Karns City Area School District

1446 Kittanning Pike
Karns City, PA 16041

P: 724-756-2030
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Eric D. Ritzert, Ed.D.
Superintendent of Schools

Dear Parents/Guardians,

Welcome to the Karns City Area School District!

At Karns City, we are committed to preparing students to be successful. We look forward to supporting you through your child's educational journey. If you have any questions or concerns throughout the school year, I encourage you to contact your child's teacher or principal. We hope you quickly feel at home and become involved in some of the many activities available to you.

At the time of registration, you will need to present the following documents:

- Copy of your child's proof of age (example: birth certificate)
- Copy of your child's immunization records (must meet PA immunization requirements)
- Two current proofs of residency (examples: mortgage statement, rental agreement, utility bill, etc.)
- Custody agreement (if applicable)

During registration, you will need the following documents to be completed prior to enrollment completion:

- Admission Form
- Transportation Form
- Home Language Survey Form
- Emergency and Health Information Form
- Health History
- Physical Examination - PA required upon original entry, 6th, 11th, and non-Pennsylvania residents
- Dental Examination - PA required upon original entry, 3rd, 7th, and non-Pennsylvania residents

Again, we are happy to have you with us this year, and we want to assure you that we will do our best to help your child experience academic, social, and emotional achievement.

Sincerely,

Eric D. Ritzert

Eric D. Ritzert, Ed.D.
Superintendent of Schools

Karns City Area School District **Admission Form**

Student Information (please print) (*) required fields

*Name: _____ _____ _____ Grade: _____
Last First Middle

*Date of Birth:_____/_____/_____ Age:_____ Gender: _ *State of Birth: _____

*Physical Address:_____/ _____/ PA / _____
Street Number Street Name City Zip Code

Ethnicity/Race: The district is required to collect ethnicity/race data in order to satisfy US Department of Education audit requirements.

☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Non Resident Alien ☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Asian ☐ Multi-Racial/Ethnic ☐ American Indian/Alaskan Native ☐ Unknown

Student Resides with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other_____
☐ Sharing housing of others due to loss of housing, economic hardship or similar reason

Guardian Information (please print) (*) required fields

*Parent/Legal Guardian 1:_____
Last, First

Parent/Legal Guardian 2: _____
Last, First

*Physical Address:_____

_____ / PA /_____
City Zip Code

Address: _____

_____/_____/_____
City State Zip Code

Home Phone: _____
Cell Phone: _____
Email Address: _____
Work Phone: _____

Home Phone: _____
Cell Phone: _____
Email Address: _____
Work Phone: _____

If your child is absent how would you like to be contacted? (Please check mark above. Limit to one phone number and two email addresses)
Is the parent/guardian an active duty member of a branch of the United States Armed Forces? ☐ Yes ☐ No
Are there custody issues concerning this child?
☐ No
☐ Yes explain _____
☐ Court documents enclosed

Previous School Information (please print)

Name of last school attended:_____Last date attended:_____/_____/_____Last grade completed: _____

Last school attended address:_____/_____/_____/ _____
Street Number Street Name City State Zip Code

Phone:_____ Fax:_____ Counselor: _____

Reason for withdrawal from previous school: _____

I hereby give permission to the previous school or agency listed to release all available information identifying official administrative records (name, address, birth date, grade level completed, grades, class standing, attendance record); standardized achievement, intelligence and aptitude test scores; record of extracurricular activities; and health records for the student named above.

Signature of Parent/Guardian Date

Student Name: _____ _____ _____
Last First Middle

Special Services *Does your child currently receive any Special Services listed below? (please check mark)*

☐ Has IEP ☐ Has GIEP ☐ Remedial Reading ☐ Early Intervention ☐ Speech ☐ Physically Handicapped ☐ Other _____

Policy Information

The Pennsylvania School Code requires that prior to admission to any school entity, the parent/guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously suspended or expelled from any public or private school of this commonwealth or any other state for an act or offense involving weapons, alcohol or drugs or for the willful infliction of injury to another person or for any act of violence committed on school property. The registration shall be maintained as part of the student's disciplinary record. It also requires the transfer of pupil records concerning these disciplinary actions and this information be released with student records to the receiving school at the time of transfer. **Any willful false statement made under this section shall be a misdemeanor of the third degree.**

My son/daughter ☐ has not been ☐ has been involved in a previous expulsion/disciplinary action.

Signature of Parent/Guardian Date

Food Services Do you have a free or reduced eligibility for the National School Lunch Program determined by your previous district/state?

☐ Yes
☐ No

Immunizations Records

All students are required by the state of Pennsylvania to submit proof of immunization or exemption from immunization prior to entry to school. Copies of immunization records for students are usually available from the transferring school. Immunization regulations are cited in 28 Pa. Code §23.83 (c), revised March 2016. State law requires that in order to attend schools, a child must receive all immunizations as mandated by the Department of Health unless a medical or religious exemption is provided to the school districts.

Does your child have a life threatening condition? ☐ No ☐ Yes Explain: _____

********** School Use Only **********

Student ID:_____ School:_____ Grade:_____Registration Date:_____Tentative Start Date: _____

☐ Admission Form
- ☐ Custody Documentation
- ☐ Expulsion/Disciplinary
- ☐ Request for Special Services

☐ Proof of Age
☐ Immunization Records
- ☐ Exemption

☐ Acceptable Use of the Internet Form
☐ Transportation Form
☐ Home Language Survey Form
- ☐ Request for ESL Services

☐ Emergency and Health Information Form
☐ Two Proofs of Residency

☐ Health History Form
☐ Transcript/Report Card/Grades/TestScores
☐ Lunch Application
☐ PA Private Physician's Report of Physician Examination (original entry into PA, grades 6 & 11)
☐ PA Private Dental Report of Dental Examination (original entry into PA, grades 3 & 7)

☐ Tyler Enrollment
☐ PIMS Enrollment
☐ PIMS Programs
☐ Email enrollment to school
☐ Enrollment filed
☐ Originals to school
☐
☐
☐ Forward Admission form to:

- ☐ Food Service Department
- ☐ Special Ed Department
- ☐ ESL Department
- ☐ IT Department
- ☐ Nurse (w/health forms K-12 grades only)
- ☐

_____

Reviewed and processed: _____

August 2016

KARNS CITY AREA SCHOOL DISTRICT

Request for Student Transportation

Type of Request ☐ **New** ☐ **Change**

If this is a change, please state the reason _____
(Ex. Moved, change from home to sitter, etc.)

Date of Request:_____ **School:**_____ **Gender:** ☐ **M** ☐ **or F**

Student's Last Name:_____ **First:**_____ **M I:**_____

Parent or Guardian's Name:_____ **Phone:**_____

Student Date of Birth:_____ **Student Grade:**_____

This Section Must Be Completed: Exact Physical Address for Pick-up and Drop-off:

Physical Address:_____

Municipality/Township/Borough:_____

City:_____ **Zip Code:**_____

Please Identify Exact Location of Residence: Please do not use Rural Route or PO Box Numbers in this section- Use Street Names and House Numbers above.
List information below to identify exact location at which your child resides.
(use nearest intersections, landmarks, house style and color, etc.)

_____
_____
_____

Mailing Address: (This might be PO box or RR number -If same as above "write same")

Street Address_____

PO Box No. **City:** **Zip Code:**_____

School Use Only ---
Student Number Assigned:_____

Bus Number _____ **Pick –Up Time**_____

Return completed form to a School Office; it will be forwarded to the Transportation Department. You will then be contacted with transportation arrangements.

Karns City High School 724-756-2030 • Chicora Elementary 724-445-3680 • Sugarcreek Elementary 724-545-2409

Karns City Area School District

HOME LANGUAGE SURVEY[1]

The Office of Civil Rights (OCR) requires that all Local Education Agencies (LEA's) identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the initial step in the identification process.

School District: _____ Date: _____

School: _____

Student's Name: _____ Grade: _____

1. What is/was the student's first language? _____

2. Does the student speak a language(s) other than English? ☐ Yes ☐ No

(Do not include languages learned in school.)

If yes, specify the language(s): _____

3. What language(s) is/are spoken in your home? _____

4. Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No

If yes, complete the following:

Name of School	State	Dates Attended

Person completing this form: _____

(if other than parent/guardian)

Parent/Guardian signature: _____

Please disregard English as a Second Language Student Background Questionaire if questions 1-3 state English only.

[1] The local education agency (LEA) has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the LEA has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the LEA may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the LEA in the future.

Karns City Area School District

The School Health Program and Your Child

Immunizations required by Pennsylvania law:

	ALL STUDENTS	7TH GRADE	12TH GRADE
Diphtheria-Tetanus-Pertussis (DTP)	4 doses(1 dose must be after 4th birthday)		
Polio	4 doses(4th dose must be after the 4th birthday)		
Measles, Mumps and Rubella (MMR)	2 doses(1st dose must be after the 1st birthday)		
Hepatitis B	3 doses		
Varicella (chickenpox) [1]	2 doses of varicella vaccine (1st dose must be after the 1st birthday) or history of disease		
Tetanus, diphtheria, acellular pertussis (Tdap) if 5 years have elapsed since last tetanus immunization		1 dose	
Meningococcal conjugate vaccine (MCV)		1 dose	1 dose

[1] If your child has had the chickenpox disease, the vaccine is not required. A signed statement from the parent or physician with the date or age of the child when chickenpox occurred is acceptable.

Screenings as required by Pennsylvania law:

A physical examination upon original entry to school and in grades 6 and 11. *
A dental examination upon original entry to school and in grades 3 and 7. *

> * *Students who do not turn in a completed, private physical or dental exam form will be scheduled for an exam with the school doctor or dentist. Exams dated up to one year before the start of the school year in which the exam is required will be accepted.*

Height and weight measurement and determination of Body Mass Index-for-Age percentile annually.
A vision test annually.
A hearing test in grades K, 1, 2, 3, 7, and 11.
Scoliosis screening in grades 6 and 7.
Screening for pediculosis (head lice) where indicated.

The purpose of the screening program is to identify possible health problems that may require further evaluation and/or treatment. School screenings are not intended to replace periodic examinations by your family health practitioners. It is recommended that physical and dental examinations be conducted by your family physician or dentist, with payment being the responsibility of the parent. You can request a screening at any time if you suspect that your child may have a problem.

Parents may assist in maintaining students' good health by:

Providing proper meals at regular times. Insist that your child eat breakfast every day.
Have a regular bedtime. *School aged children need 9 – 12 hours of uninterrupted sleep every night.*
Dress young children according to weather conditions.
Keep a sick child home from school.
Please follow these guidelines for keeping your child home from school.

- A fever of 100 or greater. A child must stay home until free of fever for 24 hours without the use of medication.
- Red eyes with drainage or that are "stuck together" upon awakening. Consult a health careprovider.
- Vomiting the night before. Must tolerate a light diet before returning to school.
- Excessive coughing or nasaldrainage

Karns City Area School District

Emergency and Health Information Form

Student Name:_____ Home Phone: _____
Last First Middle

Physical Address:_____/ _____/ PA / _____
Street Number Street Name City Zip Code

Date of Birth:_____ /_____/_____ Grade:_____ Room No.: _____

Student Lives With: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other _____

	Father	*Mother*	*Guardian (Relationship)*
Name:			
Place of Employment:			
Work Phone:			
Cell Phone:			
Email Address:			

PLEASE FURNISH THE NAMES OF EMERGENCY CONTACT(S). Do not list relatives or neighbors if they have not consented. List individuals in order of preference who are available and have transportation.

Contact:_____ Phone: _____

Contact:_____ Phone: _____

STUDENT REVIEW

My signature below indicates I have received and reviewed the Medication Policy Statement and consent to Emergency Medical Transportation and Testing.

MEDICATION POLICY STATEMENT

The law which regulates the administration of medication in the school is the same as that applied to hospitals and other institutions, which is: Medication will be administered only with the written order of the individual's private physician or dentist. Ibuprofen (e.g. Motrin, Advil, etc.) and or acetaminophen (e.g. Tylenol), Cough Drops (Mentholated), Tums/Antacid, Benadryl/Antihistimine, and Ora-gel/Anbesol may be administered to students for mild pain and/or discomfort upon parental permission. The dosage of these analgesics will be administered according to orders as written by the school physician. Dosage will be determined by the student's weight. Dosages that exceed those recommended by the school physician WILL NOT be administered without a written order from the student's personal physician. Prescription medication should be sent to school in the original container accompanied by the parent or guardian requesting the medication be given.

PARENTAL CONSENT TO EMERGENCY MEDICAL TRANSPORTATION AND TESTING

In the event of an emergency, your child will be transported via ambulance to the nearest hospital. If an ambulance is necessary, the closest will be called.(If possible, the Karns City Area School District will attempt to contact the parent/guardian prior to transporting an injured or ill student. **Payment for ambulance service to transport the student will not be the responsibility of the Karns City Area School District**.)

Signature of Parent/Guardian Date

Student Name: _____ _____ _____
Last First Middle

Please answer the following questions in order to update your child's health record. This form must be completed by a Parent/Guardian.

1. Does your child have any chronic health conditions? No
Yes please explain and include any surgeries or hospitalizations

_____

_____

2. Is your child prescribed any medications or treatments? No
Yes, please list medication, dosage, and time

_____

_____

3. a. Does your child have any life threatening allergies? (foods, insects, medicine, or plants)? No
Yes

b. Does your child have an Epi-Pen* prescribed by his/her physician? No
*Please contact the school nurse regarding your child's Epi-Pen instructions Yes

If yes to either of the above, please list allergies and symptoms _____

_____

4. Has your child had any immunizations in the past year? No
Yes If yes, please provide a copy of their immunization record to the health office.

Parent Permission for school nurse to administer the medications below:
*Please note students may not carry or self-administer these medications.

I wish for my child to receive Acetaminophen (Tylenol) when needed for pain.	Yes	No
I wish for my child to receive Ibuprofen (Motrin, Advil) when needed for pain.	Yes	No
I wish for my child to receive Cough drops(Mentholated).	Yes	No
I wish for my child to receive Antacids/Tums	Yes	No
I wish for my child to receive Benadryl/Antihistimine	Yes	No
I wish for my child to receive Ora-gel/Anbesol	Yes	No

All other medication will require a prescription from child's personal Physician or PCP

Parent/Guardian Signature: _____ Date: _____

*Please note Acetaminophen/Ibuprofen will not be given for a fever, a child with a fever must be sent home.

Student's Doctor: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Karns City Area School District

Private Physician Request for Medication Administration in School

REQUIRED TO BE COMPLETED BY LICENSED PRESCRIBER

Student Name: **Grade_____Room_____**

Medications	**#1**	**#2**	**#3**
Diagnosis			
Dosages			
Times of Administration			
Length of Administration	Start Stop	Start Stop	Start Stop
Reasons for Medication			
Administration Instructions			
Side Effects			
Field Trip	Please choose an option below for when a nurse/parent/guardian is unable to attend field trip: ____Yes, the prescribed dose can be withheld on the day of the field trip. ____Yes, the time can be adjusted with the parent /guardian to be administered upon return to school ____No, this medication must be given to the child at the prescribedtime. Explain:		
Competency for Self Administration	I certify that this student has a potentially life- threatening allergy and/or asthma and requires an **inhaler** or **epinephrine auto injector**. This student is competent and has been instructed in the proper method of self -administration of: __INHALER __EPINEPHRINE This student may therefore carry and self -administer his/her inhaler and/or auto injecting epinephrine.		
Signature of Licensed Prescriber	**Print Prescriber's Name :** _____ **Prescriber's Signature** **Date:** **(Not Valid without licensed prescriber signature)** **Phone:**		

ONLY PRESCRIBED MEDICATION CAN BE ADMINISTERED BY THE LICENSED SCHOOL NURSE

REQUIRED TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to receive the medication as ordered by the licensed prescriber. I also authorize, as needed, the sharing of information related to my child's health condition and this medication between the school nurse and the licensed prescriber of the medication.

Parent/Guardian Signature_____ **Date**

(Not Valid without signature)

Contact Information:

Parent/Guardian Call 1st Call 2nd

According to Pennsylvania state medication guidelines, medication not picked up by the parent/guardian at the end of the school year will be disposed of. Medications must be picked up on or before the last day of school at Karns City Area School District - school nurses are not available after that day.

KARNS CITY SCHOOL DISTRICT

Medication Procedure

The following procedures should be followed when requesting school health personnel to administer medication to your school child during school hours.

- The Karns City School District will cooperate with parents and their medical practitioners in administering prescribed medications when these must be given during school hours (e.g. failure to take such medications would jeopardize the health of the student if the medication were not made available during school hours). In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, **each student/parent** must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber (provided either by a prescriber's script or prescriber complete the district medication consent form).

- All medication(s) must be supplied to the school health office in its original prescription bottle/container from a pharmacy. The container for the medication which is taken to school shall be the most current prescription container from the drugstore which includes all administration information such as the label from the pharmacy. Over the counter medication must also be supplied in its original container from the pharmacy or store. Medications in plastic bags or containers other than their original pharmacy container are NOT acceptable and NO expired medication will be administered.

- A parent/guardian or a responsible adult designated by the parent/guardian should deliver all medications to the school.

- Bring only enough medication to be taken at school for the duration of the prescription and no more than a 30 day supply. Your pharmacist will, upon request, divide the prescription medication into two separate, labeled containers – one for use at home, the second for use at school. ***In some rare incidences the medication cannot be separated (eye drops), please make specific arrangements with the School Nurse or Health room Technician regarding when the medication will be picked up by parent or designee.***

- If the student is to take only a half of a pill, the pill should be cut at home.

- When available, the certified school nurse shall administer medication. In the absence or unavailability of the certified school nurse, the CSN will designate the health room technician (RN or LPN) to be responsible for these duties. Access to all medications is limited to approved personnel such as the CSN, RN, and LPN, except that in life threatening emergencies, designated personnel may have access. The need for emergency medication may require that a student carry the medication on his/her person or that it be easily accessed.

- The parent of the child must assume the responsibility for informing the school of any change in the child's health, or change in medication prescription. A new medication form must be completed by the parent and prescriber with each change in medication or at the beginning of each school year.

- Students are permitted to have throat lozenges (Fruit Breezers, Luden's, etc.) at school and keep them at his/her desk or locker in order to minimize the disruption of the classroom. If the student at any time shows irresponsibility with the throat lozenges, this privilege will be taken away.

- Cough drops that contain Menthol (cough suppressant) must be kept in health office due to the control of how often these cough drops can be given.

- Students are permitted to possess asthma inhalers and to self administer the prescribed medication used to treat asthma or any other respiratory disorder. Before a student may possess inhaler, they must provide written orders from the prescriber stating that student is qualified and able to self administer medication. A backup inhaler must be kept in the health office and student must notify health personnel each time the medication was administered during the school day to assess student's condition. If the child shows irresponsibility or is found to be unable to adequately self administer medication, the privilege may be taken away and the student must take medication in health office with the supervision of school nurse. The above procedure also applies for students that take part in before and after school activities.

- Students are permitted to possess required emergency medication such as an automatic injectable epinephrine for the purpose of an anaphylactic reaction to an allergen. Before a student may possess injectable emergency medications, they must provide written instructions from the prescriber stating that student is qualified and able to self administer medication. A backup of the injectable medication must be kept in the health office. The student will notify health personnel if emergency medication was administered so that proper emergency measures are taken. The above procedure also applies for students that take part in before and after school activities.

- Over the counter medication (e.g., Tylenol, Motrin, Benadryl. etc.) may be administered in accordance with our school physician's standing orders during school hours if medically necessary to keep the student in school. The parent must provide a signed district OTC medication permission form. The parent/guardian may provide over the counter medication to keep at school (See "Standing Orders for the School Nurse").

- The medication shall be locked in a cabinet and is available only to the Certified School Nurse, Health Technician and, in an emergency, a trained administrator.

- In the case of a school trip, the school may ask a parent to accompany his or her child that requires medication during the school day but cannot require the parent to do so. Administration of medications is a support service that must be provided. If a parent of a student that requires medication during the school day cannot accompany the student on the field trip, a school nurse, health room technician, substitute nurse or a licensed designee that is approved by the district must accompany student on field trip.

- The school district will keep a record of the administration of medication. Any medication left over or not used by the student will be brought to the parent/guardian's attention for pick up. Any medication not picked up by the end of the school year will be documented and properly disposed of.

Karns City Area School District

Health History Form (Kindergarten-12th grades)

To Parent/Guardian: The information requested on this form will be of help to the school personnel in understanding the health status for your child and in assisting him/her to receive maximum benefits from the educational program. You may choose not to complete some areas of this history. However, this may limit our awareness of your child's needs.

Student Name: _____ _____ _____
Last First Middle

Date of Birth:_____/_____/_____ Telephone Number: _____

Physical Address:_____/ _____/ PA / _____
Street Number Street Name City Zip Code

Name of Father/Guardian: _____

Mother's Full Name: (include maiden): _____

Name of student's Physician: _____ Has your child had a medical examination in the past year? ☐ No ☐ Yes

Name of student's Dentist: _____ Has your child had a dental examination in the past year? ☐ No ☐ Yes

A. Pre-Natal Health History

Did the mother have any illness during the pregnancy? ☐ No ☐ Yes Explain: _____

Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? ☐ No ☐ Yes

Did the baby come on time? ☐ Yes ☐ No Explain: _____

B. Developmental History

What was the baby's birth weight?_____ Did the baby have any trouble while in the hospital? ☐ No ☐ Yes

Did the baby have any special problems in the first six months? ☐ No ☐ Yes

At what age did the child sit alone without support? _____ At what age did the child walk alone without support? _____

At what age did the child begin to say two or three words together? _____

Can the child use the toilet without help? ☐ No ☐ Yes If the child has stopped wetting the bed, at what age did he/she stop? _____

C. Family Health History

1. Indicate on the line which family member (parent, grandparent, aunt, uncle, brother, sister, etc) had any of the following diseases:

Allergy _____ Asthma _____ Cancer _____

Diabetes _____ Seizures _____ Heart Disease __

Nervous Breakdown _____ Tuberculosis _____ Sickle Cell _____

Drug/Alcohol Addiction _____ Vision _____ Anemia _____

Lead Poisoning_____ Hearing/Learning Problems _____

Other inherited or family diseases: _____

2. Family Members (note any special relationship such as step-parent, adopted, foster child, etc)

Relationship	Age	Name	State of Health	Occupation/School	Grade reached in school
Mother					
Father					
Brother(s)					
Sister(s)					

3. Have any members of the family died? (notmiscarriages) ☐ No ☐ Yes

4. Including the child, how many people live in the same house? _____

5. Are there any family problems such as: problems with housing, employment, food, etc? ☐ No ☐ Yes

D. Health History

1. If the child has had any of the following, please indicate the date:

Bronchitis_____ Chicken Pox _____ Diabetes_____
Malignancy_____ Jaundice _____ Mumps_____
Scarlet Fever _____ Rheumatic Fever _____ Tuberculosis _____
Seizure Disorder _____ Whooping Cough _____
Measles (Rubeola)_____ German Measles (Rubella) _____

Fractures? (Please list bone and date):

_____

_____

Surgeries? (Please list type and date):

_____

_____

Please list any serious accidents:

_____

2. Is your child subject to any of the following? (Please check and explainbriefly):

Allergies (specify)_____ Asthma_____

Blood Disorder_____ Bone/Joint/Muscle Problems_____

Ear/Hearing Problems_____ Fainting_____

Frequent Colds_____ Frequent Sore Throat _____

Headaches_____ Heart Problems_____

Intestinal Problems_____ Kidney/Urinary Problems_____

Liver Problems_____ Nosebleeds_____

Seizures_____ Sinus Infections_____

Skin Problems_____ Speech Problems_____

Stomach Problems_____ Visual Impairment_____

List any known serious sensitivity or conditions requiring IMMEDIATE MEDICAL ATTENTION:

_____

Is your child currently under care for any chronic condition?

☐ No
☐ Yes Please give the name of the physician if it is different from the familyphysician: _____

E. Please check mark any of the following things which worry you about your child:

☐ Bedwetting	☐ Feelings easily hurt	☐ Disobedient
☐ Wetting during the day	☐ Wanting too much attention	☐ Lying
☐ Thumb sucking	☐ Wanting too much comfort/support from parent	☐ Selfish in sharing
☐ Stammering/Stuttering		☐ Jealous of siblings
☐ High strung/Easily upset	☐ Day dreams	☐ Fighting with other children
☐ Too Restless	☐ Nightmares	☐ Purposely destroys things
☐ Shy	☐ Temper tantrums	☐ Feeding
☐ Sad/Sulky	☐ Contrary/Stubborn	☐ Bowels

☐ Any other problems not mentioned? Describe: _____

Health history obtained from:

_____ _____

Parent/Guardian Signature Date

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.

Student's name_____ Today's date_____

Date of birth_____ Age at time of exam_____ Gender: ☐ Male ☐ Female

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

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL HEALTH: ***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 ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ 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 ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

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

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
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:

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		D M D 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**	**8** C	**7** D	**8** E	**9** F	10 G	**11** H	**12** I	**13** J	**14**	.**15**	**18**	Upper
LOWER		32	31	30	29 T	**28** S	27 R	**28** a	25 p	24 0	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