

AMBRIGDE AREA SCHOOL DISTRICT

Pre-K Registration Fact Sheet

2026-2027

The Ambridge Area School District operates five PA Pre-K Counts Classrooms. The Pre-K Counts Program service three-year old and four-year old students; with four-year old students having the first priority. The Pre-K Counts Program is available at each of our Elementary Schools with 20 students being the maximum capacity in each. Students are enrolled in the Elementary School closest to their geographic home, regardless if they have siblings in that building or not. A student cannot be considered for enrollment without having the completed registration form AND the required documents (See Below). Once the classroom meets the required limit, a waiting list will be established. Both breakfast and lunch are provided. Transportation is ONLY available for students who live within the Ambridge Area School District. This is NOT a first come first served program. Enrollment eligibility is determined through the State Approved Pre-K Counts Selection Criteria, Income, and Birth Certificate that indicates the child is 3 years old by September 1st.

REQUIRED DOCUMENTS AT TIME OF REGISTRATION:

1. Completed Registration Packet

2. Two (2) Proofs of Residency:

- | | |
|--|---|
| -Rental or lease Agreement | -Driver's License |
| - Deed or Mortgage | -Current Insurance Policy |
| -Tax bill or payment from Ambridge,
Baden, Harmony Twp., or South Heights | -Utility Bill |
| | -OR Certificate of Residency – MUST
BE NOTARIZED |

3. Original Birth Certificate

4. Verification of ALL Income from BOTH PARENTS:

- | | |
|-----------------------|------------------------|
| W-2 | Child Support |
| Tax Return | SSI Statement |
| Three (3) Check Stubs | Unemployment Statement |
| Employee Letter | Foster Care Letter |

5. Physical signed by a Doctor

6. Dental signed by a Doctor

7. Immunization Records

8. Custody Agreement

9. IEP or IFSP

10. Home Language Survey – ESL Students

Questions Contact: Jo Ann Hoover, Principal State Street Elementary School 724-266-2833 ext. 4213 or 4215
Mark Iwanejko, Principal Economy Elementary School 724-266-2833 ext. 6245
Stephanie Hull, Principal Highland Elementary School 724-266-2833 ext. 7202

2026-27 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

Date Form Completed: / /
MM DD YY

Legal Last Name (Child)	Legal First Name (Child)	Middle Initial
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Street Address		County	
City	State PA	Zip Code	
School District of Residence			
Home Phone	Work Phone	Email Address	

Child's Date of Birth	Age at start of program year <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Race (optional)	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Not Applicable	
Ethnicity (optional)	
<input type="checkbox"/> Hispanic	Primary Language
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> English
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Spanish
	<input type="checkbox"/> Other _____ (please specify)

Name of Parent or Guardian completing this application	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Relationship to Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____ (please specify)	(Select) <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Adoptive <input type="checkbox"/> Other _____ (please specify)
---	--

Role	
<input type="checkbox"/> Primary Guardian	<input type="checkbox"/> Legal Guardian
<input type="checkbox"/> Secondary Guardian	<input type="checkbox"/> Other _____ (please specify)

List Household Members below for determination of family size (required):

	Relationship to Child	Age
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of \$0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

DETERMINED FAMILY SIZE =

Employment Status of parent/guardian

- Employed Full-Time
 Employed Part-Time
 Unemployed
 Other _____

Employment Status of 2nd parent/guardian (if applicable)

- Employed Full-Time
 Employed Part-Time
 Unemployed
 Other _____

Household Income Sources (Must check all that apply):

- Employment Self-Employment Unemployment Compensation Worker's Compensation TANF Cash payments
 Social Security SSI Child Support Alimony Other

Other Child Eligibility Risk Factor Criterion (Must check all that apply):

	Risk Factor	Definition
<input type="checkbox"/>	Preschooler with an Individualized Education Program (IEP)-	Defined as a child who is currently enrolled in the Early Intervention program with an active IEP. Verification includes a copy of the IEP or other source of documentation from the parent or the Early Intervention agency.
<input type="checkbox"/>	Migratory (Non-Immigrant) Seasonal Student	Defined as a child who has moved from one school district to another to accompany or join a parent or guardian who is a migratory agriculture worker or fisher within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work, including agri-related businesses such as meat or vegetable processing, or work in nurseries such as Christmas and evergreen tree farming.
<input type="checkbox"/>	English Language Learner	Defined as a child whose first language is not English and who is in the process of learning English. Ask these two questions, as established by the Pennsylvania Department of Education, to determine if a child qualifies as an English language learner: 1) What is/was the child's first language? 2) Does the child speak a language other than English? (Do not include languages learned in school).
<input type="checkbox"/>	Homeless	If any of the situations below apply a family is eligible under McKinney-Vento. Additional guidance is available from the National Center for Homeless Education . <ul style="list-style-type: none"> - If the family is staying with others, was this a result of a loss of housing, economic hardship, or other similar reason? - Is the family living in a shelter? (Includes youth, emergency, transitional living, domestic violence, etc.) - Is the family living in a motel, hotel, or campground? - Is the family staying in a public or private place not ordinarily used as a regular sleeping accommodation for human beings? - Is the family living in cars, parks, public places, abandoned buildings, transportation stations, or similar settings? - Is the family living in substandard (limited or no utilities, unsafe conditions, etc.) housing? - Has the child been abandoned, in a hospital, or awaiting foster care placement?
<input type="checkbox"/>	Child in or Part of Family in Child Welfare System	Defined as a child who is a foster child, a kinship care child, or receiving Children and Youth Services.
<input type="checkbox"/>	Child's Family or Living Structure	Defined as a child with a single parent, divorced parents, or with relatives as guardians.
<input type="checkbox"/>	Child Receiving Behavioral Supports	Defined as a child who is referred to Pennsylvania Pre-K Counts from an appropriately credentialed health or mental health provider (not employed by the Pennsylvania Pre-K Counts program) or a child who is receiving mental health treatment. Additional verification beyond the interview is required.
<input type="checkbox"/>	Teen Parent	Defined as a mother or father who was under the age of 18 when the child was born.
<input type="checkbox"/>	Incarcerated Parent	Defined as a child for whom one or both of the child's parents are currently incarcerated.

<input type="checkbox"/>	Education Level of Guardian	Defined as when the parent or legal guardian of the child does not have a high school diploma, high school equivalency, or postsecondary degree.
<input type="checkbox"/>	Eligible for or Receives the Following Public Assistance: TANF, SSI, SNAP	This risk factor was added in 2024. Defined as a family who can produce documentation of eligibility for or receipt of TANF, SSI, or SNAP. (Categorically eligible for Head Start, please refer to HS program if available.)
<input type="checkbox"/>	Child Enrolled in Infant Toddler Contracted Slots Program (ITCSP)	Defined as a child enrolled in ITCSP and eligible to transition into PA PKC.
<input type="checkbox"/>	Child Lives in Geographic Area of High Poverty	Providers wishing to prioritize specific geographic regions with higher rates of poverty may do so. This might include specific zip codes, school districts, or other factors.
<input type="checkbox"/>	Concerns Regarding Child's Physical Development or Existing Medical Condition (Currently Not Receiving EI Services)	If a family concern is shared that is not covered by any of the other risk factors and the child has not yet been referred to EI for evaluation, the program should share information on EI.
<input type="checkbox"/>	Concerns Regarding Child's Speech or Language Development (Currently Not Receiving EI Services)	If a family concern is shared that is not covered by any other risk factors and the child has not yet been referred to EI for evaluation, the program should share information on EI.
<input type="checkbox"/>	Concerns Regarding Child's Social, Emotional, or Behavioral Development (Currently Not Receiving EI Services)	If a family concern is shared that is not covered by any other risk factors and the child has not yet been referred to EI for evaluation, the program should share information on EI.

Family Assurances

By signing below, I acknowledge and agree to the following:

- I understand that my child's eligibility for Pennsylvania Pre-K Counts (PA PKC) is subject to the program's two-year participation limit. My child must be at least three years old by the kindergarten cutoff date set by the school district where we live to assure compliance with receiving only two-years of PKC programming.
- Once my child reaches the age required to enroll in kindergarten in the public school district where we live, I understand they will no longer be eligible for PA PKC funding.
- I understand that my child's enrollment is contingent upon meeting the eligibility criteria, including income verification and prioritization based on risk factors.
- I understand that the PA Pre-K Counts (PKC) program is an educational program with attendance requirements. I agree to ensure my child's regular attendance and to notify the program in case of absences. My program's PA Pre-K Counts hours of operation are:

- I understand that the PKC portion of the day will be secular (non-religious) in nature and will not include religious instruction during the PKC portion of the day. My program's PA Pre-K Counts hours of operation are:

- I understand that once an enrollment start date is confirmed, the child's PA Pre-K Counts enrollment status may be shared with other OCDEL-funded programs, such as the Early Learning Resource Center (ELRC) or Early Intervention, to ensure proper coordination of funding and services.

Parent/Guardian Certification

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or give proof of information provided.

I certify that all information provided is accurate. I understand that eligibility is subject to verification and providing false information may result in disqualification.

Parent/Legal Guardian (Signature)

Date

Parent/Legal Guardian Name (Print Name)

Family and Program Administrator to Complete This Portion Together

For Head Start Eligible families (100% of FPL or below) Check if not applicable

I have been informed of my child's eligibility for Head Start and given the following:

- Contact information for the following Head Start location

- Application and/or assistance with referral
- Brochure or website with information about Head Start
- I understand that my signature below indicates that I have been informed about my options for Head Start, and that I may choose to enroll in either the Pre-K Counts program or Head Start if eligible for both.

Parent/Legal Guardian (Signature)

Date

FOR OFFICE USE ONLY

Income Verification

2025 Federal Poverty Level Guidelines Based On Annual Income

Family Size	100% (Head Start Eligible)	300% (Pre-K Counts Eligible)
1	\$15,960	\$47,880
2	\$21,640	\$64,920
3	\$27,320	\$81,960
4	\$33,000	\$99,000
5	\$38,680	\$116,040
6	\$44,360	\$133,080
7	\$50,040	\$150,120
8	\$55,720	\$167,160
Each Additional	+\$5,680 for each additional family member	+\$17,040 for each additional family member

Pay Frequency Calculation Guide:

Weekly	Multiply gross weekly income by 52
Bi-Weekly	Multiply gross income by 26
Semi-Monthly	Multiply gross income by 24
Monthly	Multiply gross income by 12

INCOME CALCULATION GRID

Name	Income Source	Pay Frequency	Gross Amount	Annualized Amount
1.				
2.				
3.				
4.				
Total Annual Income:			\$ _____	

Actual Annual Verified Gross Household (Family) Income: \$ _____

*Attach copies of documents used to verify income prior to enrollment

Family Size (per PKC guidelines): _____

Family income is at or below 300% of federal poverty level relative to family size (required risk factor). Consider all sources of income. Must be verified prior to enrollment.

Dual Enrollment Verification (Complete once eligibility and enrollment is confirmed)

This section helps process the PA PKC Verification Form, which documents a child's enrollment in the PA PKC Program and is submitted to the ELRC. Additionally, it ensures families seeking wraparound services receive referrals to the local ELRC and accurate notification of the PKC enrollment start date.

Is this child currently receiving CCW subsidy (at any program)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the family interested in receiving ELRC contact information to determine eligibility for CCW wrap around care (at any program)? Referral for ELRC # _____ Contact email or Phone number shared with family _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the PA PKC program submitted a Verification Form to/communicated with the appropriate ELRC to confirm PKC enrollment with Child Care Works (CCW) and received confirmation back? Use the PA PKC and CCW dual enrollment contacts list on the PKC portal for this information	<input type="checkbox"/> Yes <input type="checkbox"/> No

AMBRIDGE AREA SCHOOL DISTRICT
Certification of Residency Instructions

This form is required **ONLY** if you and your student(s) are residing in the Ambridge Area School District but the lease or sales agreement and utility bill are not in your name.

The resident with whom you are living must complete this form. You and the resident must sign the form verifying that the information provided is correct. The form must be notarized.

In addition to the completed Certification of Residency form, the resident must also provide his/her proof of residency (copy of original lease or sales agreement and utility bill).

I do hereby certify:

The _____ family is residing with me (*resident's name*) _____

at _____
 (*street, city, state, zip code*)

 (*List all children and their date of birth*)

 (*List all children and their date of birth*)

The child(ren) listed above is/are the (daughter/son) of (*parent's name*) _____
 who permanently resides at my address in the Ambridge Area School District.

I certify that those listed above is/are bona fide residents in the Ambridge Area School District and I agree to pay all tuition that would be payable by a non-resident student if it determined that any facts in this certificate are false.

Resident's Signature

Parent/Guardian's Signature

Resident's Telephone Number

Parent/Guardian's Telephone Number

Sworn to and subscribed before me

This ____ day of _____, 20 ____

 (Notary Public)

4903. False swearing

- a) *False swearing in official matters: "A person who makes a false statement under oath or equivalent affirmation, or swears or affirms the truth of such a statement previously made, when he does not believe the statement to be true is guilty of a misdemeanor of the second degree if: (2)falsification is intended to mislead a public servant in performing his official function/"*

In addition, residency may be verified by the school district's home school visitor periodically through the year and if the Ambridge Area School District discovers the fact set forth are false; it will seek restitution from the resident.

**AMBRIDGE AREA SCHOOL DISTRICT
STUDENT HEALTH HISTORY**

Name _____ Sex _____ Date of Birth _____ Grade _____

HEALTH CONDITIONS: check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis, type _____ | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nosebleeds (freq.) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Birth/congenital malformations | <input type="checkbox"/> Headaches (freq.) | <input type="checkbox"/> Sinus infections (freq.) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Chicken Pox (year) | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tics/nervous twitches |
| <input type="checkbox"/> Constipation or diarrhea (freq.) | <input type="checkbox"/> Meningitis/encephalitis | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Diabetes, type _____ | | |
| <input type="checkbox"/> Other _____ | | |

Please comment on any of the above checked items:

1. Does your child have any allergies (foods, medications/drugs, bee or other insect stings, etc.): Yes No

If yes, list allergy to what, type of reaction and the recommended treatment, if any.

2. Does your child have asthma? Yes No

3. Does your child take any medication on a regular basis? Yes No

Name of medication(s) _____
Reason(s) _____

4. Has your child ever had a serious illness, injury or operation? Please describe and give dates.

5. Does your child have any vision problems? _____ wear glasses/contacts _____

6. Does your child have any hearing problems? _____

7. Are there any other health problems (physical or emotional) you feel we should be aware of _____

8. Additional comments _____

Parent/Guardian Signature _____ Date _____

The above information will be reviewed and other forms will be sent to you if additional information is required.

**Ambridge Area School District
Emergency Record for Accident or Illness**

Student's Last Name First Name Grade/ School Yr. Date of Birth

Street Address City Zip Code

Home Phone Cell Phone Parent/Guardian Email Address

Siblings: Please list first and last name, school and grade

Please indicate with whom your child is living with at the above address and the relationship to the child
(Parent, guardian, step-parent, grandparent)

Mother's Place of Employment:

Phone: _____

Father's Place of Employment:

Phone: _____

Emergency Contacts: (Parent will be contacted first in case of emergency; this person should be able to supply transportation for your child if called.)

Name and Relationship: _____ Phone: _____

Name and Relationship: _____ Phone: _____

Child's Medication: _____ **For:** _____ **Child's Doctor:** _____

Put an (X) in each box if your child has (or has had) any of the following: (give details on back)

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Physical Handicap | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Other: _____ | | | |

Ambridge Area School District Medical Information Authorization Form

In order to comply with federal and state laws, the Ambridge Area School District requires that this form be completed in its entirety.

I authorize Kristine McCloskey, Ashley Ananea, Stuart Rusnak, and/or any School Nurse from the Ambridge Area School District to use/disclose the following Protected Health Information from the records of:

Individual/Student Name Date of Birth

as described below to: Any other AASD teacher or staff member, including substitutes, building principals and secretaries who may be responsible for my child.

The information is requested for the purpose of: To inform any such staff member or administrator who may be responsible for my child of any serious medical conditions, allergies, medications and/or emergency contacts.

The information to be used/disclosed is identified as follows (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Medical History & Physical Exams | <input type="checkbox"/> Psychiatric/Psychological Evaluations |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> IEP | <input type="checkbox"/> ER's |
| <input type="checkbox"/> Discharge Summary/Instructions | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Verbal Information |

Other (please specify): Any health information appearing on the Student Emergency Information Card submitted to the School Nurse regarding serious medical need/conditions, allergies, medications, emergency contacts or health insurance.

I understand the following:

- That the information used or disclosed may include records relating to my identity, diagnosis, prognosis and treatment;
- That the information used or disclosed may relate to psychiatric disorders, drug and/or alcohol use, AIDS and HIV, as the same are permitted by the Mental Health Procedures Act, the Confidentiality of Alcohol and Drug Abuse Individual Records Act, the Confidentiality of HIV-Related Information Act and the Privacy Rule of the Health Insurance Portability and Accountability Act;
- That I have the right to revoke this authorization at any time, except to the extent that Ambridge Area School District has already acted in reliance on the Authorization and that such revocation must be made in writing and directed to the Privacy Officer, Superintendent, Dr. Joseph Pasquerilla;

- That the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law;
- That Ambridge Area School District may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization, except as provided by law; and
- That if the Ambridge Area School District seeks this Authorization for the use or disclosure of Protected Health Information, the district must provide me with a copy of the signed Authorization.

Date

Signature of Individual/Student

Date

Signature of Parent/Legal Guardian/Personal Representative

Print Name

Specify Relationship/Authority

Ambridge Area School District
Home Language Survey*

Economy State St. Highland MS SH Date: _____

Student Name: _____

Date of Birth: _____ M F Grade: _____

Home Phone: _____ Cell Phone: _____

*The Civil rights Act of 1964, Title VI-Language Minority Compliance Procedures, requires that school districts/charter schools identify limited English proficient (LEP) students. Pennsylvania Department of Education has selected the Home Language Survey as the method for the identification.

What is the students first language? _____

Does the student speak a language other than English? Yes No

If yes, please indicate language; do not include languages learned in school.

What languages are spoken in your home?

Has the student attended any U.S. schools in any three (3) years during his/her lifetime?

Yes No If yes, please complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

U.S. Entry Date: _____

Name of person completing this form (if other than parent/guardian): _____

Parent/Guardian Signature: _____ Date: _____

****ONLY** complete if it is determined your child is an "English as a second language student" ******

**English as a Second Language
Student Background
Questionnaire**

Student's Name: _____

Native Language: _____ Native Country: _____

Parent's Name: _____ Cell Phone: _____

Names/ages of siblings: _____

English speaking contact (if needed): _____

When did this student come to the United States? _____

What language is used with parents? _____ With siblings? _____

With friends? _____

Can student read home language? No Easy words Easy sentences Yes

Can student write home language? No Easy words Easy sentences Yes

Can student understand English? No Easy words Easy sentences Yes

Can student speak English? No Easy words Easy sentences Yes

Can student read English? No Easy words Easy sentences Yes

Can student write English? No Easy words Easy sentences Yes

If student studied English:

How long? 1 year or less 1-2 years 3-4 years more

How often? Once a week 2-4 times a week 5 or more

Class lasted? 45 minutes or less 45 minutes-1 hour more

Ambridge Area School District
Transportation Office
901 Duss Avenue
Ambridge, PA 15003

Bus Rider Registration Information

Welcome to the Ambridge Area School District!

To maintain a high level of safety for bus riders, the Transportation Department has implemented a bus rider registration procedure.

Even if you do not need transportation, please complete this form.

Thank you for your assistance and cooperation.

Name of Student: _____ Telephone No.: _____

Address: _____ Alternate No.: _____

If there is another adult who is authorized to receive a student at the bus stop, please provide his/her name and telephone number: _____

If you will require transportation from a babysitter/daycare, please be advised of the following:
The babysitter/daycare must be located within the Ambridge Area School District and on an established route to/from your child's school.

Babysitter/Daycare: _____

Address/Telephone: _____

Will your child require transportation from a babysitter/daycare both ways? _____

If not, please specify pick-up/drop-off arrangements: _____

PLEASE LIST BROTHERS/SISTERS – GRADE/SCHOOL: _____

*NOTE: To balance classroom size, it may be necessary to assign a student to a building based on enrollment and not residence address.



McKinney-Vento Homeless Assistance Act

Life is uncertain, but your child's education doesn't have to be. Even if you lack a permanent residence, your child can receive help to stay in their home school district. Pennsylvania's Education for Children and Youth Experiencing Homelessness Program ensures every child deserves school stability.

The McKinney-Vento Homeless Assistance Act can help provide school stability for your child if you do not have a permanent home and are:

- Staying with friends or family because you lost housing.
- Living in a shelter, including transitional programs
- Staying in motels because you cannot get your own home.
- Living on the streets, in a car, van, tent or other nonpermanent structure.

Information for School-Age Youth

You may qualify for certain rights and protections under the federal McKinney-Vento Act. If you live in any of the following situations:

- A shelter.
- A motel or campground due to the lack of an alternative adequate accommodation.
- A car, park, abandoned building, bus to train station.
- Doubled up with other people due to loss of housing or economic hardship.

As an eligible student you have the right to:

- Receive a free, appropriate public education.
- Enroll in school immediately, even if lacking documents normally required for enrollment.
- Enroll in the local school or continue attending your school of origin (the school you attended when permanently housed or the school in which you were last enrolled), if that is your preference and is feasible.

If the school district believes that the school selected is not in your best interest, the district must provide you with a written explanation of its position and inform you of your right to appeal its decision.

- Receive transportation to and from the school of origin, if you request this.
- Receive educational services comparable to those provided to other students, according to your needs as a student.

If you believe you may be eligible, contact one of the individuals below to find out what services and supports may be available:

Ambridge Area School District: Jo Ann Hoover, Principal 724-266-2833 ext. 4213

Local Contact: Visit: <http://homeless.center-school.org/homelessdirectory>

Storm Camara State Coordinator (717)772-2066

STUDENT REFERRAL

DATE	EXAMINED or SCREENED BY	REFERRED TO	REMARKS (if yes, provide details at bottom of page)
1ST EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
2ND EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
3RD EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
4TH EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
5TH EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>

DENTAL FINDINGS – Check Applicable Items

GRADE	DATE	EXAMINED or SCREENED BY	PROPHYLAXIS	SPECIAL PROJECTS (Specify)	FLUORIDE		NUTRITION COUNSELING	SEALANTS			TOTALS		TOOTHBRUSH INSTRUCTIONS	Oral Evaluation Passed/ Referred
					VARNISH			PREMOLARS	1 ST MOLARS	2 ND MOLARS	Def DMF	OHI Index		
K														
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
Other														

Remarks

DATE	
DATE	
DATE	
DATE	



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 <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>
Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20____
Print name of examiner _____
Print examiner's office address _____ Phone _____
Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>

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)					

