictions
☐ Eating Disorder
☐ Fainting Spells
☐ Gastrointestinal Condition
☐ Headaches/Migraines
☐ Head Injury/Concussion
☐ Hearing Deficit
☐ Heart Condition
☐ High Blood Pressure
☐ Kidney Condition
☐ Lung Condition
☐ Malignancy
☐ Neurological Disorder
☐ Neuromuscular Disorder
☐ Nosebleeds
☐ Oppositional Defiance Disorder (ODD)
☐ Orthopedic Conditions
☐ Psychiatric Condition /Emotional
☐ Self Harm (History of)
☐ Seizures
Type _____
☐ Skin Disorder
☐ Speech Difficulty
☐ Past Surgery
☐ TB Exposure
☐ Vision Deficit
- ☐ severe loss
- ☐ eye surgery
- ☐ glasses/contacts

*If you checked any of above, please explain further here: _____
_____
_____
_____

I understand and agree that any medical information may be shared with appropriate school and medical personnel on a need to know basis.

_____ _____ _____
Signature of Parent/Guardian Relationship Date

Teacher/Homeroom _____ KARNS CITY AREA SCHOOL DISTRICT Grade _____

# Health and Emergency Information

Student's Full Name: _____Birth Date: _____

Student's Address (include P.O. Box if assigned):_____ City: _____ Zip Code: _____

Parent/Guardian(s) Full Name(s): _____ _____

Father/Guardian Phone(s): Landline_____ Work: _____ Cell: _____

Mother/Guardian Phone(s): Landline_____ Work: _____ Cell: _____

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other : _____ Email Address: _____

Student pick up authorization: Please list, in order, two additional persons (besides parents/guardians) that can be contacted to pick up your child during school hours for any medical/health or evacuation reason if parent/guardian cannot be reached.

(1) Name: _____Relationship to student _____ Phone # _____

(2) Name: _____Relationship to student _____ Phone # _____

LIST ALL ALLERGIES: ☐ None: _____

If applicable, ,how do you treat allergic reaction : _____

MEDICAL DIAGNOSIS OR RESTRICTIONS (i.e., Asthma, ADHD, etc). : ☐ None ☐ Yes - Please Explain: _____

_____

Student's Doctor: _____ Address: _____Phone: _____

Insured Parent/Guardian: _____Insurance Company:_____

Group #_____ Policy #_____

Medications that your child takes at home:

Medication: _____ Dosage: _____ Time: _____ Reason: _____

Medication: _____ Dosage: _____ Time: _____ Reason: _____

Medication: _____ Dosage: _____ Time: _____ Reason: _____

Medications that may be given via standing school physician orders – initial what student is permitted to take during school hours

| Medication | Dose | Time Schedule | Reason | Initial |
|---|---|---|---|---|
| Acetaminophen/ Tylenol | Per manufacturer's recommendation | Every 4-6 hours as needed | Fever/pain/headache | |
| Ibuprofen/Motrin/Advil | Per manufacturer's recommendation | Every 4-6 hours as needed | Fever/pain/headache | |
| Tums/Antacid | Per manufacturer's recommendation | 1-2 tabs as needed | Upset stomach/heartburn/indigestion | |
| Benadryl | Per manufacturer's recommendation | Every 6 hours as needed | Allergy | |

- The information provided on this emergency card may be released to other school personnel on a "need to know basis" (e.g. field trips, serious allergies or medical conditions, information to assist in classroom teaching etc.). I further consent to allow health information to be shared that is relevant to participation in athletics/activities with Licensed Athletic Trainer(s), coaches, and other school personnel as deemed necessary. This may include, but not limited to, injuries, diagnosis, medical condition/status, and/or athletic participation status.
- Students who must receive medication during school hours must submit a district medication administration permission form to the school nurse. The medication is to be given to the school nurse. No medication is to be kept in a student's possession or locker unless the school nurse receives an order from the student's primary care physician (see medication procedure and policy).
- Students becoming ill during the school day should report to the health office or school office. If it is necessary for the student to be sent home, the nurse or other health personnel will inform the parent/guardian or designee. A student will be released from school only with the parent/guardian's permission. Any student who leaves the building without following this procedure will be considered truant.
- In the event that I cannot be reached in an emergency, I hereby give my permission to transport the student to a medical facility for treatment, either from school or an athletic event. Furthermore, I authorize the attending physicians and hospital staff to secure proper treatment for my child.

Parent/Guardian Signature: _____ Date: _____

**By typing your name above you are understanding this is a legal signature.**

**KARNS CITY SCHOOL DISTRICT**

**Medication Procedure**

The following procedures should be followed when requesting school health personnel to administer medication to your school child during school hours.

- The Karns City School District will cooperate with parents and their medical practitioners in administering prescribed medications when these must be given during school hours (e.g. failure to take such medications would jeopardize the health of the student if the medication were not made available during school hours). In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, **each student/parent** must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber (provided either by a prescriber's script or prescriber complete the district medication consent form).

- All medication(s) must be supplied to the school health office in its original prescription bottle/container from a pharmacy. The container for the medication which is taken to school shall be the most current prescription container from the drugstore which includes all administration information such as the label from the pharmacy. Over the counter medication must also be supplied in its original container from the pharmacy or store. Medications in plastic bags or containers other than their original pharmacy container are NOT acceptable and NO expired medication will be administered.

- A parent/guardian or a responsible adult designated by the parent/guardian should deliver all medications to the school.

- Bring only enough medication to be taken at school for the duration of the prescription and no more than a 30 day supply. Your pharmacist will, upon request, divide the prescription medication into two separate, labeled containers – one for use at home, the second for use at school. ***In some rare incidences the medication cannot be separated (eye drops), please make specific arrangements with the School Nurse or Health room Technician regarding when the medication will be picked up by parent or designee.***

- If the student is to take only a half of a pill, the pill should be cut at home.

- When available, the certified school nurse shall administer medication. In the absence or unavailability of the certified school nurse, the CSN will designate the health room technician (RN or LPN) to be responsible for these duties. Access to all medications is limited to approved personnel such as the CSN, RN, and LPN, except that in life threatening emergencies, designated personnel may have access. The need for emergency medication may require that a student carry the medication on his/her person or that it be easily accessed.

- The parent of the child must assume the responsibility for informing the school of any change in the child's health, or change in medication prescription. A new medication form must be completed by the parent and prescriber with each change in medication or at the beginning of each school year.

- Students are permitted to have throat lozenges (Fruit Breezers, Luden's, etc.) at school and keep them at his/her desk or locker in order to minimize the disruption of the classroom. If the student at any time shows irresponsibility with the throat lozenges, this privilege will be taken away.

- Cough drops that contain Menthol (cough suppressant) must be kept in health office due to the control of how often these cough drops can be given.

- Students are permitted to possess asthma inhalers and to self administer the prescribed medication used to treat asthma or any other respiratory disorder. Before a student may possess inhaler, they must provide written orders from the prescriber stating that student is qualified and able to self administer medication. A backup inhaler must be kept in the health office and student must notify health personnel each time the medication was administered during the school day to assess student's condition. If the child shows irresponsibility or is found to be unable to adequately self administer medication, the privilege may be taken away and the student must take medication in health office with the supervision of school nurse. The above procedure also applies for students that take part in before and after school activities.

- Students are permitted to possess required emergency medication such as an automatic injectable epinephrine for the purpose of an anaphylactic reaction to an allergen. Before a student may possess injectable emergency medications, they must provide written instructions from the prescriber stating that student is qualified and able to self administer medication. A backup of the injectable medication must be kept in the health office. The student will notify health personnel if emergency medication was administered so that proper emergency measures are taken. The above procedure also applies for students that take part in before and after school activities.

- Over the counter medication (e.g., Tylenol, Motrin, Benadryl. etc.) may be administered in accordance with our school physician's standing orders during school hours if medically necessary to keep the student in school. The parent must provide a signed district OTC medication permission form. The parent/guardian may provide over the counter medication to keep at school (See "Standing Orders for the School Nurse").

- The medication shall be locked in a cabinet and is available only to the Certified School Nurse, Health Technician and, in an emergency, a trained administrator.

- In the case of a school trip, the school may ask a parent to accompany his or her child that requires medication during the school day but cannot require the parent to do so. Administration of medications is a support service that must be provided. If a parent of a student that requires medication during the school day cannot accompany the student on the field trip, a school nurse, health room technician, substitute nurse or a licensed designee that is approved by the district must accompany student on field trip.

- The school district will keep a record of the administration of medication. Any medication left over or not used by the student will be brought to the parent/guardian's attention for pick up. Any medication not picked up by the end of the school year will be documented and properly disposed of.

H514.027 (08/2011-under review)

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 |
|---|---|---|---|---|
| _____ Last First Middle | | ☐ M ☐ F | | |

ADDRESS

_____
No. and Street City or Post Office Borough/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 | | | | | | | | | | | | | | | | | 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

pennsylvania
DEPARTMENT OF HEALTH

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:** ***Has the student…*** | **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:** ***Has the student…*** | **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:** ***Has the student...*** | **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:** ***Has the student...*** | **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:** ***Has the student…*** | **YES** | **NO** |
| 27. Had any rashes, pressure sores, or other skin problems? | | |
| 28. Ever had herpes or a MRSA skin infection? | | |

| **GENITOURINARY:** ***Has the student…*** | **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:** ***Has the student…*** | **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 PERFOMING 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)<br>Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio<br>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)<br>Type: HPV2 or HPV4 | 1 | 2 | 3 | 4 | 5 |
| Influenza<br>Type: TIV (injected)<br>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)<br>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)** | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

 **ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)**