EASTERN LEBANON COUNTY SCHOOL DISTRICT
ENROLLMENT CHECKLIST
DISTRICT OFFICE (717) 866-7117 / Fax# (717) 866-7084

STUDENT NAME: _____ **GRADE:** _____
DATE: _____ **LEARNING OPTION**: ☐ELCO IN-PERSON ☐ELCO VIRTUAL ACADEMY

☐ **ONLINE FORMS COMPLETED** (TO BE DONE PRIOR TO SCHEDULING AN IN-PERSON APPOINTMENT)

→ **To Schedule a Registration Appointment:** https://elcoregistration.as.me/

DOCUMENTS TO BE SUBMITTED AT SCHEDULED APPOINTMENT

☐ **PROOF OF AGE** Examples: Birth Certificate, Passport, Baptismal Certificate

☐ **PROOF OF RESIDENCY** Examples: Lease, Mortgage, Utility Bill *(printed bill from online account is acceptable),* Property Tax Bill, or Pay Stub showing Name, Address & Date.

☐ **IMMUNIZATION RECORDS** Doctor's offices may fax to: (717) 866-7084

☐ **PARENT/LEGAL GUARDIAN ID** Example: Driver's License

ENROLLMENT FORMS to be completed at the scheduled enrollment appointment. To expedite the appointment, forms may be downloaded from the ELCO website Student Registration page and completed in advance of the appointment.

☐ **RESIDENCY AFFIDAVIT** – Attach Proof of Residency **See Examples Above*
If renting, landlord's signature is required on Residency Affidavit unless student's name is listed on the lease.
If homeowner is other than self, see center section of Residency Affidavit and have homeowner sign the form.

☐ **RELEASE OF INFORMATION** *N/A for kindergarten students enrolling for the first time

☐ **BUS STOP REQUEST FOR CHILDCARE:** Complete if pick up/drop off are different than home address.

KINDERGARTEN STUDENTS *Both forms to be returned prior to or soon after the start of school.
☐ * **PRIVATE PHYSICIAN'S REPORT**
☐ * **PRIVATE DENTIST REPORT**

ADDITIONAL DOCUMENTS TO BRING TO APPOINTMENT (IF APPLICABLE AND/OR AVAILABLE):

If other than the natural, adoptive, or foster parent(s) the following is required:
☐ **COURT ORDER** If Applicable, Granting Legal Guardianship
- OR -
☐ **GUARDIANSHIP - SWORN STATEMENT BY RESIDENT UNDER 13-1302:**
Contact Tina Kunder at (717) 866-7117 ext. 10803 or tkunder@elcosd.org to discuss. *MUST BE NOTARIZED.
☐ **CUSTODY AGREEMENT:** If Applicable
☐ **FOSTER CARE FORM**
☐ **ACADEMIC RECORDS**: Transcripts, Most Recent Report Card, Progress Reports, etc.
☐ **SPECIAL EDUCATION FILES:** If Applicable (Current Copy of IEP and Most Recent Evaluations)
☐ **ATHLETIC REGISTRATION QUESTIONNAIRE**: HS Students Only

TO BE COMPLETED BY THE SCHOOL ☐ **Re-Enroll** ☐**FZ** -OR- ☐**JA** **Appt:** _____

Student I.D. # _____ **School Year** _____
District Entry/Reentry Date _____ **PA Entry Date:** _____
Library/Cafeteria ID # _____ **HS - 9th Grade Entry Date:** (YYYY-MM-DD) _____
Admission Code _____ **HS - Expected Graduation** (MM/YY) _____
Transfer From: _____ **Special Ed** _____ **ESL** _____
Temporary Living Situation: _____ **Records to Sec Address** ☐ **F&R** ☐

Revd. 2/15/2024

EASTERN LEBANON COUNTY SCHOOL DISTRICT
RESIDENCY AFFIDAVIT

I/We attest that all information provided here is correct and current. I/We understand that if residency should change, for any reason, it is the responsibility of the resident to notify the Eastern Lebanon County School District and amend the residency affidavit. Any false statements can and will be punishable by law.

Student Name: _____

I/We, _____ currently reside at
Parent/Guardian Name(s)

_____
Address

PROOF OF RESIDENCY – Must provide one of the following documents showing name, street address of homeowner or lessee and current date:

- ☐ Signed Lease/Rental Agreement
- ☐ Sales Agreement/Mortgage
- ☐ Utility Bill within past 45 days
- ☐ Property Tax Bill
- ☐ Pay Stub from Wages, Public Assistance, or Social Security

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HOMEOWNER'S VERIFICATION ***If homeowner is other than self***

Homeowner's Name _____ **Telephone #** _____

Approval has been granted for _____ to reside
Student & Parent(s) / Guardian(s)

with _____ at the address identified above.
Homeowner

Homeowner's Signature _____ **Date** _____

LANDLORD VERIFICATION ***If renting***

Landlords Name _____ **Telephone #** _____

Approval has been granted for _____ to reside
Student & Parent(s) / Guardian(s)

with _____ at the address identified above.
Lessee

Landlord's Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date:** _____

If at any time, the ELCO School District should have any questions regarding the accuracy of the residency information provided above, you may be required to provide more documentation and/or proof of residency and have this form notarized.

24 P.S. § 13-1302 Guidelines

Revd. 1/20/2021

EASTERN LEBANON COUNTY SCHOOL DISTRICT
RELEASE OF INFORMATION

STUDENT: _____ **DATE:** _____

DOB: _____ **SCHOOL YEAR**: _____

GRADE: _____

TRANSFERRING FROM:

SCHOOL DISTRICT: _____

BUILDING: _____

SCHOOL ADDRESS: _____

SCHOOL PHONE#: _____

I hereby consent to the release of all pertinent education, medical, and psychological information to the Eastern Lebanon County School District. I understand this information will be treated in a confidential and professional manner.

_____ _____

Parent/Guardian Signature ***Relationship to Student***

_____

Address ***City*** ***State*** ***Zip***

FOR OFFICE USE:

DATE REQUEST SENT: _____

DATE RECORDS RECEIVED: _____

Revd: 1/25/2021

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: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____ 20_____

Print name of examiner _____

Print examiner's office address _____ **Phone** _____

Signature of examiner _____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

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

H514.027 (2/2024)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20___

NAME OF STUDENT	DATE OF BIRTH	GRADE	SECTION/ROOM
Last First Middle			

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION/SCREENING

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
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Sealants on Permanent Molars No Yes

Treatment Urgency: None Early Urgent

_____
Date

_____ _____
Signature of Dental Provider Print Name of Dental Provider

_____
Address of Dental Provider