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:	

2025-26 PA Pre-K Counts Enrollment Form

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

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

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

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

Child's Date of Birth	Age at start of program year	Gender
	☐ 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

- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other _____ (please specify)

(Select)

- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other _____ (please specify)

Role

- ☐ Primary Guardian
- ☐ Secondary Guardian
- ☐ Legal 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	**Employment Status of 2nd parent/guardian (if applicable)**
☐ Employed Full-Time	☐ Employed Full-Time
☐ Employed Part-Time	☐ Employed Part-Time
☐ Unemployed	☐ Unemployed
☐ Other _____	☐ Other _____

Household Income Sources *(Must check all that apply)*:

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

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

	Risk Factor	Definition
☐	Preschooler with an Individualized Education Program (IEP)-	Defined as a child who is currently enrolled in the Early Intervention program with an active IEP. Verification includes a copy of the IEP or other source of documentation from the parent or the Early Intervention agency.
☐	Migratory (Non-Immigrant) Seasonal Student	Defined as a child who has moved from one school district to another to accompany or join a parent or guardian who is a migratory agriculture worker or fisher within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work, including agri-related businesses such as meat or vegetable processing, or work in nurseries such as Christmas and evergreen tree farming.
☐	English Language Learner	Defined as a child whose first language is not English and who is in the process of learning English. Ask these two questions, as established by the Pennsylvania Department of Education, to determine if a child qualifies as an English language learner: 1) What is/was the child's first language? 2) Does the child speak a language other than English? (Do not include languages learned in school).
☐	Homeless	If any of the situations below apply a family is eligible under McKinney-Vento. Additional guidance is available from the National Center for Homeless Education. - If the family is staying with others, was this a result of a loss of housing, economic hardship, or other similar reason? - Is the family living in a shelter? (Includes youth, emergency, transitional living, domestic violence, etc.) - Is the family living in a motel, hotel, or campground? - Is the family staying in a public or private place not ordinarily used as a regular sleeping accommodation for human beings? - Is the family living in cars, parks, public places, abandoned buildings, transportation stations, or similar settings? - Is the family living in substandard (limited or no utilities, unsafe conditions, etc.) housing? - Has the child been abandoned, in a hospital, or awaiting foster care placement?
☐	Child in or Part of Family in Child Welfare System	Defined as a child who is a foster child, a kinship care child, or receiving Children and Youth Services.
☐	Child's Family or Living Structure	Defined as a child with a single parent, divorced parents, or with relatives as guardians.
☐	Child Receiving Behavioral Supports	Defined as a child who is referred to Pennsylvania Pre-K Counts from an appropriately credentialed health or mental health provider (not employed by the Pennsylvania Pre-K Counts program) or a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	Teen Parent	Defined as a mother or father who was under the age of 18 when the child was born.
☐	Incarcerated Parent	Defined as a child for whom one or both of the child's parents are currently incarcerated.

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

Family Assurances

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

☐ I understand that my child's eligibility for Pennsylvania Pre-K Counts (PA PKC) is subject to the program's two-year participation limit. My child must be at least three years old by the kindergarten cutoff date set by the school district where we live to assure compliance with receiving only two-years of PKC programming.

☐ Once my child reaches the age required to enroll in kindergarten in the public school district where we live, I understand they will no longer be eligible for PA PKC funding.

☐ I understand that my child's enrollment is contingent upon meeting the eligibility criteria, including income verification and prioritization based on risk factors.

☐ I understand that the PA Pre-K Counts (PKC) program is an educational program with attendance requirements. I agree to ensure my child's regular attendance and to notify the program in case of absences. My program's PA Pre-K Counts hours of operation are:

_____

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

_____

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

Parent/Guardian Certification

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

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

_____ _____

Parent/Legal Guardian (Signature) **Date**

_____

Parent/Legal Guardian Name (Print Name)

Family and Program Administrator to Complete This Portion Together

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

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

☐ Contact information for the following Head Start location

_____

☐ Application and/or assistance with referral

☐ Brochure or website with information about Head Start

☐ I understand that my signature below indicates that I have been informed about my options for Head Start, and that I may choose to enroll in either the Pre-K Counts program or Head Start if eligible for both.

_____ _____

Parent/Legal Guardian (Signature) Date

FOR OFFICE USE ONLY

Income Verification

2025 Federal Poverty Level Guidelines Based On Annual Income

Family Size	100% (Head Start Eligible)	300% (Pre-K Counts Eligible)
1	$15,650	$46,950
2	$21,150	$63,450
3	$26,650	$79,950
4	$32,150	$96,450
5	$37,650	$112,950
6	$43,150	$129,450
7	$48,650	$145,950
8	$54,150	$162,450
Each Additional	+$5,500 for each additional family member	+$16,500 for each additional family member

Pay Frequency Calculation Guide:

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

INCOME CALCULATION GRID

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

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

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

Family Size (per PKC guidelines): _____

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

_____ _____

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

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

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

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

Student ID#_____

Frazier School District

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

REGISTRATION FORM 2025 - 2026

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

2025 - 2026

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*

DR. ANNE STILLWAGON
PRINCIPAL - Pre-K through 5th 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 2025-2026

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 2025-2026

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
2025-2026

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 2025-2026

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

CENSUS FORM
2025 /2026

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_____

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 (To be answered by 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 (To be answered by 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 (To be answered by 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 (To be answered by 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: (To be answered by student)	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY (To be answered by 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 (To be answered by student)	**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		
BEHAVIORAL HEALTH (To be answered by 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 (To be answered by student)	**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'S HEALTH HISTORY (to be completed) REVIEWED PRIOR TO PERFORMING 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 TESTING	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)

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: _____

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