



REGISTRATION PROCEDURES

Welcome to the Montrose Area School District!

In order to establish and verify your residence within the Montrose Area School District, a few documents need to be completed and approved. All procedures are in accordance with Sections 1301 and 1302 of the Pennsylvania School Code and Regulations 11.11 and 11.19 of the Pennsylvania State Board of Education, Sections 1301 and 1302 authorize Montrose Area School District to request proof of residence or guardianship **prior** to admission to our school programs.

The biological parent, adoptive parent, court appointed guardian, or a resident within the district may enroll a student into MASD. A district resident enrolling a student whose parent(s) do not live within the district, must complete a Sworn Statement by Resident Under 13-1302 form. The person enrolling the student must come in person to the registration office to sign the Residency Affidavit page. If unable to appear in person, the signature must be notarized.

Registration packets can be picked up in advance at any school office, can be mailed to you or can be downloaded from the district webpage at www.masd.info. To have a packet mailed to you, please call Mrs. JoAnne McCain at 570-278-6227.

Registration hours are 8:00 am to 3:00 pm Monday thru Friday excluding holidays and emergency closures. All registrations are conducted at the District Administration office located behind the high school at 273 Meteor Way, Montrose PA 18801. Please use this checklist to make sure you have all necessary documents for registration and bring the completed packet checklist at registration.

WHAT TO BRING WHEN YOU REGISTER YOUR CHILD

You will need to bring the following information with you in order to register your child:

- **Proof of Residency:** May be any of the following: a deed, a lease, current property tax bill, current utility bill, current credit card bill, valid vehicle registration, valid driver's license or State ID indicating an address within the Montrose Area School District.
- **Proof of Guardianship:** Legal custody agreement, if applicable, copy to be placed in the student's file.
- **Proof of Child's Age:** Original state issued birth certificate, valid passport, baptismal certificate, notarized or duly certified record of baptism, or a prior school record indicating date of birth.
- **Record of Immunizations:** State law requires that a complete record of immunizations be provided. You can get a copy of your child's health records from the school you are leaving. Shot records are also available from your doctor's office. Physicals are also required at certain grade levels.

It is necessary to have the name and address, including the city and state, of the previous school in order to obtain records.



MONTROSE AREA SCHOOL DISTRICT RESIDENCY AFFIDAVIT

Identifying Information – please print

This form is to be completed by the student’s parent or legal guardian and signed/witnessed by a school district employee. You must submit a separate Residency Affidavit for each child enrolled in the district.

Student Information:

Student Name _____
Legal Last Name Legal First Name Legal Middle Name

Date of Birth ____/____/____

Student Lives With: Print name(s) and CHECK RELATIONSHIP TO STUDENT:

Parent or Guardian Name _____
Legal Last Name Legal First Name Middle Initial

Relationship to Student Mother Father Stepparent Guardian Foster Parent Other _____

Parent or Guardian Name _____
Legal Last Name Legal First Name Middle Initial

Relationship to Student Mother Father Stepparent Guardian Foster Parent Other _____

PLEASE NOTE THAT POST OFFICE BOXES ARE NOT ACCEPTABLE AS A RESIDENCE ADDRESS BUT MAY BE USED AS A MAILING ADDRESS BELOW.

Physical Address _____
Street Address City State Zip Code

Mailing Address _____
Street Address City State Zip Code

Phone Number _____
Home Father/Guardian (Work) Mother/Guardian (Work)

Proof of Residency

_____ Deed or Lease _____ Current Property Tax Bill _____ Current Credit Card Bill
_____ Current Utility Bill _____ Valid Driver's License or State ID _____ Valid Automobile Registration

Parent/Guardian Signature **Date** **Witness Signature** **Date**



Student Biographical Data

Student Name _____ Birthdate ____/____/____ Age ____
(Last) (First) (Middle) (mm) (dd) (yyyy)

Address(Physical) _____

Address (Mailing- If Different) _____

Gender M F Grade Entering _____ Proof of Age Documentation **attached** Y N

Name of Last School Attended _____

Has student ever attended school in PA? Y N Has student ever attended in this school district? Y N

Is there a Court Order involving this student? Y N If **YES**, please provide a copy to the school office, otherwise we are unable to abide by its contents.

For state and federal reporting requirements, use the following definitions (select one race code and one primary ethnicity):

Race Code: Asian/Pacific Islander; Black/African American; American Indian/Alaskan Native; Caucasian/White

Select Primary Ethnicity Hispanic; Non-Hispanic
(any race) (any race)

**Resident Adult(s) with whom student resides
Print name and Check relationship to student**

First Adult in residence:

Parent/Guardian Name _____ Mr./Mrs./Ms./Dr. (circle one)
(Last) (First)

Relationship to student Father Mother Guardian Step Parent Other Please specify _____

Primary Phone Numbers: Home ____ - ____ - ____ Work ____ - ____ - ____ Cell ____ - ____ - ____

Email: _____ Primary email? Yes ___ No ___

Second Adult in residence:

Parent/Guardian Name _____ Mr./Mrs./Ms./Dr. (circle one)
(Last) (First)

Relationship to student Father Mother Guardian Step Parent Other Please specify _____

Primary Phone Numbers: Home ____ - ____ - ____ Work ____ - ____ - ____ Cell ____ - ____ - ____

Email: _____ Primary email? Yes ___ No ___



Second Parent Information - Parent that student does NOT reside with

Parent Name _____ Mr./Mrs./Ms./Dr. (circle one)
(Last) (First)

Relationship to student Father Mother

Is this parent to receive notices? Yes No Is this parent allow to pick student up? Yes No

Primary Phone Numbers: Home _____ - _____ - _____ Work _____ - _____ - _____ Cell _____ - _____ - _____

Mailing Address: _____

Email : _____

***Please Note:**

If there are custody arrangements please make sure to have a copy of the court order on file. The Montrose Area School district cannot withhold information regarding a student to a parent without a court order on file.

OFFICE USE ONLY

Student ID# _____ Date Entered/Reentered _____ Homeroom _____

PA Secure ID # _____

Proofs of Residency verified:

Verification by: _____

(List A)

Lease Deed Current property tax bill

(List B)

Valid PA DL/State ID card Valid PA auto registration Current utility bill Current Credit Card Bill

Institutionalized Child (1306) Y N If yes submitted 4605?: Y N

Foster Child (1305) Y N (If yes, attach 1305 – Affidavit)

1302 Child: Y N (if yes, attach 1302 affidavit)

Building Enrolled In:

Montrose Area Jr/Sr High School Lathrop Street Elementary Choconut Valley Elementary

Data Entry Secretary's Initials _____



Household Census Information

Address: PLEASE NOTE THAT POST OFFICE BOXES ARE NOT ACCEPTABLE AS A RESIDENCE ADDRESS BUT MAY BE USED AS A MAILING ADDRESS.

Physical Address: _____

Mailing Address (if different): _____

The Residence is: Single Family Home _____ Hotel/Motel _____ Multi-Family Home _____ (doubled up)
Apartment _____ Campground/Campsite _____ Vehicle _____ Other _____

Municipality to which you pay taxes: Apolocon Bridgewater Choconut Friendsville Franklin Forest Lake
Jessup Liberty Little Meadows Montrose Borough Silver Lake

Please List All Adults Living at this address:

- 1.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
- 2.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
- 3.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
- 4.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____

Please List All Children living at this address:

- 1.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 2.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 3.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 4.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 5.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 6.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____
- 7.) Full Name _____ Birthdate ____/____/____ Gender Male _____ Female _____
Grade _____ School _____



HOME LANGUAGE SURVEY

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS 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 method for identification.

Student's Name _____ **Grade** _____ **Birth Date** _____

What was the student's first language? _____

Does the student speak English? YES NO

Does the student speak a language other than English? YES NO (Do **not** include languages learned at school)

If yes, please specify other language(s) spoken _____

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

Person completing this form (if other than parent/guardian): _____

Parent/Guardian Signature: _____

The school district 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 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 school district 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 in the future.



Student School History

Student Name	<div style="display: flex; justify-content: space-between; width: 100%;"> Last First Middle </div>
Name and address of last school attended	Name of School: Address :
School telephone Numbers	Phone () ____ - ____ Fax () ____ - ____
Academic Grade	K <u> </u> 1 <u> </u> 2 <u> </u> 3 <u> </u> 4 <u> </u> 5 <u> </u> 6 <u> </u> 7 <u> </u> 8 <u> </u> 9 <u> </u> 10 <u> </u> 11 <u> </u> 12 <u> </u>
Documents / Records brought from Last School Please Check all That apply	Grades <u> </u> Schedule <u> </u> Transcript <u> </u> Report Card <u> </u> Other <u> </u>
Grade 9 Start year	If student is in the High School what year did they start grade 9?

Do any of the following apply to this student from his/her previous school? Please check all that apply

<input type="checkbox"/> Student has an IEP	<input type="checkbox"/> Student has GIEP (Gifted)
<input type="checkbox"/> Student received Speech / Language Therapy	<input type="checkbox"/> Student received Physical Therapy
<input type="checkbox"/> Student is Deaf / Hearing Impaired	<input type="checkbox"/> Student is Blind / Visually Impaired
<input type="checkbox"/> Student received Occupational Therapy	<input type="checkbox"/> Student received Emotional Support
<input type="checkbox"/> Student received Learning Support Services	<input type="checkbox"/> Student had 504 Agreement
<input type="checkbox"/> Student received Autistic Support	<input type="checkbox"/> English as a Second Language
<input type="checkbox"/> Student received Adaptive Physical Education	<input type="checkbox"/> Student received Alternative Education Services
<input type="checkbox"/> Other (please list)	<input type="checkbox"/> None of the Above



Authorization to Release School Records

TO WHOM IT MAY CONCERN:

According to the Family Educational Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976. Vol. 41, No. 118, Page 24673, it is not necessary to obtain written consent to release records between schools. It states that school officials, including teachers within the educational institution and officials of another school in which the student intends to enroll may receive a student's record without consent for such release.

STUDENT'S NAME _____

DATE OF BIRTH _____ GRADE LEVEL _____

DATE OF ENTRY _____

SIGNATURE OF PARENT/GUARDIAN

DATE

REQUEST FOR HEALTH AND SCHOOL RECORDS

Please send the following information

PA SECURE ID _____

TRANSCRIPT OF GRADES

GRADES AT TIME OF WITHDRAWAL

STANDARDIZED TESTING

ATTENDANCE HISTORY

ATTENDANCE IMPROVEMENT PLANS

HEALTH RECORD

DISCIPLINE SUMMARY

PSYCHOLOGICAL TESTING / IEP

COPY OF BIRTH CERTIFICATE

OTHER AVAILABLE SCHOOL RECORDS

PLEASE SEND RECORDS TO:

MONTROSE AREA HIGH SCHOOL
ATTN: MS. PATTY BENDOCK
75 METEOR WAY
MONTROSE, PA 18801-9446
PH. 570-278-6253
FAX. 570-278-9040
EMAIL: pbendock@masd.info

LATHROP STREET ELEMENTARY
ATTN: MRS. MARY WAGER
130 LATHROP STREET
MONTROSE, PA 18801-9446
PH. 570-278-0311
FAX 570-278-4799
EMAIL: mwager@masd.info

CHOCONUT VALLEY ELEMENTARY
ATTN: MRS. JACQUIE MEEHAN
4458 STANLEY LAKE ROAD
FRIENDSVILLE, PA 18818-8781
PH. 570-278-7300
FAX 570-278-7310
EMAIL: jameehan@masd.info

High School Counselors:

Grade 7/8: Mrs. Torilynn Rezykowski
570-278-6231

Grade 9/10: Mrs. Loriann Matulevich
570-278-6235

Grade 11/12: Mrs. Angela Nebzydoski
570-278-6233

Lathrop Street Counselor:

K-6: Mrs. Alexis Hayes
570-278-0313

Choconut Valley Counselor:

K-6: Mrs. Laura Tomeo
570-278-7309



TRANSPORTATION REQUEST FORM

Date Transportation to begin on _____

Student Name _____ Grade _____

Male _____ Female _____

Parent/Guardian Name _____ Home Phone _____

Address: _____

Place of Employment _____ Work # _____

Directions to stop _____

Sitter's Name if applicable _____ Phone # _____

If there is a student that you know who currently gets on at the same bus stop, provide name below:

Transportation Office use only

School Attending:

_____ Choconut Valley Elementary _____ Lathrop Street Elementary _____ Montrose Area Jr/Sr High School

AM Bus #: _____ Pick Up Time: _____ Bus Stop Location: _____

PM Bus #: _____ Drop Off Time: _____ Bus Stop Location: _____

Transfer Bus#: _____ Transfer Time: _____ Transfer Location: _____

Bus Contractor: _____

If you do not hear from the transportation department within 24 hours please call:

Mrs. JoAnne McCain – Dir. Of Transportation
570-278-6227



PARENTAL REGISTRATION STATEMENT

Student Name _____

Date of Birth _____ Grade _____

Parent/Guardian Name _____ Phone (____) _____ - _____

Address _____

Pennsylvania School Code 13-1304-A states in part "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 of 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."

PLEASE COMPLETE THE FOLLOWING:

I hereby swear or affirm that my child WAS____ WAS NOT____ 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. * I make this statement subject to the penalties of 24 P.S. 13-1304-A(b) and 18 Pa. C.S.A 4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

Signature of Parent

Date

*Name and address of the school from which student was suspended or expelled

REASON FOR SUSPENSION/EXPULSION: _____

DATES OF SUSPENSION OR EXPULSION: _____

NOTICE: ANY WILLFULLY FALSE STATEMENT MADE ABOVE SHALL BE A MISDEMEANOR OF THE THIRD DEGREE. THIS FORM SHALL BE MAINTAINED AS PART OF THE STUDENT'S DISCIPLINARY RECORD.



Montrose Area School District
Emergency Contact Information Form

PLEASE CONTACT THE FOLLOWING IN CASE OF EMERGENCY:

Please include the contact information for people who are able to pick up your child in case we are unable to reach you.

Student Name Student Grade Student Date of Birth
Address

Is this information an update for a current student? YES NO

Name of Contact #1 to call Relationship to Student
Phone Number # 1 Home Cell Work Phone Number #3 Home Cell Work
Phone Number # 2 Home Cell Work Phone Number #4 Home Cell Work

Name of Contact #2 to call Relationship to Student
Phone Number # 1 Home Cell Work Phone Number #3 Home Cell Work
Phone Number # 2 Home Cell Work Phone Number #4 Home Cell Work

Name of Contact #3 to call Relationship to Student
Phone Number # 1 Home Cell Work Phone Number #3 Home Cell Work
Phone Number # 2 Home Cell Work Phone Number #4 Home Cell Work

Name of Contact #4 to call Relationship to Student
Phone Number # 1 Home Cell Work Phone Number #3 Home Cell Work
Phone Number # 2 Home Cell Work Phone Number #4 Home Cell Work

Name of Contact #5 to call Relationship to Student
Phone Number # 1 Home Cell Work Phone Number #3 Home Cell Work
Phone Number # 2 Home Cell Work Phone Number #4 Home Cell Work

Additional Information

Medical Emergency Information: (special conditions, physical restrictions, allergies, etc.):

MAY YOUR CHILD BE GIVEN MEDICATION AND FIRST AID UNDER THE SCHOOL DOCTOR'S STANDING ORDERS AT THE DISCRETION OF THE NURSE? YES NO

Local Family Physician: Phone

Local Dentist: Phone

Hospital Preference: Phone

List Children in School, include year of Birth:

1. 2. 3. 4.

I GIVE PERMISSION TO THE STAFF OF THE MONTROSE AREA SCHOOL DISTRICT TO TRANSPORT, OR TO MAKE ARRANGEMENTS FOR THE TRANSPORTATION OF MY CHILD TO EMERGENCY MEDICAL CARE, AND HEREBY GIVE PERMISSION FOR MEDICAL TREATMENT DECLARED IMMEDIATELY NECESSARY BY THE PHYSICIAN, IN THE EVENT THE PERSONS LISTED ABOVE CANNOT BE CONTACTED.

Signature of Parent or Guardian

Date



PENNSYLVANIA SCHOOL IMMUNIZATION REQUIREMENTS

Children in **ALL GRADES** (K-12) need the following immunizations for attendance:

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

* Usually given as DTaP or DTP or 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

7th – 12th Grade **ADDITIONAL** immunization requirements for attendance:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)
- 2 doses of meningococcal conjugate vaccine (MCV)
 - First dose given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade.
 - If the dose was given at 16 years of age or older, only one dose is required.

Exemptions to the school laws for immunizations are:

- Medical reasons
- Religious beliefs
- Philosophical/strong moral or ethical conviction

If your child is exempt from immunizations, he/she may be removed from school during an outbreak.

Pennsylvania's school immunization requirements can be found in 28PA Code Ch. 23 (School Immunizations)

Contact your health care provider or the Pennsylvania Department of Health at:
1-877-PA-HEALTH (1-877-724-3258)



Student Name

THE NATURE AND PURPOSE OF THE HEALTH RECORD

I understand that the information I give to the school nurse is important to the school staff to understand and help promote the health and education of my child.

I understand that the information will be shared with other professionals in the school only when the school Nurse and/or school physician believe that it is in the best interests of my child's health and education.

I understand that if my child transfers to another school a copy of the health record will be sent to that school.

Signature of Parent/Guardian

PERMISSION FOR EXAMINATIONS AND TESTS

I understand that state law requires:

- Periodic Physical examination
- Periodic Dental examination
- Screening tests for – height, weight, body mass index, scoliosis (curvature of spine), hearing and vision.

I understand that I will be informed, in writing, of any abnormal results of examinations and tests given to my child.

I understand that I may have the periodic physical examinations and dental examinations done by my private physician/dentist at my own expense. I further understand that I will be responsible for sending reports of these examinations to the school health office on forms provided by the school prior to a date set by the school.

I give permission for the following: Screening tests for – height, weight, body mass index, scoliosis (curvature of spine), hearing and vision.

____/____/____
Date

Parent/Guardian Signature



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form **before**
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____

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

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

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)

Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

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

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	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 <input type="checkbox"/>				
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 15 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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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)					



**Dental Examination Permission Form
Brief Dental History**

Pennsylvania law requires students to have dental exams in kindergarten, third grade, and seventh grade. Your child can receive this exam at school at no cost and results will be sent home. If you prefer your child's private dentist complete the exam, please return the Private Dentist Report form by November 6.

Child's Name _____

_____ **Yes**, I give permission for the school dental hygienist to do my child's dental examination.

Does your child have a heart condition that requires medication prior to having dental work done? _____ Yes _____ No

Does your child have any unusual dental health condition? If yes, please explain

Does your child have a health condition that you believe the dental hygienist needs to know about ? Please describe

_____ **No**, I do not give permission for my child to be examined by the school dental hygienist. **I understand that I will be required to provide a report from my child's dentist in grades Kindergarten, Third and Sixth.**

Parent's Signature _____ Date ____/____/____



THIS FORM FOR ELEMENTARY ENROLLMENTS ONLY

Montrose Area School District

273 Meteor Way
Montrose, PA 18801
(570)278-3731

HEALTH HISTORY

Name of Child _____

Date of Birth ____/____/____

PREGNANCY AND BIRTH

Circle your answer

- 1. Did the mother have any illness during the pregnancy? If yes please explain.
_____ Yes No
- 2. Did the mother take any medicines, alcohol or drugs (other than iron or Vitamins) during the pregnancy? If yes please explain _____ Yes No
- 3. Was the mother or the family under any unusual strain during the pregnancy? If yes please explain. _____ Yes No
- 4. Did the baby come on time? Yes No
If premature did the baby require neonatal intensive care: Yes No
If the baby required neonatal intensive care, for how long? _____
Did the baby require oxygen or assistance with breathing for a prolonged period of time? Yes No
- 5. Was the baby born with any apparent complications? Yes No
If yes please explain _____
- 6. What was the baby's birth weight? _____
- 7. Did the baby have any problems while in the hospital that required medical attention? If yes please explain _____ Yes No
- 8. How many days did the baby stay in the hospital? _____

EARLY CHILDHOOD HISTORY

- 1. Would you describe the baby as average, quiet or active? _____
- 2. Did the baby have any special problems in the first six months? If yes please explain. _____
- 3. At what age did the child sit alone? _____
- 4. At what age did the child start to crawl? _____
- 5. At what age did the child stand alone? _____
- 6. At what age did the child walk alone? _____
- 7. At what age did the child speak their first words? _____
- 8. At what age did the child speak short sentences (two or three words)? _____
- 9. At what age did the child become toilet trained? _____
- 10. At what age did the child stay dry at night? _____

INSURANCE INFORMATION

- 1. Does the family have coverage for medical expenses? Yes No
What type? _____ Private Insurance
_____ Pennsylvania access card
_____ CHIP
_____ None