KINDERGARTEN ENROLLMENT

Greensburg Salem School District

Welcome!

The Greensburg Salem School District would like to welcome you to our learning community. We recognize the value of each individual, and we promote personal growth and academic achievement through the implementation of innovative strategies and the integration of current technologies in a safe and caring environment. We look forward to working with you as your child grows and develops throughout their school experience with us!

Students must be 5 on or before August 1, 2023 for enrollment into kindergarten.

School age shall be defined as the period from the earliest admission age for the District's kindergarten program (five (5) years of age on or before the first day of August of the school year in which they are attending) until graduation from high school or the end of the school term in which a student reaches the age of twenty-one (21) years, whichever occurs first.

Enrollment Requirements

- ◊ **Enrollment Form**
- ◊ **Proof of Child's Age (e.g. birth certificate, baptismal certificate, or passport).**
- ◊ **Proof of Residency – Two (2) *Original* sources (e.g. driver's license, current utility bill, lease, etc.). If none of these documents are available, a parent can provide a sworn, notarized statement.**
- ◊ **Home Language Survey**
- ◊ **Immunizations (Please see below)**
- ◊ **Health History Form**
- ◊ **Physical Examination**
- ◊ ***Original* Legal Documents* (e.g. custody orders, guardianship, PFA, name change) - **Recommended***

Immunization Requirements

- ◊ **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 (Chicken Pox) or evidence of immunity**

***Usually given as DTP or DTaP or if medically advisable, OT 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**

Hutchinson Elementary

Phone: 724-832-2885

Jennifer Kapusta, Principal

Anthony Barbato, Associate Principal

Metzgar Elementary

Phone: 724-668-2237

Dr. Tina Federico, Principal

Nicely Elementary

Phone: 724-832-2865

Christopher Thomas, Principal

2/2020

The district must be provided with immunization records, along with the record of birth prior to the first day of school. The school nurse must review these records and all records must be up-to-date, or your child will not be permitted to attend school.

Greensburg Salem School District

ENROLLMENT FORM

Please Print

2/2018

_____ _____ ☐ M ☐ F KINDERGARTEN

Child's Legal Name (*Last, First, Middle*) Birth Date Gender

_____ _____

Address (House Number, Street, City, Zip Code) List PO Box (if used for mailing)

_____ Use this Number for Alert Notifications ☐ Yes ☐ No

Home Phone (Is this a cell number) ☐ Yes ☐ No

Ethnicity: Hispanic/Latino ☐ Yes ☐ No

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan ☐ Multi Racial (if Multi Racial please indicate 2 or more race descriptions)
☐ Native Hawaiian/other Pacific Islander

BIRTH CITY AND STATE:_____

NATIVE LANGUAGE: ☐ English ☐ Spanish ☐ Japanese ☐ Chinese ☐ Hindi ☐ Other _____

FAMILY INFORMATION: (provide address if different from above)

Father

		√ if lives w/child	√ if deceased
	Home #	☐	☐
	Cell #	**Correspondence**	
	Work #	Yes ☐	No ☐
	EMAIL		

Mother

		√ if lives w/child	√ if deceased
	Home #	☐	☐
	Cell #	**Correspondence**	
	Work #	Yes ☐	No ☐
	EMAIL		

Step Parent / Foster Parent / Guardian(s)

		√ if lives w/child	√ if deceased
	Home #	☐	☐
	Cell #	**Correspondence**	
	Work #	Yes ☐	No ☐
	EMAIL		

Legal Custody/Court Document/Special Arrangements (Please list): _____

_____

If Foster Child, list Agency Name and Telephone Number: _____

Home District at Time of Foster Placement: _____

Attended Preschool ☐ Yes ☐ No Preschool Name: _____ Dates Attended:

Preschool Address: _____

Signature of Parent or Guardian: _____ ***Date***:_____

Office Use Only: ☐Migrant ☐ Immigrant ☐ Foreign Exchange ☐ Military Family

GUIDELINES FOR REASONABLE INFORMATION THAT CAN BE REQUESTED TO SUBSTANTIATE A SWORN STATEMENT BY A RESIDENT UNDER 24 P.S. §13-1302

Pursuant to Act 35 of 2001, school districts may, upon adoption of a school board policy, request copies of one of the items in each category below, in substantiation of the assertions made in a sworn statement of a resident. If the school district has elected to require such substantiating information and advised the resident thereof, then the resident must submit the required documentation along with the sworn statement before the district is required to accept the child as a student. The Greensburg Salem School has adopted a policy requiring substantiation of statements.

Reasonable information to substantiate the sworn statement shall include the following:

SIGNER IS A RESIDENT OF THE DISTRICT

- Any two of the following:

  ✓ Utility bill listing the name and address of the signer, or

  ✓ Pennsylvania Department of Transportation identification or driver's license, or

  ✓ Pennsylvania department of transportation vehicle registration, or

  ✓ Copy of a State/Federal program enrollment, or

  ✓ Copy of a paycheck stub with name and address of employee and employer.

SIGNER IS SUPPORTING THE CHILD GRATIS

- Copy of completed IRS form transferring tax emption of child to resident, or
- Copy of Federal or State tax form which lists the child as a dependent of the resident, or
- Copy of a completed county form transferring child support payments to the resident, or
- Copy of a completed form notifying the department of Welfare of a child's new residence, or
- Copy of an insurance policy/card/statement listing the child as eligible for services, or
- Copy of a lease/rental agreement listing the child as a tenant, and
- Residency affidavit.

SIGNER WILL ASSUME ALL PERSONAL OBLIGATIONS FOR THE CHILD RELATIVE TO SCHOOL REQUIRMENTS

- The sworn statement by the resident shall be satisfactory evidence thereof.

SIGNER INTENDS TO SO KEEP AND SUPPORT THE CHILD CONTINUOUSLY AND NOT MERELY THROUGH THE SCHOOL TERM

- Sworn statement by the resident shall be satisfactory evidence thereof.

RESIDENCY INFORMATION

If you have provided two original sources of residency, you do not need to complete the **Residency Affidavit.** An acceptable form of residency is as follows: a deed, a lease, current utility bill, current credit card, property tax bill, vehicle registration, driver's license, and a DOT identification card.

If you do not have two original sources of residency, please complete the attached **Residency Affidavit** form. The **Residency Affidavit** form must be completed and notarized in the presence of a Notary.

If the student is living with a resident of Greensburg adult other than the student's parent/s, please complete **Attachment B – Sworn Statement by Resident.** The **Attachment B – Sworn Statement by Resident** form must be completed and notarized in the presence of a Notary.

If the student is living with a resident of Greensburg adult other than a parent and you have the appropriate legal documentation to show dependency or guardianship, which may include a custody order, you do not need to complete **Attachment B – Sworn Statement by Resident**.

Greensburg Auto Tag & Notary provides notary services free of charge to parents of new Greensburg Salem School District students.

Greensburg Auto Tag & Notary

Mr. Robert F. Nowlin, Jr.

249 West Pittsburgh Street

Greenburg, PA 15601

GREENSBURG SALEM SCHOOL DISTRICT
1 Academy Hill Place ◘ Greensburg, Pennsylvania 15601-1567 724-832-2901

Residency Affidavit

24 P.S. § 13-1302

I/We attest that all of the information here is correct and current. I/WE understand that if residency should change, for any reason, it is the responsibility of he resident to notify the Greensburg Salem School District and to amend this Residency Affidavit. Any false statements can and will be punished as prescribed by law.

I/We _____ currently reside at

_____

This is our legal, full-time residence.

I/We ☐ rent or ☐ own this residence

I/We are the parent(s)/guardian(s) of the following school-age children who live at this address with us:

_____

_____

_____

If children reside in the residence for which the identified adults are neither parents or guardians, please request a modified form of this affidavit.

Through my/our notarized signature(s), I/We grant the Greensburg Salem School District permission to investigate the accuracy of the information I/We have presented in this affidavit for confirmation and factual accuracy.

Signed by resident(s) and notarized:

_____ _____

Resident Signature Notary Signature

GREENSBURG SALEM SCHOOL DISTRICT

Attachment B - Sworn Statement by Resident

Attachment B - SWORN STATEMENT BY RESIDENT UNDER §13-1302 TO BE COMPLETED BY RESIDENT ONLY

Instructions: Please complete the following statement. If the potential student is living, or will be living, in a household with more than one resident adult who will assume responsibility for the student, all such adult residents must complete and sign this statement.

This is a legal document. You may ask to see a copy of 24 P.S. §13-1302 prior to signing this document, and consult with an attorney if you have any questions or do not understand any portion of this document.

1. Your Name _____

   Home Address_____

   Home Telephone Number _____ Work Number _____

2. Do you live in the school district and does the child live with you? Yes _____ No _____

3. Child's Full Name _____

Birth Date_____ Grade _____

Name & Address of Last School Attended _____

_____

Date child began/will begin to reside in your home _____

4. Are you supporting this child gratis (without personal compensation or gain)? Yes _____ No _____

5. Will you assume all personal obligations related to school requirements for this child that may include providing for required immunizations, uniforms, fees/fines, citations/fines for truancy, attending parent-teacher conferences, or attending meetings/hearings concerning discipline? Yes ____ No ____

6. Do you intend to keep and support the child continuously and not merely through the school term? Yes ___ No ___

Through my notarized signature, I/We understand that the school district, pursuant to guidelines issued by the Department of Education and their own written policy, may require other reasonable information to be submitted to confirm this sworn statement.

Signed by resident(s) and notarized _____

Per 24 P.S. §13-1302, a person who knowingly provides false information in the above statement for the purpose of enrolling a child in a school district for which the child is not eligible commits a summary offense and shall, upon conviction for such violation, be sentenced to pay a fine of no more than three hundred dollars ($300) for the benefit of the school district in which the person resides or to perform up to two hundred forty (240) hours of community service, or both. In addition, the person shall pay all court costs and shall be liable to the school district for an amount equal to the cost of tuition calculated in accordance with §2561 during the period of enrollment.

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

GREENSBURG SALEM SCHOOL DISTRICT
1 Academy Hill Place ◘ Greensburg, Pennsylvania 15601-1567 724-832-2901

We would like to welcome you to the Greensburg Salem School District. It is our intention to provide every child with broad and sound educational opportunities. Therefore, the District's Health Department will assist you with questions regarding State regulations pertaining to immunization requirements prior to the start of school. The District's Health Department will provide vision and hearing screenings in accordance with State regulations. If your child has a special health condition, please notify the appropriate school nurse. It is important to guard the health of every child in the Greensburg Salem School District. We recommend that arrangements for your child's medical checkup and immunizations is completed as soon as possible to avoid scheduling difficulties at local physician offices.

Your child's birth certificate is required at the Kindergarten Registration. The birth certificate is required to verify your child's legal name. If your child does not have a birth certificate, one may be obtained with a fee from the Pennsylvania Department of Health, Division of Vital Statistics (www.vitalcheck.com).

The following are Pennsylvania Mandates:

1. Records and Immunizations

State law requires each school to maintain permanent health and dental records for each child enrolled. So that we obtain the information required, please fill out and return the enclosed Health History form at the Kindergarten Registration Day at your school. The school nurse will also need a copy of the immunization record that has been medically documented by the physician or clinic that has administered the immunizations.

Every Pennsylvania school district, both public and private, is required by State law to refuse admission to any child who has not been completely immunized receiving diphtheria, tetanus, pertussis, polio, measles and mumps vaccines, hepatitis B series, and either the chicken pox vaccine (varivax) or documentation of month and year of chicken pox disease.

Pennsylvania allows the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction outlined in PA Code Ch. 23 Section § 23.84. The District must be notified in writing prior to the start of school of any exemption. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable diseases.

Verification by month, day and year must be provided for receiving the following immunizations/ vaccines. **An official copy of the immunization/vaccination record signed by the physician's office must be brought to registration.**

Immunizations and Vaccinations	
4 doses of the Acellular Pertussis 4 doses of the Diphtheria 4 doses of the Tetanus	* The 4"' dose for each is given on or after the 4th birthday * Usually given as DTP or DTaP or DT or Td
4 doses of the Polio	* 4th dose on or after 4th birthday and at least 6 months after previous given dose * A 4th dose is not necessary if the 3rd dose was administered at age 4 years or older and at least 6 months after the previous dose
2 doses of the Measles 2 doses of the Mumps 2 doses of the Rubella	Usually all three are given as MMR
3 doses of the Hepatitis B	
2 doses of the Varicella (chicken pox) or evidence of immunity	

2. Physical Examination

The District encourages to have your child under the regular care of a physician of your choice. The Pennsylvania Public School Code Section 1402. Health Services (e) requires that students upon original entry be given a "comprehensive appraisal" of their health. **The physical is to be completed within 1 year prior to the start of the school year.** In addition, Section 1402(c) requires the completion of medical questionnaires which are to become part of the student's health record.

Schools may accept exams on the private physician's own form as long as it comparable to the DOH approved form.

3. Dental Examination

The school will request reports from your child's dentist in grades kindergarten or first, third, and seventh. If these reports are not returned in the fall of the current year, the dental examination will be given in school. The school nurse will send letters home with details.

4. Vision Screening

A vision screening will be conducted during Kindergarten Registration. The Westmoreland United Way of Southwestern Pennsylvania will be conducting the screening this year. The screening is not a substitute for routine doctor's care and examinations. **Please complete the form and return to the school at Kindergarten registration**.

If you have any questions regarding the contents of this letter, please do not hesitate to contact your child's school for further information.

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

United Way
United Way
of Southwestern Pennsylvania

PRESCHOOL VISION SCREENING PERMISSION FORM

CHILD'S NAME _____
(**Please Print**) LAST FIRST MIDDLE

CHILD'S BIRTHDATE _____ AGE_____SEX_____

PARENT'S NAME _____ E-MAIL_____

ADDRESS _____ HOME PHONE _____
STREET

_____ WORK PHONE _____
CITY STATE/ZIP CODE

This screening is to measure how well your child can see. Suggestions will be made for follow-up and evaluation as necessary. A medical diagnosis will not be given based on this screening. We acknowledge that the physical condition of a child's eye can change. We recommend annual screenings. This screening is not a substitute for routine doctor's care and examinations.

I have read and understand the above and hereby give my permission for the above named child to participate in the Preschool Vision Screening Program. I have received a copy of the United Way of Southwestern Pennsylvania's Use of Information Notice and understand that the results of this screening may be shared with teachers, health coordinators, school nurses and others as appropriate.

_____ _____
SCREENING LOCATION PARENT OR GUARDIAN SIGNATURE

_____ _____
DATE OF SCREENING DATE OF SIGNATURE

HEALTH HISTORY

Greensburg Salem School District ❒ 1 Academy Hill Place ❒ Greensburg, PA 15601

PARENTS: PLEASE FILL OUT BOTH SIDES OF THIS FORM

When completed, please return this form to your child's homeroom teacher as soon as possible.

TO PARENTS OR GUARDIAN: The information requested on this form will be of help to school authorities in determining the health status of your child and in assisting him to receive maximum benefits from his educational opportunities.

School _____ Teacher _____ Grade _____

Name of child: _____ Address: _____

Birth date: _____ _____

Father's name: _____ Mother's full name: _____

Has your child had any of the followng? Give details.

Yes	No		Yes	No	
❒	❒	Allergy _____	❒	❒	Seizure Disorder _____
❒	❒	Operation (Note type) _____	❒	❒	Emotional Problems _____
❒	❒	Chicken Pox: Month_____ Year _____	❒	❒	Orthopedic Problems _____
❒	❒	Diabetes _____	❒	❒	Serious Accidents _____
❒	❒	Asthma _____	❒	❒	Chronic Ear Infections _____
❒	❒	Heart Problems _____	❒	❒	Tubes in Ears _____
❒	❒	Attention Deficit Disorder _____	❒	❒	Birth Defects _____

❒ ❒ Is your child taking any medications on a regular basis?

If yes, list name(s) of Drug(s) and how often:

Date: _____ Signature of parent or guardian: _____

Home telephone number: _____

GENERAL INFORMATION

You are encouraged to have the school health examination performed by your family physician. The school nurse will provide the proper forms which are to be completed by your family physician and returned promptly; if the physical form is not returned, signed by your doctor, the physical exam will be done by the school doctor.

PLEASE FILL OUT BOTH SIDES OF THIS FORM (OVER)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you want your child taken to Westmoreland Hospital
Emergency Room if parent or physician cannot be contacted? ❒ Yes ❒ No

If your child just entered our school, give name and address of school from which he/she came:

Please list any other information that the school nurse should be aware of:

Comments:

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:_____

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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)					

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