Central Greene Kindergarten Registration

Central Greene School District will be holding Kindergarten Registration by appointment only for the 2022-23 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-I - Wednesday, May 11, 2022

Student Last Name J-R – Wednesday, May 18, 2022

Student Last Name S-Z – Wednesday, May 25, 2022

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


3. Available to print from website 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 is now 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.
**Central Greene School District**

**Registration**

**Student Number:**

**Class Assigned to:**

**Bus # AM:**

**PM:**

**Chorus**

**Band**

**Locker #**

**School**

**Grade**

**Retained**

**IEP**

**YES**

**NO**

**Student’s Name**

**Last**

**First**

**Middle**

**Sex**

**Birth Date:**

**Birth City & State:**

**Home Phone:**

**Township:**

**Address:**

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

**Verification:**

**Birth Certificate #**

**Hospital Record #**

**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**

**Employer**

**Mother’s Name**

**Employer**

**Step-parent**

**Occupation**

**Work Phone**

**Occupation**

**Work Phone**

**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**

**Agency**

**Caseworker**

**Phone**

**Other children living at this address:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Grade</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Birthdate</td>
<td>Grade</td>
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</tr>
<tr>
<td>Name</td>
<td>Birthdate</td>
<td>Grade</td>
<td>School</td>
</tr>
</tbody>
</table>

1305 ____ 1306 ____ **Resident** ____ **Non-Resident** ____

**Previous Central Greene Student?**

Office  Nurse  Central Office  Registrar’s Initials
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
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 –

   [ ] 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, you do not need to complete the remainder of this form. Submit the form to school personnel now.

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: __________________________________________________________________
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.

1. Is your child’s speech difficult to understand? Yes No
2. Does your child sound different from other children their age? Yes No
3. Was your child late in starting to talk? Yes No
   If so explain ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Central Greene School District does not discriminate on the basis of race, sex, color, disability, national and ethnic origin in administration of its educational or employment policies
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 does not discriminate on the basis of race, sex, color, disability, national and ethnic origin in administration of its educational or employment policies.
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 ...

( ) Has crossed eyes
( ) Shuts or covers one eye
( ) Holds books close to his/her eyes
( ) Becomes irritable when doing close work
( ) Tilts or thrusts head forward to see
( ) Other observations:

( ) Rubs his/her eyes a great deal
( ) Seem to blink more than usual
( ) Stumbles easily over small objects
( ) Squints, frowns when looking at something closely
( ) Has red or watery eyes

Thank you!

Date: __________________________ Results: __________________________

Screeener’s Initials: __________________________
Central Greene School District
Hearing Screenings
Kindergarten Registration

Please answer the following questions:

Child’s name: ____________________  Birth Date: ______________
Parent/Guardian’s name: __________  Phone Number: __________
Address: ____________________________

1.) Does your child have a hearing impairment?  Yes  No

2.) Does your child have a history of ear infections?  Yes  No
   - If yes, how many in one year? ______

3.) Does your child have tubes in his/her ears?  Yes  No
   - If yes, when were the tubes put in? ______

Hearing Specialist use only

250  500  1000  2000  4000  8000

R
L

Pass  Fail

1.28.2022
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 of 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 required and recorded on a form provided by the school are accepted for the required examination year.

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 Parent/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)
RELEASE OF INFORMATION

I, ________________________________, parent/guardian of ________________________________, hereby give permission to The Central Greene School District to release information on the above named student to faculty/staff on a need to know basis concerning any health needs or problems that my child currently has or may develop in the future.

This sharing of information with other faculty/staff is important to ensure the welfare and safety of your child during school hours.

_____________________________       __________________________
Parent/guardian signature        date

_____________________________       __________________________
Witness signature                  date
**CENTRAL GREENE SCHOOL DISTRICT**  
WAYNESBURG, PENNSYLVANIA

**TEACHER**  
**GRADE**  
**DATE**

**NAME**  
(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**

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

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.

<table>
<thead>
<tr>
<th>PROBLEM:</th>
</tr>
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<tbody>
<tr>
<td>YOUR SPECIFIC DIRECTIONS IN THE EVENT OF AN EMERGENCY:</td>
</tr>
<tr>
<td>1.</td>
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<td>2</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

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

Revised 1-02
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 I School
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.

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

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>DATE</th>
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<tr>
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<td>20</td>
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<tr>
<th>NAME OF CHILD</th>
<th>AGE</th>
<th>SEX</th>
<th>GRADE</th>
<th>SECTION/ROOM</th>
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<tbody>
<tr>
<td>Last</td>
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<td>First</td>
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<td>Middle</td>
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<thead>
<tr>
<th>ADDRESS</th>
<th>No. and Street</th>
<th>City or Post Office</th>
<th>Borough or Township</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
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<thead>
<tr>
<th>REPORT OF EXAMINATION</th>
<th>TOOTH CHART</th>
<th>UPPER</th>
<th>LOWER</th>
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<th>TOOTH CHART</th>
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<td>16</td>
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</tbody>
</table>

Is The Child Under Treatment: Yes [ ] No [ ]

Treatment Completed: Yes [ ] No [ ]

Date of Dental Examination:

Signature of Dental Examinee: __________________________

Print Name of Dental Examiner: __________________________

Address: __________________________
# Physical Examination of School Age Student

**Student's Name:**

**Date of Birth:**

**Age at Time of Exam:**

**Today's Date:**

**Gender:**
- Male
- Female

**Medications and Allergies:**
- List all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking.

**Does the student have any allergies?**
- Yes

**Does the student have any medication allergies?**
- Yes

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

### General Health: Has the Student...

1. **YES**
   - Any ongoing medical conditions? If so, please identify:
     - Asthma
     - Anemia
     - Diabetes
     - **Infection**
     - Other:

2. **YES**
   - Ever stayed more than one night in the hospital?

3. **YES**
   - Ever had surgery?

4. **YES**
   - Ever had a seizure?

5. **YES**
   - Had a history of being born without or missing a kidney, an eye, a testicle (males), spleen, or any other organ?

6. **YES**
   - Ever become ill while exercising in the heat?

7. **YES**
   - Had frequent muscle cramps when exercising?

### Head/Neck/Spine: Has the Student...

8. **YES**
   - Had headaches with exercise?

9. **YES**
   - Ever had a head injury or concussion?

10. **YES**
    - Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

11. **YES**
    - Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?

12. **YES**
    - Ever been unable to move arms or legs after being hit or falling?

13. **YES**
    - Noticed or been told he/she has a curve in spine or scoliosis?

14. **YES**
    - Had any problem with his/her eyes (vision) or had a history of an eye injury?

15. **YES**
    - Been prescribed glasses or contact lenses?

### Heart/Lungs: Has the Student...

16. **YES**
    - Ever used an inhaler or taken asthma medicine?

17. **YES**
    - 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

18. **YES**
    - Been told by the doctor to have a heart test? (For example, ECG, EKG, echocardiogram)?

19. **YES**
    - Had a cough, wheezing, difficulty breathing, shortness of breath or felt light headed during or after exercise?

20. **YES**
    - Had discomfort, pain, tightness or chest pressure during exercise?

21. **YES**
    - Felt his/her heart race or skip beats during exercise?

### Bone/Joint: Has the Student...

22. **YES**
    - Had a broken or fractured bone, stress fracture, or dislocated joint?

23. **YES**
    - Had an injury to a muscle, ligament, or tendon?

24. **YES**
    - Had an injury that required a brace, cast, crutches, or orthotics?

25. **YES**
    - Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?

26. **YES**
    - Had joints that become painful, swollen, feel warm, or look red?

### Skin: Has the Student...

27. **YES**
    - Had any rashes, pressure sores, or other skin problems?

28. **YES**
    - Ever had herpes or a MRSA skin infection?

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 □

<table>
<thead>
<tr>
<th>Physical exam for grade:</th>
<th>CHECK ONE</th>
<th>*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>K/1 □ 6 □ 11 □ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>TUBE CULIN TEST</th>
<th>DATE APPLIED</th>
<th>DATE READ</th>
<th>RESULT/FOLLOW-UP</th>
</tr>
</thead>
</table>

**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 □
**IMMUNIZATION HISTORY**

**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.

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/Teipnus/Pertussis (child)</td>
<td></td>
</tr>
<tr>
<td>Type: DTaP, DTP or DT</td>
<td></td>
</tr>
<tr>
<td>Diphtheria/Teipnus/Pertussis (adolescent/adult)</td>
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<tr>
<td>Type: Tdap or Td</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
</tr>
<tr>
<td>Type: OPV or IPV</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td></td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td></td>
</tr>
<tr>
<td>Mumps disease diagnosed by physician [ ] Date: __________</td>
<td></td>
</tr>
<tr>
<td>Varicella: Vaccine [ ] Disease [ ]</td>
<td></td>
</tr>
<tr>
<td>Serology: (Identify Antigen/Date/POS or NEG)</td>
<td></td>
</tr>
<tr>
<td>i.e. Hep B, Measles, Rubella, Varicella</td>
<td></td>
</tr>
<tr>
<td>Meningococcal Conjugate Vaccine (MICV4)</td>
<td></td>
</tr>
<tr>
<td>Human Papilloma Virus (HPV)</td>
<td></td>
</tr>
<tr>
<td>Type: HPV2 or HPV4</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Type: TIV (injected)</td>
<td></td>
</tr>
<tr>
<td>LAIV (nasal)</td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza Type b (Hib)</td>
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<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
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</tr>
<tr>
<td>Type: 7 or 13</td>
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</tr>
<tr>
<td>Hepatitis A (HepA)</td>
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</tr>
<tr>
<td>Rotavirus</td>
<td></td>
</tr>
<tr>
<td>Other Vaccines: (Type and Date)</td>
<td></td>
</tr>
</tbody>
</table>