FOR OFFICE USE ONLY

Frazier School District
KINDERGARTEN CHECK-OFF LIST

STUDENT NAME: _____

1. _____ Birth Certificate
2. _____ Immunization Records
3. _____ Student Registration Form
4. _____ Sworn Admission Statement
5. _____ Proof of Residency (2 forms)
6. _____ Record Release Form
7. _____ Faxed/Emailed for Records (Date :_____)
8. _____ Home Language Survey
9. _____IEP (Individualized Education Program) Does your Child have one? NO _____

   YES _____ Notified Special Education Director Date: _____
10. _____ Kindergarten Registration Survey
11. _____Census Form
12. _____Permanent Record Card
13. _____Posted to SKYWARD
14. _____Photo / Digital Media Release Form
15. _____Health Information Form
16. _____Permission to Screen
17. _____Custody Papers (if applicable) _____YES _____ NO
18. _____Per Diem Letter (Foster Child Only) _____YES _____NO
19. _____Emergency Card
20. _____Bus Assignment
21. _____Lunch Application Information

Initial _____

Student ID#_____

Frazier School District

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

REGISTRATION FORM 2024-2025

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

2024-2025

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*

AMANDA R. LAW
PRINCIPAL – Pre-K through 5th Grade
724-736-9507 Ext. 102

KINDERGARTEN – COMPLETE IF ATTENDED A PREVIOUS SCHOOL

_____
Previously Attended Institution

_____
Address

_____
City *State* *Zip*

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS/INFORMATION

STUDENT NAME_____ CURRENT GRADE_____

Please forward all health records, transcripts, evaluations, psychological reports, IEP's, due process', discipline reports (including Act 26 actions), and any forms of documentation relative to custodial rights to:

FRAZIER SCHOOL DISTRICT
REGISTRATION DEPARTMENT
142 CONSTITUTION STREET
PERRYOPOLIS, PA 15473-1390

Frazier School District utilizes IEP Writer; please transfer all Special Education, Gifted and 504 Plans.

If you have any questions, please contact the Registration Office at 724-736-9507, ext. 115.

Thank you for your prompt consideration of this request.

I hereby authorize the above-named institution to release all requested information to the Frazier School District.

DATE_____ SIGNATURE_____
(Parent / Guardian)

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

CENSUS FORM
2024/ 2025

Last Name_____ Other Last Name_____

P.O. Box _____ House #_____ Street_____ Zip_____ Number in Dwelling_____

Describe location of residence_____ Municipality_____ Twp_____ Boro____

BE SURE TO LIST ALL PERSONS LIVING IN THE HOUSEHOLD – SUPPLY ALL INFORMATION COMPLETELY AND ACCURATELY

Husband: If deceased, check _____	Wife: If deceased, check _____	Other Adults: 18 or Older	
Name_____	Name_____	Name_____	Name_____
Age_____ –	Age_____ –	Age_____ –	Age_____ –
Date of Birth_____	Date of Birth_____	Date of Birth_____	Date of Birth_____
Employed_____ Unemployed_____	Employed_____ Unemployed_____	Employed_____ Unemployed_____	Employed_____ Unemployed_____
Occupation_____	Occupation_____	Occupation_____	Occupation_____
Employer_____	Employer_____	Employer_____	Employer_____
Employer's Address	Employer's Address	Employer's Address	Employer's Address
_____	_____	_____	_____
_____	_____	_____	_____

LIST BELOW ALL CHILDREN UNDER 18 (FROM OLDEST TO YOUNGEST)

Name	Sex	Age	Birthdate	At Home	In School	Grade	Handicapped	Employed

Person Providing Information_____ Date_____

Frazier School District

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

Photo / Digital Media Release Form
2024-2025

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: _____

KINDERGARTEN REGISTRATION SURVEY
2024-2025

Child's Name: _____

1. Did the child you are registering for Kindergarten attend a preschool program?

- ☐ Yes, Preschool Program
- ☐ Yes, Day Care Program
- ☐ Yes, Frazier Pre-K Program
- ☐ Yes, Head Start
- ☐ Yes, Early Head Start
- ☐ No

2. Name of Preschool program or day care your child attended.

3. If your answer was yes, was the program……

- ☐ Half Day Program
- ☐ Full Day Program
- ☐ N/A

4. How many years did your child attend the program you indicated?

- ☐ Attended Head Start as a three year old.
- ☐ Did not attend Preschool or Head Start at any time.
- ☐ ½ Year
- ☐ 2 years
- ☐ 3 years
- ☐ More than 3 years

5. Do you feel the program they attended prepared them for Kindergarten?

- ☐ Yes
- ☐ No
- ☐ N/A

6. **Will your Kindergarten child attend our Readiness Program in the Summer?**

☐ Yes

☐ No

7. **If you do not plan on having your child attend, please indicate the reason why not.**

☐ I don't feel I know enough about the program.

☐ I don't think it is necessary.

☐ We have vacation plans.

☐ Other (please specify)

8. **Is there any other information you need about Kindergarten at this time?**

9. **Do you have any input for information you think would be helpful to parents for our Kindergarten orientation?**

10. **Would you be interested in participating in parent workshops during the school year that focus on how you can support your child's education at home?**

☐ Yes

☐ No

11. **If we offer parent workshops, when would you most likely be able to attend?**

☐ Mornings (9:00 AM – 11:00 AM)

☐ Afternoons (1:00 PM – 3:00 PM)

☐ After School (4:00 PM – 6:00 PM)

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 2024-2025

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

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

HEALTH INFORMATION FORM 2024-2025

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

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

PARENT NOTIFICATION 2024-2025

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

Transportation
Bus Assignment Form*

SCHOOL YEAR: **2024 -2025**

DATE: _____

BUS #_____

_____ **ADD STUDENT** _____ **DELETE STUDENT**

BUS STOP: _____

STUDENT'S NAME: _____

STREET ADDRESS: _____

_____

MAILING ADDRESS: _____

_____

GRADE: _____ **SCHOOL:** _____

RUN: _____**SECONDARY** _____**ELEMENTARY**

STARTING DATE: _____

*** Please forward a copy of this form to the Transportation Coordinator and the Bus Driver**

Revised 01/2007

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, CONTINUE to Questions 5.

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: _____

FREE / REDUCED LUNCH APPLICATIONS

DO NOT APPLY BEFORE AUGUST 1, 2024

Attached is a Lunch Application for the **2024-2025** school year.

We strongly recommend that if you have Internet access to apply online at www.schoolcafe.com. The application will be processed faster.

Attached are frequently asked questions about Free and Reduced price meals.

If you need help completing the application online, please give us a call at 724-736-9507 ext. 115 or you may request an appointment for us to complete the application together; you will need to bring the following information with you:

1. If you receive food stamps or cash assistance, please bring your county record number. It will begin with the county code of 26 followed by your 7 digit record number.
2. If you have income, please bring your current pay stubs from your employer or a letter proving that you receive unemployment benefits, retirement benefits, child support or any other type of income that you may have.

If you **DO NOT** have Internet access and will need a paper application, please give us a call at 724-736-9507 ext. 115.

PLEASE REMEMBER: If you received free/reduced meals during the previous school year, you **MUST RE-APPLY within the first 30 days** of school unless you received a Direct Certification letter in July stating you were automatically eligible.

Appendix F

H514.027 (2/2023)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20___

NAME OF STUDENT	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		M F		

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

		RIGHT								**LEFT**								
UPPER		1	2	3	4 A	5 B	6C	7 D	8 E	9 F	10 G	11 H	12 I	13J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address of Dental Examiner

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

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

Student's name _____ Today's date _____

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

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

_____

_____

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

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

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

GENITOURINARY: ***Has the student...***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student...***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

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

Signature of parent / guardian / emancipated student _____ Date _____

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

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

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

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:

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

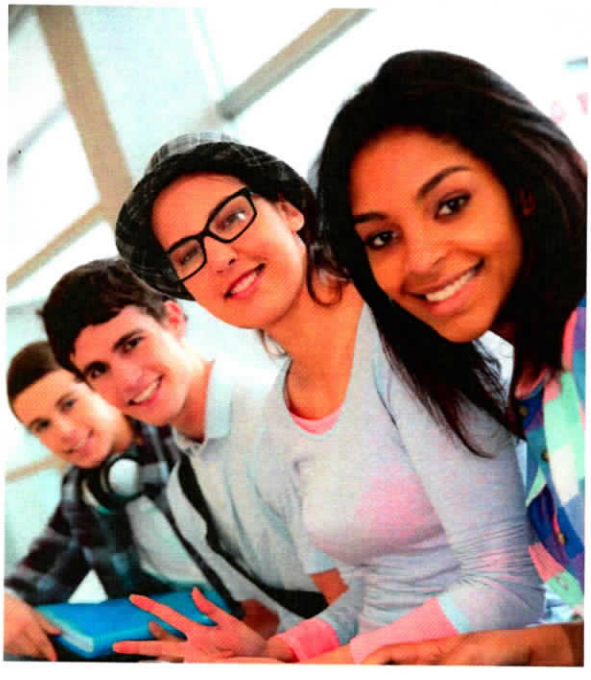
Referred: Yes ___ ID # _____ No ___ C B H A NA O (circle one)

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