



Dear Parent / Guardian:

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

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

- Gather the following **required documents**:
 - Child's birth certificate
 - (2) Proofs of Residency (can include driver's license, utility bill, lease agreement)
 - Proof of household income for all working parents/ guardians in the household - may include:
 - 3 recent pay stubs
 - W2 from 2022
 - Plus evidence of child support or other income
- Return the completed application and above documents to Frazier Elementary for review. Only complete applications with supporting documentation will be considered for enrollment.

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

Sincerely,

Dr. Stillwagon

Dr. Stillwagon

Pre-K Counts Coordinator

Mrs. Law

Mrs. Law

Principal

2023 PA Pre-K Counts Enrollment Form

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

Date Form Completed: / /
MM DD YY

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

Child's Date of Birth	Age <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Race (optional)	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Not Applicable	
Ethnicity (optional)	Primary Language
<input type="checkbox"/> Hispanic	<input type="checkbox"/> English
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Spanish
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Other _____ (please specify)

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

- Primary Guardian
 Secondary Guardian

- Legal Guardian
 Other _____

(please specify)

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

	<i>Relationship to Child</i>	<i>Age</i>
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		

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

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

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

DETERMINED FAMILY SIZE =

Employment Status of parent/guardian

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

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

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

Household Income Sources (Must check all that apply):

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

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

<input type="checkbox"/>	Behavioral Supports: A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
<input type="checkbox"/>	Child Protective Services: A child who is a foster child, a kinship care child or receiving Children and Youth services.
<input type="checkbox"/>	Education Level of Guardian: Does not have high school diploma or GED or post-secondary degree.
<input type="checkbox"/>	English Language Learner: A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
<input type="checkbox"/>	Individualized Education Plan (IEP): A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
<input type="checkbox"/>	Incarcerated Parent: A child for whom one of the child's parents is currently in prison.
<input type="checkbox"/>	<p>Homeless: A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following:</p> <p>A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;</p> <p>B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;</p> <p>C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.</p>
<input type="checkbox"/>	Migrant (Non-Immigrant)/Seasonal Student: A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
<input type="checkbox"/>	Teen Mother: A child whose mother was under the age of 18 when the child was born.
Self-Help Skills: Does the child use the toilet independently or with minimal assistance?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

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

Parent/Guardian (Signature)

Date

Parent/Guardian Name (Print Name)

FOR OFFICE USE ONLY

Income Verification

2023 Federal Poverty Level Guidelines Based On Annual Income

Family Size	100% (Head Start Eligible)	300% (Pre-K Counts Eligible)
1	\$14,580	\$43,740
2	\$19,720	\$59,160
3	\$24,860	\$74,580
4	\$30,000	\$90,000
5	\$35,140	\$105,420
6	\$40,280	\$120,840
7	\$45,420	\$136,260
8	\$50,560	\$151,680
Each Additional	+\$5,140	+\$15,420 for each additional family member

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

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

Family Size (per PKC guidelines): _____

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

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

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

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

- Contact information for the following Head Start location _____
- Application and/or assistance with referral
- Brochure or website with information about Head Start

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

Parent/Guardian Signature **Date**

Staff Signature **Date**

FOR OFFICE USE ONLY

Frazier School District

PRE-K REGISTRATION
CHECK-OFF LIST

STUDENT NAME: _____

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? NO _____
YES _____ Notified Special Education Director Date: _____
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

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)

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 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

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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
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

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

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.

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

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

**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 _____

Name _____ Name _____

Age _____ Age _____

Date of Birth _____ Date of Birth _____

Employed _____ Unemployed _____ Employed _____ Unemployed _____

Occupation _____ Occupation _____

Employer _____ Employer _____

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 _____



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				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	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)					

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	29	28	27	26	25	24	23	22	21	20	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



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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Shuts or covers one eye | <input type="checkbox"/> Squints at objects |
| <input type="checkbox"/> Complains about eyes | <input type="checkbox"/> Tilts or thrusts head forward | <input type="checkbox"/> Holds objects close to eyes |
| <input type="checkbox"/> Blinks more than usual | <input type="checkbox"/> Rubs eyes excessively | |
| <input type="checkbox"/> 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)



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. <div style="text-align: center;"></div> <p>If you checked this section, CONTINUE to Questions 5.</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: _____

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.