FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

Dear Parent / Guardian:

Thank you for your interest in our Pre K Counts Program at Frazier Elementary. Enclosed you will find the application for the Pre K Counts Program.

Next steps to be considered for enrollment for the Pre K Counts Program include:

- Gather the following **required documents**:
  - Child's birth certificate
  - (2) Proofs of Residency (can include driver's license, utility bill, lease agreement)
  - Proof of household income for all working parents/ guardians in the household - may include:
    - 3 recent pay stubs
    - W2 from 2021
    - Plus evidence of child support or other income
- Return the completed application and above documents to Frazier Elementary for review. Only complete applications with supporting documentation will be considered for enrollment.

If you have any questions, please contact Frazier Elementary at 724-736-9507 x 102.

Sincerely,

Dr. Stillwagon

Dr. Stillwagon
Pre-K Counts Coordinator

Mrs. Law

Mrs. Law
Principal

2022 PA Pre-K Counts Enrollment Form

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

Date Form Completed: _____ / _____ / _____
MM **DD** **YY**

Last Name (Child)	**First Name (Child)**	**Middle Initial**

Street Address	**County**	
City	**State** PA	**Zip Code**
School District of Residence		
Home Phone	**Work Phone**	**Email Address**

Child's Date of Birth	**Age**	**Gender**
	☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Male ☐ Female

Race *(optional)*

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Not Applicable
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other

Ethnicity *(optional)*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

Name of Parent or Guardian completing this application	**Gender**
	☐ Male ☐ Female

Relationship to Child	**(Select)**
☐ Father	☐ Biological
☐ Mother	☐ Foster
☐ Guardian	☐ Adoptive
☐ Other _____ (please specify)	☐ Other _____ (please specify)

Role

☐ Primary Guardian ☐ Legal Guardian

☐ Secondary Guardian ☐ 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):*

☐	**Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	**Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
☐	**Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
☐	**English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
☐	**Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐	**Incarcerated Parent:** A child for whom one of the child's parents is currently in prison.
☐	**Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐	**Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory 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, working in nurseries such as Christmas and evergreen trees farming.
☐	**Teen Mother:** A child whose mother was under the age of 18 when the child was born.
☐	**Child Family or Living Situation:** Divorced, Single Parent, Relatives as Guardians
☐	**Concerns:** Speech / Language Development (Not receiving Early Intervention Services)
	Self-Help Skills: Does the child use toilet independently or with minimal assistance ☐ **Yes** ☐ **No**

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 substantiate information provided.

Parent/Guardian (Signature) **Date**

Parent/Guardian Name (Print Name)

FOR OFFICE USE ONLY

Income Verification

2022 Federal Poverty Level Guidelines

Family Size	100% (Head Start Eligible)	300% (Pre-K Counts Eligible)
1	$13,590	$40,770
2	$18,310	$54,930
3	$23,030	$69,090
4	$27,750	$83,250
5	$32,470	$97,410
6	$37,190	$111,570
7	$41,910	$125,730
8	$46,630	$139,890
Each Additional	+$4,720	+$14,160 for each additional family member

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.

_____ _____

Staff Verifying Income and Risk Factors Signature **Date**

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

My signature below indicates that I have been informed about my options but may still choose to enroll in the Pre-K Counts program.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

FOR OFFICE USE ONLY

Frazier School District

PRE-K REGISTRATION CHECK-OFF LIST

STUDENT NAME: _____

Item:	Check when Received or Completed:	Date Received or Completed:
1. Birth Certificate		
2. Immunization Records		
3. Student Registration Form		
4. Proof of Residency (2 Forms)		
5. Pre-K Counts Enrollment Form & Head Start Eligibility Notice		
6. Proof of Income		
7. Home Language Survey		
8. IEP (Individualized Education Program) Does your Child have one? _____YES _____NO		
9. Census Form		
10. Permanent Record Card		
11. Posted to SKYWARD		
12. Health Information Form		
13. Permission to Screen		
14. Permission to Publish Student Name/Photo		
15. Custody Papers (if applicable) _____YES _____NO		
16. Per Diem Letter (Foster Child Only) _____YES _____NO		
17. Brigance		
18. Save the Date Readiness Notice		
19. Risk Factor Indicator		
20. Lunch Application		
21. Completed Packet Received	Initials:	

Student ID#_____

Frazier School District

142 Constitution Street Perryopolis, PA 15473 FAX (724) 736-0688

REGISTRATION FORM 2022-2023

Registration Date_____ Grade_____ Homeroom_____

Last Name_____ First Name_____

Full Middle Name_____ Generation_____

Nickname_____ Primary Phone #_____

Place of Birth_____ Date of Birth_____
(City) (State) Female_____ Male_____

Race/Ethnicity: _____Hispanic _____White, not of Hispanic origin _____Asian
_____Black, not of Hispanic origin _____American Indian

Preferred Language: _____ Does the student have? ☐ I.E.P ☐ 504 Plan ☐ Gifted

Is there a Custody Agreement in place? ☐ YES ☐ NO If yes, please send us a copy.

Student Address: P.O. Box _____ House #_____ Street_____

City_____ Zip Code_____

Mother's Full Name_____ **Email Address:** _____

Mother's Address_____

Mother's Phone #: Home_____ Cell_____ Work_____

Father's Full Name_____ **Email Address:** _____

Father's Address_____

Father's Phone #: Home_____ Cell_____ Work_____

Guardian's Full Name_____ **Email Address:** _____

Guardian's Address_____

Guardian's Phone #: Home_____ Cell_____ Work_____

Is the Student's Parent/Guardian an active duty member of the Military? _____YES _____NO

School Previously Attended_____

Address_____

First Day of Class at FRAZIER (Date)_____

_____ _____

*Parent / Guardian **(SIGNATURE REQUIRED)** *Admission Clerk **(SIGNATURE REQUIRED)**

Student ID#_____

Frazier School District

142 Constitution Street Perryopolis, PA 15473 FAX (724) 736-0688

2022-2023

REGISTRATION FORM – EMERGENCY INFORMATION
(List someone other than the Parents/Guardians)

Student Last Name_____ Student First Name_____

EMERGENCY CONTACT:

Name_____Relationship:_____

Phone #: Home_____ Cell_____ Work_____

This person is allowed to pick up my child. ☐ YES ☐ NO

EMGERGENCY CONTACT:

Name_____Relationship:_____

Phone #: Home_____ Cell_____ Work_____

This person is allowed to pick up my child. ☐ YES ☐ NO

EMGERGENCY CONTACT:

Name_____Relationship:_____

Phone #: Home_____ Cell_____ Work_____

This person is allowed to pick up my child. ☐ YES ☐ NO

PROVIDER INFORMATION:

Physician:_____Phone:_____

Dentist:_____Phone:_____

Hospital:_____Phone:_____

Insurance:_____

_____

*Parent / Guardian **(SIGNATURE REQUIRED)**

Frazier School District

142 Constitution Street *Perryopolis, PA 15473* *FAX (724) 736-0688*

AMANDA R. LAW
PRINCIPAL - Pre-K through5th grade
724-736-9507 Ext. 102

ADMISSIONS SWORN STATEMENT

I, _____, parent/guardian of _____
(Parent/Guardian Name) (Student's Name)
who is seeking admission to the **Frazier Elementary School**, affirm that he/she **has not been suspended or expelled from any public or private school of the Commonwealth of Pennsylvania** 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. Furthermore, I affirm that **no allegations, charges or actions** concerning the above stated offenses are pending from any school.

I understand that a copy of _____'s disciplinary record will be
(Student's Name)
transmitted to the Frazier School District and that it will be inspected only by the student, school officials, state and local law enforcement officials or me, as parent/guardian to verify my statements.

I understand that any willful false statement made regarding the student's disciplinary record shall be a misdemeanor of the third degree.

_____ _____
(Date) (Signature of Parent/Guardian)

_____ previously enrolled as a student at:
(Student's Name)

Name of District/Private School	Grade	Building
_____	_____	_____
_____	_____	_____

Frazier School District

142 Constitution Street *Perryopolis, PA 15473* *FAX (724) 736-0688*

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 the method for the identification.

INSTRUCTIONS: At registration, please ask all parents or guardians the following questions about the language use of the child. Print responses. If one of the answers is a language other than English or the country of origin is other than the United States, contact the person in the district responsible for language proficiency assessment/instructional placement or Intermediate Unit I. Otherwise, the student is considered English language proficient and no further action is needed. A copy of this survey shall be placed in the student's permanent folder.

School _____ Date _____

Student's Name_____ Grade_____

Date of Birth_____ Age_____ Phone Number_____

Country of Origin_____

Other Countries of Residence_____

1. What was the student's first language?

   _____ Dialect_____

2. Does the student speak a language other than English? (Do not include languages learned in school)

   _____ Dialect_____

3. What language(s) is/are spoken most often in your home?

   _____ Dialect_____

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

Parent/Guardian signature_____

*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 Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, 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.

Frazier School District

OFFICE OF THE SCHOOL NURSE
142 Constitution Street Perryopolis, PA 15473-1390
PHONE: (724) 736-9507 FAX: (724) 736-0688

HEALTH INFORMATION FORM 2022-2023

Dear Parent/Guardian:

Please take a few moments to complete the following student health information so that we may update your child's health record. Please be sure to include ALL information you would like us to be aware of, even if you have provided this information in the past.

Student's Name_____ Grade_____

Birth Date_____

Medical Condition/Diagnosis: _____
_____
_____

Allergies: _____
_____

Medications (Please indicate whether taken/available at home or in school):
_____ _____
_____ _____

Procedures (Please indicate whether performed at home or in school):
_____
_____

History of Illness/Accident/Surgery: _____
_____
_____

Immunizations during the Past Year (month/day/year):
Diphtheria & Tetanus: _____ Polio: _____
Measles, Mumps, Rubella: _____ Hepatitis B: _____
Varicella: _____ Other: _____

Parent/Guardian Signature: _____ Date: _____

I request the above health information be shared with teachers/staff members in contact with my child throughout the school day. I understand that the confidentiality of the information will be maintained by those who receive it. I will notify Frazier School District immediately if my child's health status changes, or there is a cancellation of a procedure or medication.

Parent/Guardian Signature: _____ Date: _____

Frazier School District

OFFICE OF THE SCHOOL NURSE
142 Constitution Street
Perryopolis, PA 15473-1390
PHONE: (724) 736-9507
FAX: (724) 736-0688

PERMISSION TO SCREEN 2022-2023

Student Name _____ Grade _____

Date of Birth _____

School health services are designed to help students maintain optimum health and promote academic success. The following screening examinations are conducted each year in accordance with the Pennsylvania School Health Act. These grades were selected because they represent critical periods of growth and development in a child's life.

_____ **Growth Measurement** – height, weight and body mass index measurements are checked once a year in grades K – 12.

_____ **Vision Screening**–near and far visual acuity is checked once a year in grades K – 12. This identifies most children needing a complete eye examination.

_____ **Hearing Screening** – hearing is checked once a year for each student in grades K, 1, 2, 3, 7 and 11.

_____ **Physical Exam** – medical screening is performed by the school physician/nurse practitioner for students in grades K, 6 and 11. This is a basic screening ONLY-there is no diagnosis or treatment.
*May choose to have completed by private physician at your own expense

_____ **Scoliosis Screening** – included in the grade 6 medical screening to detect deviations from the normal curvature of the spine through observation.

_____ **Dental Exam** – dental health screening is performed by the school dentist for students in grades K, 3 and 7. This is a basic screening ONLY-there is no diagnosis or treatment.
*May choose to have completed by private dentist at your own expense

Please give your permission for these state-mandated screenings by signing your **initials on the line** next to the individual screening descriptions and then signing and dating the bottom of this form.

This form will be placed in your child's school health record and remain in effect while in attendance here at the Frazier School District unless otherwise directed by you, the parent/guardian, in writing.

Thank you for your interest in helping to maintain the health and well being of our children.

_____ _____

Parent Signature Date

Frazier School District

142 Constitution Street *Perryopolis, PA 15473* *Telephone: 724-736-9507*
FAX (724) 736-0688

Photo / Digital Media Release Form
2022-2023

Throughout the school year, we like to use the students' photographs to highlight their accomplishments. Several places we may use the students' photos are:

- In the hallways
- In slide show presentations
- In our yearbook or local newspaper articles about our school
- On the Web Page (students will not be identified by name)
- In movies created in the classroom (including student teaching videos)
- Social Media (students will not be identified by name)

To give or not give your consent, please complete this form. **This will remain in effect throughout your child's schooling. If you wish to make any changes to this form in the future, you must submit a hand written note to the building principal.**

Thank you for your prompt attention.

Photo / Digital Media Release Form

Student's Name: _____

_____YES, I give my permission for my child's photo to be used for school purposes.

_____NO, I would prefer my child's photo not be used.

Parent Signature: _____

Parent Name (Please print): _____

Date: _____

Frazier School District

142 Constitution Street *Perryopolis, PA 15473* *Telephone: 724-736-9507*
FAX (724) 736-0688

PARENT NOTIFICATION 2022-2023

By law, if parents are legally separated or divorced, each parent has equal rights to the access of the child/children or the child's/children's school records **UNLESS** a parent provides the Frazier School District a with a court order that indicates which parent has access to the child/children or the child's/children's school records. The school **MUST HAVE A COPY OF THE COURT ORDER** on file, otherwise, either parent may check the child/children out of the school with proper identification or be given access to the child's/children's school records.

If such an order exists regarding your child/children, please provide a copy of the order to the school so that it may be placed in their file.

***If we already have an order on file, please notify us of any recent changes and forward us a copy of the most recent order. ***

Thank you for your cooperation.

Student's Name: _____

Please indicate if you currently have a court order for your child/children. _____**YES** _____ **NO**

_____

Parent Signature

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name: _____ Birth Date: _____

   Person completing form: _____ Relationship to child: _____

2. In what type of setting is the student living now?

   Check one box below:

SECTION A	SECTION B
☐ In an emergency or transitional shelter ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations ☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings ☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings CONTINUE to Question 3 if you checked any box in SECTION A	☐ None of the choices in Section A apply.  If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.

3. Contact number for person completing the form: _____

   Address where student is now living: _____

4. The student lives with:

   Check all that apply

   ☐ Parent(s) or legal guardian
   ☐ Relative, friend(s), or other adult(s)
   ☐ Alone
   ☐ Other: _____

5. School student attended last : _____

   Address of school: _____

   Telephone number of school: _____

6. Does the student have an IEP, GIEP, or a Chapter 15/504 Service Agreement?
   - ☐ NO
   - ☐ YES

Signature of Parent/Legal Guardian: _____

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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 NAME:

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:

H514.027 (08/2011-under review)

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 CHILD	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	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
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address

FAYETTE COUNTY ASSOCIATION FOR THE BLIND

CONSENT FORM

-School Vision Screening

Please Fill Out In Full

Child's Name _____ Age _____ Sex: M___ F___

Address _____

City/State/Zip _____

Parent/Guardian Name (Print): _____

Phone Home (_____)_____ Phone Cell (_____)_____

Email Address: _____

Screening Location: _____

As the undersigned parent/guardian, I hereby grant permission to Fayette County Association for the Blind to screen the vision of the above-named child.

I understand that this procedure is a ***limited vision screening***, designed only to detect certain symptoms of potential vision problems in children. It is not an eye examination and is not intended to take the place of a professional eye exam. **If a professional examination is recommended,** I give my consent to permit Fayette County Association for the Blind to obtain information, from the examining eye specialist, regarding my child's eye examination and recommended treatment, and to furnish such information, as needed, to the appropriate school/ agency. I also understand that follow-up is required and that I may be contacted by the agency for further information.

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

Has your child had a professional eye Examination? YES ( ) NO ( )

CHECK ALL THOSE THAT APPLY:

___Wears glasses ___Shuts or covers one eye ___Squints at objects
___Complains about eyes ___Tilts or thrusts head forward ___Holds objects close to eyes
___Blinks more than usual ___Rubs eyes excessively
___Either eye turns in, out, up or down (which one?) _____
Family history of eye problems (specify): _____
Other observations (describe): _____

Thank you, Fayette County Association for the Blind

For Office Use Only

Referred: Yes ___ ID # _____ No ___ C B H A NA O (circle one)

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