

**Frazier Elementary School**  
**KINDERGARTEN SCREENING**  
**2023-2024**

Registration for Kindergarten for the 2023-2024 school year will take place on **Tuesday, June 6, 2023, Wednesday, June 7, 2023, and Thursday June 8, 2023.**

Please enter through the  
Frazier Middle School Gymnasium Doors on the side of the school.

**Registration will take place by appointment only!**

*Children must be age 5 before or on September 1, 2023.*

**PLEASE BRING THE FOLLOWING DOCUMENTS:**

1. Immunization Records (most up to date)
2. Physical Exam or provide permission for School Exam
3. Dental Exam or provide permission for School Exam
4. Proof of Frazier School District residency - two (2) items are required:
  - i. one must be a driver's license with current address **AND**
  - ii. one of the following:
    - utility bill
    - rental receipt
    - property tax receipt
    - mortgage deed or lease agreement
    - vehicle registration
5. Birth certificate - Child must be age 5 before or on September 1, 2023.

**PLEASE BRING THE CHILD YOU ARE REGISTERING** - School personnel will complete the following Kindergarten screening activities with your child:

1. Brigance Early Childhood Screen - used to assess a child's school readiness levels in the areas of early development and academic skills
2. Speech Screening
3. Kindergarten Readiness Screening
4. Vision Screening

If you would like the registration packet sent home please contact the office at  
724-736-9507 ext. 102

# 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 \_\_\_\_\_

**Frazier School District**

142 Constitution Street

Perryopolis, PA 15473

FAX (724) 736-0688

**REGISTRATION FORM****2023-2024**

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 IndianPreferred Language: \_\_\_\_\_ Does the student have?  I.E.P  504 Plan  GiftedIs 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

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**2023-2024**

## 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

### EMERGENCY CONTACT:

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

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

### EMERGENCY 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 through 5<sup>th</sup> 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 5<sup>th</sup> 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**  
**2023/ 2024**

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	Age	Name	Age	Name	Age
_____	_____	_____	_____	_____	_____
Date of Birth _____	_____	Date of Birth _____	_____	Date of Birth _____	_____
Employed _____ Unemployed _____	_____	Employed _____ Unemployed _____	_____	Employed _____ Unemployed _____	_____
Occupation _____	_____	Occupation _____	_____	Occupation _____	_____
Employer _____	_____	Employer _____	_____	Employer _____	_____
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 2023-2024

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.

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### 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

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 2023-2024

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  
PHONE: (724) 736-9507

Perryopolis, PA 15473-1390  
FAX: (724) 736-0688

## HEALTH INFORMATION FORM

2023-2024

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**

## **2023-2024**

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 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:**            2023 -2024

**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**



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

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, 2023**

Attached is a Lunch Application for the **2023-2024** school year.

**We strongly recommend that if you have Internet access to apply online at [www.schoolcafe.com](http://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.

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

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

**REPORT OF EXAMINATION**

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K				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



Bureau of Community Health Systems  
Division of School Health

## Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

### PARENT / GUARDIAN / STUDENT:

Complete page one of this form before  
student's exam. Take completed form to  
appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

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

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

Medicines  Pollens  Food  Stinging Insects

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

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

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

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

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

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

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( )%				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**  
 (Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

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

**IMMUNIZATION EXEMPTION(S):**

- Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_
- Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_
- Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT					
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td					
Polio Type: OPV or IPV					
Hepatitis B (HepB)					
Measles/Mumps/Rubella (MMR)					
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>					
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella					
Meningococcal Conjugate Vaccine (MCV4)					
Human Papilloma Virus (HPV) Type: HPV2 or HPV4					
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)					
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13					
Hepatitis A (HepA)					
Rotavirus					
<b>Other Vaccines: (Type and Date)</b>					





**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