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
- ☐ Consent for Release of Preschool Records – Signed
- ☐ Computer & Digital Technology Form – Signed
- ☐ Home Language Survey – Signed
- ☐ 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
____ Release of Records
____Technology Form
____ Language Survey
____ Safe Schools
____ 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

V 1/2023

Butler Area School District – 110 Campus Lane – Butler PA 16001 – 724-287-8721

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., us MOST CURRENT move dates.

Date Moved into PA	Date Moved into U.S.	Total Years in U.S. Schools

Date Child Entered 9th 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	Phone Number

Street Address (House Number, Street Name) ***If different than student***	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	Phone Number

Street Address (House Number, Street Name) ***If different than student***	City, State, Zip Code

Email Address	Employer Name	Employer Phone Number

CHILDREN IN HOUSEHOLD NOT LISTED ABOVE

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

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				

1/2021

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	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): *(Must live locally)*	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): *(Must live locally)*	
Full Name	Phone #
Address	Relationship to Student

EMERGENCY DATA CONTACT(S): *(Must live locally)*	
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: _____

BUTLER AREA SCHOOL DISTRICT

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? _____

- 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*

V 1/2023

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.)
- ✔ Academic records
- ✔ Health records (including immunizations)
- ✔ Psychological records (please sign another release for the doctor's office.)
- ✔ Disciplinary records
- ✔ Special education records

Send records to:

- **Broad Street Elementary:** 200 Broad St.,, Butler PA 16001 PH 724-214-33630 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
- **McQuistion 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 724-214-4100
- **Summit Elementary**: 351 Brinker Road, Butler PA 16002 PH 724-214-3880 FAX 724-287-2734

Parent's Signature: _____ Date: _____

BUTLER AREA SCHOOL DISTRICT

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

BROAD STREET	CENTER TOWNSHIP	CONNOQUENESSING
EMILY BRITTAIN	MCQUISTION	NORTHWEST
	SUMMIT	

BUTLER AREA SCHOOL DISTRICT

STUDENT PROGRAM INFORMATION

Student Name: _____

School: _____ Grade: _____

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

☐ Individual Education Plan (IEP)	☐ Gifted Individual 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

BUTLER AREA SCHOOL DISTRICT

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_____

Address_____ Phone_____

Birthdate_____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** _____

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_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO 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 ☐**

STUDENT NAME:

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)					

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

Appendix F

H514.027 (2/2023)

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 STUDENT	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	6C	7 D	8 E	9 F	10 G	11 H	12 I	13J	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
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address of Dental Examiner

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

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.

1. 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.

2. 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:

Broad Street	Lynn Zidek, 724-214-3632
Center Avenue	Ashley Casey, 724-214-3965
Center Township	Lynn Zidek, 724-214-3806
Connoquenessing	Amber Corace, 724-214-4043
Emily Brittain	Tracy Futscher, 724-214-4204
McQuistion	Michele Harold, 724-214-3903
Northwest	Amber Corace, 724-214-4104
Summit	Tracy Futscher, 724-214-3883
Intermediate High	Morgan Boulanger, 724-214-3430
Senior High	Kimberly Halter, 724-214-3227

Sincerely,

Brian White Jr., Ed.D.
Superintendent

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

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 the 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 the 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 (6^{th}) and eleventh (11^{th}) 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 (3^{rd}) and seventh (7^{th}) 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 (6^{th}) and seventh (7^{th}) grade.

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