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
2. Available upon request at Packet Pick-up/Drop-off.
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 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.

CENTRAL GREENE SCHOOL DISTRICT Registration

Student Number: _____
Class Assigned to: _____
Bus # AM: _____ PM: _____
Chorus _____ Band _____
Locker # _____

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 # _____
Hospital Record # _____
Other: _____

Race:
_____ Hispanic/Latino
_____ Not Hispanic/Latino

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? ____

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

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
☐ 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

Excellence is Our Standard

Edith Woods
Director of Special Education
90 Zimmerman Dr
Waynesburg, Pa 15370
(724) 627-3081

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 _____

_____

_____

_____

		Yes	No
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

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

VISION SERVICES
OF WASHINGTON-GREENE

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
( ) 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
( ) Other observations: _____

Thank you!

Date: **Results:** **Screener'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 or state. These grades were selected because the 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 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 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)

WCES is a Title I School

CENTRAL GREENE SCHOOL DISTRICT

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_____ **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?**
    List medication being taken._____ Yes No
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.

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

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)

WLES is a Title I School

209-AR-3

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last: First: Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address

209-AR-2

pennsylvania
DEPARTMENT OF HEALTH
Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

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

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits, withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight, been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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 NAME:

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

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

TUBERCULIN 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 ☐**

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME: