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
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 #: ________

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 ________

Race: ________

Hispanic/Latino ________
Not Hispanic/Latino ________

Previous Schools Attended: ____________________

Medical conditions, Allergies, etc.: ____________________

Father’s Name: ____________________

Employer: ____________________

Occupation: ____________________

Work Phone: ____________________

Mother’s Name: ____________________

Employer: ____________________

Occupation: ____________________

Work Phone: ____________________

Step-parent: ____________________

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:

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? ______

Registrar’s Initials: ____________________

Office ______ Nurse ______ Central Office ______
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?  Yes (language) __________

2. Does your child communicate in a language other than English?  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 –

<table>
<thead>
<tr>
<th>SECTION A</th>
<th>SECTION B</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ In an emergency or transitional shelter</td>
<td>☐ None of the choices in Section A apply.</td>
</tr>
<tr>
<td>☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</td>
<td>If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.</td>
</tr>
<tr>
<td>☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</td>
<td></td>
</tr>
<tr>
<td>☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</td>
<td></td>
</tr>
<tr>
<td>☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</td>
<td></td>
</tr>
</tbody>
</table>

CONTINUE to Question 3 if you checked any box in SECTION A

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 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)
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 as 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)
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 DOCTOR'S 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 trouble 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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Revised 3-02
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 1 School
Central Greene Speech-Language Screening

Name of Child: ___________________________ Date: __________
Parent Name: ____________________________ School: __________
Address: ________________________________ Home Phone: _______
City/Zip: ________________________________ Date of Birth: _______
Teacher: ________________________________ Age: __________

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?  
   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: 

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5. Can your child imitate sounds?
   Can your child imitate words?
   Can your child name pictures/objects?
   Can your child use appropriate sentence structure?
   
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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 your may have regarding your child: 

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Examiner's initials: __________________________ Parent's Signature: __________________________

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Central Greene School District
Hearing Screening
Kindergarten Registration

Please answer the following questions:

Child’s name ____________________________
Parent/Guardian name ____________________
Address __________________________________

Birth Date ______
Telephone # ______

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
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 ( ) Rubs his/her eyes a great deal
( ) Shuts or covers one eye ( ) Seem to blink more than usual
( ) Holds books close to his/her eyes ( ) Stumbles easily over small objects
( ) Becomes irritable when doing close work ( ) Squints, frowns when looking at something closely
( ) Tilts or thrusts head forward to see ( ) Has red or watery eyes
( ) Other observations: _______________________________________________________

Thank you!

Date: ___________ Results: ______________________ Screener’s Initials: ______________________
Private or School
PHYSICAL EXAMINATION
OF SCHOOL AGE STUDENT

Student's name _____________________ Date of birth _____________
Age at time of exam __________________
Today's date ____________________________
Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

☐ 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...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other: ________________</td>
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<tr>
<td>2. Ever stayed more than one night in the hospital?</td>
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<tr>
<td>3. Ever had surgery?</td>
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<tr>
<td>4. Ever had a seizure?</td>
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<tr>
<td>5. Had a history of being born without or is missing a kidney, an eye, a testicle (male), spleen, or any other organ?</td>
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<tr>
<td>6. Ever become ill while exercising in the heat?</td>
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<tr>
<td>7. Had frequent muscle cramps when exercising?</td>
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</table>

**HEAD/NECK/SPINE: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>8. Had headaches with exercise?</td>
<td></td>
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<tr>
<td>9. Ever had a head injury or concussion?</td>
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<tr>
<td>10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
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<tr>
<td>11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?</td>
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<tr>
<td>12. Ever been unable to move arms or legs after being hit or falling?</td>
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<tr>
<td>13. Nosed or been told he/she has a curved spine or scoliosis?</td>
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<tr>
<td>14. Had any problem with his/her eyes (vision) or had a history of an eye injury?</td>
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<td>15. Been prescribed glasses or contact lenses?</td>
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**HEART/LUNGS: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>16. Ever used an inhaler or taken asthma medicine?</td>
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<tr>
<td>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: ________________</td>
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<tr>
<td>18. Been told by the doctor to have a heart test? (For example: ECG/EKG, echocardiogram)?</td>
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<tr>
<td>19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded during or after exercise?</td>
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<tr>
<td>20. Had discomfort, pain, tightness or chest pressure during exercise?</td>
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<tr>
<td>21. Felt his/her heart race or skin heats during exercise?</td>
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**BONE/Joint: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>22. Had a broken or fractured bone, stress fracture, or dislocated joint?</td>
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<tr>
<td>23. Had an injury to a muscle, ligament, or tendon?</td>
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<tr>
<td>24. Had an injury that required a brace, cast, crutches or orthotics?</td>
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<tr>
<td>25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?</td>
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<td>26. Had joints that become painful, swollen, feel warm or look red?</td>
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**SKIN: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>27. Had any rashes, pressure sores or other skin problems?</td>
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<tr>
<td>28. Ever had herpes or a MRSA skin infection?</td>
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**GENITOURINARY: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>29. Had groin pain or a painful bulge or hernia in the groin area?</td>
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<tr>
<td>30. Had a history of urinary tract infections or bedwetting?</td>
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<tr>
<td>31. FEMALES ONLY: Had a menstrual period? □ Yes □ No</td>
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<tr>
<td>If Yes: At what age was her first menstrual period? ____________ Date of last period: ____________</td>
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**DENTAL:**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tr>
<td>32. Has the student had any pain or problems with his/her gums or teeth?</td>
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<tr>
<td>33. Name of student's dentist: ____________________</td>
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**SOCIAL/LEARNING: Has the student...**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?</td>
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<td>35. Been bullied or experienced bullying behavior?</td>
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<td>36. Experienced major grief, trauma, or other significant life event?</td>
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<tr>
<td>37. Exhibited significant changes in behavior, social relationships, grades: eating or sleeping habits, withdrawn from family or friends?</td>
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<tr>
<td>38. Been worried, sad, upset, or angry much of the time?</td>
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<td>39. Showed a general loss of energy, motivation, interest or enthusiasm?</td>
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<tr>
<td>40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?</td>
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<td>41. Used (or currently uses) tobacco, alcohol, or drugs?</td>
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**FAMILY HEALTH:**

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<tbody>
<tr>
<td>42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other: ________________</td>
<td></td>
</tr>
<tr>
<td>43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ CT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other: ________________</td>
<td></td>
</tr>
<tr>
<td>44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?</td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
</tr>
</tbody>
</table>

**QUESTIONS or CONCERNS:**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.)</td>
<td></td>
</tr>
</tbody>
</table>

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

**Physical exam for grade:**
- K/1 □
- 6 □
- 11 □
- Other □

**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>TUBERCULIN TEST</th>
<th>DATE APPLIED</th>
<th>DATE READ</th>
<th>RESULT/FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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 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

<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/Tetanus/Pertussis (child)</td>
<td></td>
</tr>
<tr>
<td>Type: DTaP, DTP or DT</td>
<td></td>
</tr>
<tr>
<td>Diphtheria/Tetanus/Pertussis (adolescent/adult)</td>
<td></td>
</tr>
<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 [ ]</td>
<td>Date: ______________</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 (MCV4)</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>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td></td>
</tr>
<tr>
<td>Type: 7 or 13</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
</tr>
<tr>
<td>Other Vaccines: (Type and Date)</td>
<td></td>
</tr>
</tbody>
</table>
**PRIVATE DENTIST REPORT**
**OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>DATE</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF CHILD</td>
<td>AGE</td>
<td>SEX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
</tr>
</tbody>
</table>

**ADDRESS**

<table>
<thead>
<tr>
<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>
</tr>
</thead>
</table>

**REPORT OF EXAMINATION**

<table>
<thead>
<tr>
<th>TOOTH CHART</th>
<th>RIGHT</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPPER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOWER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

__________________________