

## Central Greene Kindergarten Registration

Central Greene School District be holding Kindergarten Registration by **appointment only** for the 2021-22 school year. Registration appointments will be from 8:30 – 11:00 and 12:30 – 2:30. Parents are to call the school to select a time on the following days:

Student Last Name A-H - Wednesday, May 5, 2021

Student Last Name I-N – Wednesday, May 12, 2021

Student Last Name O-Z – Wednesday, May 19, 2021

In order to speed up the process, registration packets may be completed in advance and brought to the elementary school main office. Central Greene School District will be distributing registration packets at:

1. Waynesburg Central Elementary School main office
2. Available upon request at Packet Pick-up/Drop-off.
3. Available to print from website [www.cgsd.org](http://www.cgsd.org)

Central Greene's policy states that any child who will be 5 years of age before June 1 may attend kindergarten. Any child who will be 6 years of age before the same date may attend first grade. A child who now is attending kindergarten already is registered for first grade and need not register again.

It is important to register your child for kindergarten or first grade even if you are not certain at this point that you will be sending you child to school.

Please bring **proof of birth** (birth certificate, notarized copy of birth certificate, baptismal certificate, copy of baptism if notarized or duly certified and showing date of birth, notarized statement from the parents or another relative indication the date of birth, or valid passport); **immunization records**; and **proof of residency** (a deed, a lease, current utility bill, property tax bill, vehicle registration or department of transportation identification card).

Immunizations records can be faxed to the WCES office at 724-852-1160.

The school nurse will check all immunization records and will give guidance on physical problems. If your child has any unusual medical conditions or history, bring the treating physician's name and address. The required immunizations for registration are as follows:

- Four D.T. immunizations (with one being on or after the fourth birthday)
- Four polio (with one being on or after the fourth birthday)
- Two measles, mumps and rubella
- Three hepatitis B
- Two chickenpox vaccine-or documented proof of disease or titer level from your physician.

For more information, call the WCES school office at 724-627-3081.

Entry Date \_\_\_\_\_

Entry Code \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Retained \_\_\_\_\_

IEP YES \_\_\_\_\_ NO \_\_\_\_\_

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_

Last First Middle

Birth Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Birth City & State: \_\_\_\_\_

Township: \_\_\_\_\_

Address: \_\_\_\_\_

Location of Address (road number, mileage, landmarks, etc.): \_\_\_\_\_

Verification:

Birth Certificate # \_\_\_\_\_

Race:

\_\_\_\_\_ Hispanic/Latino

Hospital Record # \_\_\_\_\_

\_\_\_\_\_ Not Hispanic/Latino

Other: \_\_\_\_\_

Ethnicity:

\_\_\_\_\_ American Indian/Alaskan Native

\_\_\_\_\_ Asian

\_\_\_\_\_ Black or African American

\_\_\_\_\_ Native Hawaiian/Other Pacific Islander

\_\_\_\_\_ White

Previous Schools Attended: \_\_\_\_\_

Medical conditions, Allergies, etc.: \_\_\_\_\_

Father's Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Step-parent \_\_\_\_\_

Occupation \_\_\_\_\_

Is there a Court Order involving this student? \_\_\_\_\_ Yes

\_\_\_\_\_ No

If YES, please provide a copy to the school, otherwise we are unable to abide by its contents.

Foster Parents \_\_\_\_\_

Caseworker \_\_\_\_\_

Agency \_\_\_\_\_

Phone \_\_\_\_\_

Other children living at this address:

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

1305 \_\_\_\_\_ 1306 \_\_\_\_\_ Resident \_\_\_\_\_ Non-Resident \_\_\_\_\_

Previous Central Greene Student? \_\_\_\_\_

# HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin **MUST** complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: \_\_\_\_\_

Child's family name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_  
(Month/Day/Year)

## Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home?    No    Yes (language) \_\_\_\_\_
2. Does your child communicate in a language other than English?    No    Yes (language) \_\_\_\_\_
3. What is the language that your child first learned to speak? \_\_\_\_\_
4. In which language do you prefer to receive information? \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interpreter Provided    No    Yes

# CENTRAL GREENE SCHOOL DISTRICT

## 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
<p><input type="checkbox"/> In an emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p>CONTINUE to Question 3  if you checked any box in SECTION A</p>	<p><input type="checkbox"/> None of the choices in Section A apply.</p> <p style="text-align: center;"></p> <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: \_\_\_\_\_

Contact person at school (if known): \_\_\_\_\_

6. Does the student have an IEP or a Chapter 15/504 agreement?

NO

YES. Please explain: \_\_\_\_\_

Signature of Parent/Legal Guardian:

\_\_\_\_\_

Date:

\_\_\_\_\_

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# CENTRAL GREENE SCHOOL DISTRICT

DEAR PARENT OR GUARDIAN:

The School Health Law requires medical examinations for children in Grades K or 1st, 6th, 11th and new students from out or state. These grades were selected because they represent critical periods of growth and development in a child's life.

These examinations can be done by our school physician, although the Pennsylvania Department of Health recommends that these examinations be done by your family physician since he/she can best evaluate your child's health and assist you in obtaining necessary treatments and corrections.

Examinations done by family physicians within one year prior to the student's entry into the grade in which the exams are required and recorded on a form provided by the school are accepted for the required examination year.

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PLEASE CHECK YOUR PREFERENCE:

\_\_\_\_\_ Student to be examined by the school physician.

Parent/Guardian will be present \_\_\_\_\_

Parent/Guardian will not be present \_\_\_\_\_

\_\_\_\_\_ Student to be examined by family physician, at personal expense of  
of Parent/Guardian. Please send me the required form.

**PLEASE COMPLETE AND RETURN THIS FORM TO THE CHILD'S  
TEACHER IMMEDIATELY.**

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(CHILD'S NAME)

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(PARENT/GUARDIAN SIGNATURE)

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(DATE)

## CENTRAL GREENE SCHOOL DISTRICT

DEAR PARENT OR GUARDIAN:

The School Health Law requires dental examinations for children in Grade K or 1st, 3rd, 7th and new students from out of state. These grades were selected because they represent critical growth and development in a child's life.

These examinations can be done by our school dental hygienist, although the Pennsylvania Department of Health recommends that these examinations be done by your family dentist he/she can best evaluate your child's health and assist you in obtaining necessary treatments and corrections.

Examinations done by family dentists within one year prior to the student's entry into the grade in which the exam is required and recorded on a form provided by the school are accepted for the required examination that year.

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PLEASE CHECK YOUR PREFERENCE:

\_\_\_\_\_ Student to be examined by the school hygienist.

\_\_\_\_\_ Student to be examined by family dentist, at personal expense of Parent or Guardian. Please send me the required form.

**PLEASE COMPLETE AND RETURN THIS FORM TO THE CHILD'S  
TEACHER IMMEDIATELY.**

\_\_\_\_\_  
(CHILD'S NAME)

\_\_\_\_\_  
(PARENT/GUARDIAN SIGNATURE)

\_\_\_\_\_  
(DATE)

**CENTRAL GREENE SCHOOL DISTRICT  
WAYNESBURG, PENNSYLVANIA**

TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH - DAY - YEAR)

SEX Male \_\_\_\_\_ Female \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ MAIDEN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME WHOM PUPIL LIVES WITH IF OTHER THAN PARENT \_\_\_\_\_

IF YOUR CHILD NEEDS TO TAKE MEDICATION AT SCHOOL FOR ANY REASON-**YOU MUST PROVIDE ALL OF THE FOLLOWING:** A DOCTORS SPECIFIC ORDER, PARENTAL CONSENT AND THE MEDICATION IN THE ORIGINAL CONTAINER FROM THE PHARMACY.

**HEALTH HISTORY -PUT A CIRCLE AROUND THE ANSWER**

1. Does your child have a bee sting allergy? Yes      No  
What type of reaction results from this? \_\_\_\_\_
2. Has the child had chickenpox? (Date of illness or vaccine) Yes      No  
\_\_\_\_\_
3. Has the child had any troubles with ears or hearing? Yes      No  
If the child has tubes, when were they inserted? \_\_\_\_\_
4. Has the child had any trouble with eyes or seeing? Yes      No  
If the child has glasses, when should they be worn? \_\_\_\_\_
5. Does your child have diabetes? Yes      No
6. Has the child ever had a convulsion (fit or seizure)? Yes      No
7. Has the child ever had a fainting spell? Yes      No
8. Has a doctor ever said the child had a heart murmur? Yes      No  
Any restrictions? \_\_\_\_\_
9. Has the child ever had an allergy? To what? (medications, foods, environment) Yes      No
10. Has the child ever had asthma? Medications taken? \_\_\_\_\_ Yes      No
11. Has the child ever been treated for ADHD, O.D.D. or any behavior disorders? Yes      No  
List medication being taken. \_\_\_\_\_
12. Has the child ever had surgery? If yes, for what reason. Yes      No
13. List any illnesses, injuries or other conditions not listed above \_\_\_\_\_

**SEE OTHER SIDE**



Outline a step-by-step emergency plan for your child for each health problem. The school nurse is available to assist you.

**PROBLEM:**

**YOUR SPECIFIC DIRECTIONS IN THE EVENT OF AN EMERGENCY:**

1.

2.

3.

List immunizations (date and kind) given since last year. Immunization dates should be accompanied by written verification from the doctor or clinic.

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WCES

Waynesburg Central Elementary School

90 Zimmerman Drive  
Waynesburg, Pennsylvania 15370-8281  
Phone: 724-627-3081  
Fax: 724-852-1160

To: Parents/Guardians  
From: School Nurses  
Subject: School Medication Procedures

Any prescribed or over the counter medication will be administered at school only by a written order from the doctor stating that it is absolutely necessary that specific medication be given during school hours. **Please make every effort to have any medication given at times other than during school hours.** (Examples of over the counter medications include Tylenol, Motrin, cough drops, cough syrup, topical creams, etc.). The school nurse has standing orders for some topical creams such as Neosporin, Cortisone and Benadryl creams. Please check with the nurse regarding your child's need. If these creams are needed, no physician order will be needed. A parent note will be sufficient.

**Medication to be given during the school day will require a medication administration form to be filled out and signed by the parent and the physician. These forms are available at the nurses' office.**

**The medication must be brought to the Nurses' office in a container that has a current prescription label from the pharmacy.** Please ask your pharmacist to provide you with an extra labeled container for school. If the medication is over the counter, please bring the medication in the original container.

Students are not permitted to carry medication or inhalers except when a physician's order is on file giving them permission to do so.

Parents are responsible for the transportation of medication to and from school. If the parent cannot bring the medication to school, another responsible adult should bring the medication to school.

This is for your child's protection as well as the protection of others. If you have any questions please contact the School Nurse.

I have read and understand the above policy:

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Teacher

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

Waynesburg Central Elementary School 724-627-3081  
Updated: 6/6/2011

WCES is a Title 1 School



To educate and prepare each student to contribute responsibly to society

Tammy D. Mandich  
Director of Special Education  
P.O. Box 472  
Waynesburg, PA 15370  
(724) 627-8151

**CENTRAL GREENE SPEECH-LANGUAGE SCREENING**

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent Name: \_\_\_\_\_ School: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City/Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Dear Parent(s):

**Please complete this form as accurately as possible.**

When a new student enters into Central Greene School District, they automatically receive a state-mandated speech-language screening. You will be notified of the results via letter or phone conference. If your child's speech and language skills are not age appropriate, with your permission, we will conduct a full speech-language evaluation.

- |   | Yes   | No    |
|---|-------|-------|
| 1. Is your child's speech difficult to understand?                | _____ | _____ |
| 2. Does your child sound different from other children their age? | _____ | _____ |
| 3. Was your child late in starting to talk?                       | _____ | _____ |

If so, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

OVER

4. Does your child have difficulty following directions?

If so, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Yes No

5. Can your child imitate sounds? \_\_\_\_\_

Can your child imitate words? \_\_\_\_\_

Can your child name pictures/objects? \_\_\_\_\_

Can your child use appropriate sentence structure? \_\_\_\_\_

6. Has your child ever received speech/language services? \_\_\_\_\_

If yes, please indicate:

Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Therapist's Name: \_\_\_\_\_

Dates of therapy from \_\_\_\_\_ to \_\_\_\_\_

7. Please describe your child's speech/language development along with any comments or concerns you may have regarding your child. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Examiner's initials: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

**Central Greene School District  
Hearing Screening  
Kindergarten Registration**

Please answer the following questions:

Child's name \_\_\_\_\_

Birth Date \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_

Telephone # \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 1. Does your child have a hearing impairment?   | Yes | No |
| 2. Does your child have a history of ear infections?<br>If yes, how many in one year? _____ | Yes | No |
| 3. Does your child have tubes in his/her ears?<br>If yes, when were the tubes put in? _____ | Yes | No |

-----  
Hearing Specialist use only

250   500   1000   2000   4000   8000

R

L

Pass      Fail

Vision Services of Washinton-Greene  
566 East Maiden Street, Washington PA 15301  
(724) 228-0770 (724) 228-6617 [laura.blindvision@gmail.com](mailto:laura.blindvision@gmail.com)



**CONSENT FORM**  
Children's Vision Screening Program

Dear Parent or Guardian:

It is important to check your child's eyes at an early age because a vision problem can be undetectable, and your child may not complain because they don't realize they have a problem.

The Prevention of Blindness Program of the Washington-Greene County Blind Association will be conducting a preschool vision screening at your child's learning center on \_\_\_\_/\_\_\_\_/\_\_\_\_.

As the undersigned parent/guardian, I hereby grant permission to the Washington-Greene County Blind Association to screen the vision of the child whose name appears below.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex    M    F

Parent(s) /Guardian's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

If a professional examination is recommended, I give my consent to permit the Washington-Greene County Blind Association 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.

In addition, 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 examination.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Has your child had a professional eye examination by an **ophthalmologist or an optometrist**?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Doctor's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please remember, as your child doesn't know how well he/she should be able to see, he/she will probably not complain of problems with vision. Therefore, it is very important to observe behavior patterns which may indicate eye disorders. In this respect, please indicate with an (X) if your child ...

- |  |  |
|--|--|
| <input type="checkbox"/> Has crossed eyes                        | <input type="checkbox"/> Rubs his/her eyes a great deal                    |
| <input type="checkbox"/> Shuts or covers one eye                 | <input type="checkbox"/> Seem to blink more than usual                     |
| <input type="checkbox"/> Holds books close to his/her eyes       | <input type="checkbox"/> Stumbles easily over small objects                |
| <input type="checkbox"/> Becomes irritable when doing close work | <input type="checkbox"/> Squints, frowns when looking at something closely |
| <input type="checkbox"/> Tilts or thrusts head forward to see    | <input type="checkbox"/> Has red or watery eyes                            |
| <input type="checkbox"/> Other observations: _____               |  |

Thank you!

Date: \_\_\_\_\_ Results: \_\_\_\_\_ Screener's Initials: \_\_\_\_\_



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, lightheadedness 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
	16	17	18	19	20
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
<b>Other Vaccines: (Type and Date)</b>					



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
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

ADDRESS

_____	_____	_____	_____	_____	_____
No. and Street	City or Post Office	Borough or 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	K	L	M	N	Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K	J	I	H	G	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