# 2026/2027 KINDERGARTEN REGISTRATION

**STEP 1:** Fill out the Registration Packet

**STEP 2:** Get your Documents

**Required Documents**

- ☐ Child's Birth Certificate
- ☐ Child's Immunization Records
- ☐ Proof of Residence for Parent/Guardian
  Example: Deed, Lease, Drivers License, Current Utility bill

Optional Documents

- ☐ Custody Order/Court Order
- ☐ Foster Care Documentation

**STEP 3:** Make your Appointment (15 Min)

Contact Mrs. Trudy Wagner, Student Data Coordinator

Phone : 570-398-5253

Email: twagner@jsasd.org

My Appointment

Date:_____

Time:_____

## APPOINTMENTS

**START ON**

2/16/2026

**END ON**

2/27/2026

8:00 AM-
3:30 PM

## MEDICAL & DENTAL FORMS

Must be completed and submitted prior to the first day of school.

# Jersey Shore Area School District

**175 A&P Drive, Jersey Shore, PA 17740**

Office Use Only:
_____Immunization (on file)
_____Birth Certificate (on file)
_____Proof of Residency (on file)

Student # _____

**Form 1**

## *New Student Registration Form*

Registration Date _____ Grade _____ ☐ SH ☐ MS ☐ JS Elem ☐ Avis Elem ☐ Sall Elem

Student Name _____ _____ _____
Last Name First Name Middle Name

Sex: M F Date of Birth _____/_____/_____ Birthplace _____ Home Phone# (____) _____
Month Date Year City State Unlisted? Y N

**Home Address**

House Number _____Apartment Number _____

Street Name _____

PO Box _____Borough/Township _____

City _____ Zip Code _____

**Ethnicity – Please check:**
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other

**Did the child ever attend school in this district?** Y N
Which School? _____ Grades? _____

**Was the child in any of the following programs at his/her previous school?**
☐ Yes ☐ No

**If yes, please check all that apply:**
☐ ESL ☐ Gifted ☐ Title I ☐ Speech ☐ Hearing Impaired
☐ Alternative Education ☐ Special Education (IEP, NoREP, ER, 504 Attached)

**Who has legal custody of student?**
☐ Both Parents ☐ Mother ☐ Father ☐ Child Care Agency
☐ Guardian ☐ Other _____

**Adults who reside with child at above address:**
☐ Mother/Father ☐ Mother ☐ Mother/Stepfather ☐ Father ☐ Father/Stepmother ☐ Other _____

**Father**
Name_____
Address _____
_____
Place of Employment _____
Primary Phone (____) _____
Secondary Phone (____) _____
Work Phone (____) _____Ext _____
Email _____

**Mother**
Name_____
Address _____
_____
Place of Employment _____
Primary Phone (____) _____
Secondary Phone (____) _____
Work Phone (____) _____ Ext _____
Email _____

**Step Parent/Guardian**
Name_____
Address _____
_____
Place of Employment _____
Primary Phone (____) _____
Secondary Phone (____) _____
Work Phone (____) _____ Ext _____
Email _____

| NAME OF ALL CHILDREN AT CHILD'S ADDRESS | RELATIONSHIP TO CHILD | AGE | SCHOOL | GRADE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Parent Signature _____ Date _____

Transportation Dept Use: ☐ Eligible ☐ Not Eligible ☐ Calendar Attached
Start Date:_____ AM: Bus# _____ Time: _____ Stop:_____
PM: Bus# _____ Time: _____ Stop:_____
Notification: (Initial & Date)
Bus Co _____ Email or Phone School _____ Email or Phone Parent _____ Email or Phone
Additional Info_____

**Jersey Shore Area School District**
**175 A&P Drive, Jersey Shore, PA 17740**

**Form 3**

# *Home Language Survey*

Date _____

Student's Name: _____ Grade: _____

What was the student's first language? ☐ English ☐ Other _____

Does the student speak a language other than English? ☐ Yes ☐ No
(Do not include languages learned in school.)

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

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 _____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS 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 school district/charter school/full day AVTS 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 school district/charter school/full day AVTS in the future.

# Jersey Shore Area School District

**175 A&P Drive, Jersey Shore, PA 17740**

**Form**

**4**

## *House Bill 26/Safe School Initiative*

### Parental Affirmation

"Prior to admission to any school entity, the parent, guardian or other person having control of the student shall upon registration, provide a sworn statement of affirmation stating whether the pupil was suspended or expelled from any public or private school in this 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."

Student Name _____

☐ Has never been suspended

☐ Has been suspended for the following reason(s):

- ☐ Weapon
- ☐ Alcohol
- ☐ Drugs
- ☐ Violence to persons
- ☐ Violence to property
- ☐ Other _____

_____ Total number of suspensions for this student

☐ Has never been expelled

☐ Has been expelled for the following reason(s):

- ☐ Weapon
- ☐ Alcohol
- ☐ Drugs
- ☐ Violence to persons
- ☐ Violence to property
- ☐ Other _____

Date(s) of expulsion _____

I affirm the above information to be accurate and further understand that any willful false statement on this form or attachments shall be a misdemeanor of the third degree. This statement is also made subject to penalties provided by 18 Pa.C.S., sect. 4904, relating to unsworn falsification to authorities.

_____ _____

Parent/Guardian Signature Date

_____ _____

School Official Date

Rev. 12/11

# Jersey Shore Area School District

**175 A&P Drive, Jersey Shore, PA 17740**

**Form 5**

## *Child Custody Information*

### Parental Affirmation

Student Name _____

☐ Child lives with both natural parents. Stop here, sign and date the bottom of the form.

☐ Child does not live with both natural parents. Continue.

The following information is needed if your child does not reside with both natural parents due to separation or divorce. The parent with whom the child resides will be considered the custodial parent; however, the non-custodial parent has access to the child's records in the absence of a court order forbidding it.

Name of custodial parent with whom the child resides: _____

Name of non-custodial parent: _____

Address (if known): _____

_____

Do you, as custodial parent, have legal custody through a court order?

☐ Yes (If yes, a copy of the court order should be supplied to the school office to be kept on file.)
☐ No
☐ Pending

If there is a court order, does it limit the non-custodial parent access to school records?

☐ Yes (If yes, a copy of the court order MUST be supplied to the school office to be kept on file.)
☐ No

May the child be released from school to the non-custodial parent?

☐ Yes
☐ No (If no, a copy of the court order MUST be supplied to the school office to be kept on file.)

Are the students restricted from a change in enrollment or residence due to a custody order?

☐ Yes (If yes, a copy of the court order MUST be supplied to the school office to be kept on file.)
☐ No

I affirm the above information to be accurate and will notify the school whenever any of this information should change or be modified.

_____ _____

Parent Signature Date

Jersey Shore Area School District

LEARNING | GROWING | SUCCEEDING

Form 6

# MEDIA RELEASE EXEMPTION FORM

Opt-Out Form

Student Name: _____ Grade: _____ Building _____

The Jersey Shore Area School District is committed to protecting the privacy of all students and their families. The following is provided to offer you as a parent the right to remove your child from being photographed, videotaped, or recorded for the local news media; publicity or for internal purposes, such as newsletters, school and district presentations; the district website; and school or school district managed sites such as JSASD Facebook, JSASD Twitter, JSASD Instagram, etc.

_____ I **DO NOT** give my permission for my child to be photographed (still or motion) and/or tape recorded (audio or video) by employees of the Jersey Shore Area School District, its education partner organizations (clubs, booster organizations, home and school association) and/or agents of the media.

_____ _____

Name of Parent/Guardian Signature

Parent permission is given while your student attends the Jersey Shore Area School District unless consent is denied using this form.

# Jersey Shore Area School District

LEARNING | GROWING | SUCCEEDING

## Acknowledgement of District Policy #206

I acknowledge and understand that Policy #206 states:

"The Superintendent periodically shall review existing attendance areas and recommend to the Board changes that may be justified by considerations of safe student transportation and travel, convenience of access to schools, financial and administrative efficiency, and effectiveness of the instructional program, including equalizing class sizes.

The Superintendent or designee may assign a student to a school other than the one designated for the attendance area when such exception is justified by circumstances and is in the educational interest of the student.

The Superintendent or designee shall assign incoming transfer students to schools, grades, and classes that afford each student the greatest likelihood of realizing his/her educational potential and academic goals."

I further acknowledge and understand that this may mean that my child is not guaranteed to attend any one district school.

The full policy can be found on the Board Docs page of the District website or you may request a copy by calling Trudy Wagner, Student Data Coordinator, at 570-398-5253.

_____ _____

Parent/Guardian Name Date

_____ _____

Parent/Guardian Signature Date

District Service Center
175 A&P Drive
Jersey Shore PA 17740

Dr. Brian Ulmer, Superintendent
Phone 570.398.1561
Fax 570.398.5089

# EMERGENCY/STUDENT INFORMATION CHANGE FORM

**Student Name**_____
Last First Middle

**Prim Phone**_____

**Primary Parent Contact**_____ **Work Phone**_____
Relationship to child_____ **Sec Phone**_____
House Number_____ Apartment Number_____
Street Name_____
PO Box_____ Borough/Township_____
City_____ Zip_____
Email Address_____
Additional Adult at this address_____
Place of employment_____

**Prim Phone**_____

**Secondary Parent Contact**_____ **Work Phone**_____
Relationship to child_____ **Sec Phone**_____
House Number_____ Apartment Number_____
Street Name_____
PO Box_____ Borough/Township_____
City_____ Zip_____
Email Address_____
Additional Adult at this address_____
Place of employment_____

**Prim Phone**_____

**Emergency Contact**_____ **Work Phone**_____
Relationship to child_____ **Sec Phone**_____

**Parents:** ☐**Married** ☐**Divorced** ☐**Separated** ☐**Single**
**Child lives with:** ☐**Both** ☐**Mother** ☐**Father** ☐**Guardian**

| **Sisters/Brothers:** | Grade | School |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Additional relatives/friends who are permitted to come for your child:
**Name**_____ **Phone**_____

**Name**_____ **Phone**_____

***When the primary parent's address has changed, then proof of residency should be submitted with this form to the child's school.***

***In case of an emergency, your child will be released to any person listed on this form.***

**Parents Signature**_____ **Date**_____

☐ SH ☐ MS ☐ JSE ☐ AV ☐ SALL

**Office Use:**
Student Number_____ GR_____
Submitted by_____ Date_____

Revised 10/15

For Central Registration Office Use:
cc. Special Education
Transportation

**Jersey Shore Area School District**
**Authorization for First Aid/Emergency Care**

Date _____ Grade _____ Homeroom _____ Birth Date _____

Student Name _____ _____ _____ Phone _____
Last First Middle
Home Address _____ Email _____

Mother's Name _____ Work Place _____ Wk# _____
Cell# _____
Father's Name _____ Work Place _____ Wk# _____
Cell# _____

Child lives with: (please circle) Both Parents Father Mother Guardian Other _____

If school is unable to reach either of the above, please list 2 relatives or friends who you give the authority to advise and/or pick up your child if sick or injured:
Name/Relationship _____ Address _____ Phone _____
Name/Relationship _____ Address _____ Phone _____

**First Person to Contact _____**

**EMERGENCY TREATMENT**

List any conditions your child may have, of which the school nurse should be aware: (Ex. Asthma, Seizure Disorder, Depression, Allergies, etc.)

_____

**BEE STING REACTION:**
Does your child have an allergy to bees which requires emergency medication? Yes No
If yes, please list medication used when stung: _____

**PERMISSION TO EXCHANGE INFORMATION:**
My child's health and/or medical information may be shared with school staff as needed so that in an emergency the staff can act in the best interest of my child.

_____
Signature Parent/Guardian

**EMERGENCY TREATMENT:**
If emergency treatment is required, the school authorities will use their judgment in sending the child to the nearest hospital

## Acetaminophen (Tylenol), Ibuprofen (Advil), Antacid (Tums):

Non-prescription medications that may be given in a non-emergency situation are Ibuprofen (Such as Advil®/Motrin®), Acetaminophen (such as Tylenol®), Antacids (such as Tums®) in accordance with the treatment protocol established by the school physician. Acetaminophen/Ibuprofen dosage is based on age and weight of the child. When health situations arise for administering these medications **and** the parent/guardian have signed the permission below for their administration, these will be offered to students. The authorization will be in effect the current school year unless revoked by the parents/guardian in writing to the School Nurse.

**Tylenol/Advil/Tums need to be supplied by the parent/guardian if taking often OR if Children's dosage (liquid/chewable) is needed.**

I agree that the District and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Jersey Shore Area School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action which may be brought against the District or its employees in connection with giving such medicine.

_____
Signature Parent/Guardian

**Jersey Shore Area School District**
**175 A&P Drive, Jersey Shore, PA 17740**

**Form**
**9**

# ***Medical Forms Cover Letter***

In order to get to know your child and complete his/her registration, certain medical forms are necessary. Attached are the following forms that need to be completed for registration:

- Health History (Form A)
- Medical Screening Acknowledgement (Form B)
- Private Physician's Form of Physical Examination (Form C)
  Upon entering into school in **grades K or 1 and in grades 6 and 11**, all students are required by the Pennsylvania State Health Department to have a physical exam. If your child will be seen by your family health care provider, please have the enclosed Commonwealth of Pennsylvania Department of Health Form #H511.336 (JSASD Med. Form C) completed and returned to the school as soon as possible. **The exam must be performed within one year of the start of the school year.**
- Private Dentist's Form of Dental Examination (Form D)
  Upon entering into school in **grades K or 1 and in grades 3 and 7**, all students are required by the Pennsylvania State Health Department to have a dental exam. If your child will be seen by your family dentist, please have the enclosed Commonwealth of Pennsylvania Department of Health Form #H514.027 (JSASD Med. Form D) completed and returned to the school as soon as possible. **The exam must be performed within one year of the start of the school year.**

Please return the completed form(s) to the nurse at your child's school. If you have any questions please contact the school nurse and/or if you prefer to have the form faxed, use the appropriate numbers below:

| | | | |
|---|---|---|---|
| Senior High | Judy Morlock RN/CSN | Ph: 570-398-7170 | Fax: 570-398-5612 |
| Middle School | Judy Morlock RN/CSN | Ph: 570-398-7400 | Fax: 570-398-5618 |
| JS ES | Hillary Leonard RN/CSN | Ph: 570-398-7120 | Fax: 570-398-5624 |
| Avis ES | Hillary Leonard RN/CSN | Ph: 570-753-5220 | Fax: 570-753-3469 |

# Jersey Shore Area School District

**175 A&P Drive, Jersey Shore, PA 17740**

**Med. Form**

**A**

# *Health History*

Name _____ Date of Birth _____

Please check all that apply

| **Does your child have:** | | | **Has your child had:** | | | |
|---|---|---|---|---|---|---|
| Cleft Palate/Lip | Yes | No | Broken Bones | Yes | No | |
| Frequent Sore Throats | Yes | No | Tonsils Removed | Yes | No | |
| Frequent Earaches | Yes | No | Head Injury(unconscious) | Yes | No | |
| Frequent Colds | Yes | No | Difficult Sleeping | Yes | No | |
| Allergies | Yes | No | Convulsions | Yes | No | |
| Speech Difficulties | Yes | No | Epileptic Seizures | Yes | No | |
| Chronic Cough | Yes | No | Chicken Pox | Yes | No | If yes, month/year:_____ |
| Emotional Problems | Yes | No | Measles (Regular/10 Day) | Yes | No | |
| Bedwetting/Wetting | Yes | No | Measles (German/3 Day) | Yes | No | |
| Frequent Nightmares | Yes | No | Mumps | Yes | No | |
| Poor Eating Habits | Yes | No | Scarlet Fever | Yes | No | |
| Stomach Problems | Yes | No | Whooping Cough | Yes | No | |
| Bowel Problems | Yes | No | Rheumatic Fever | Yes | No | |
| HIV/AIDS | Yes | No | | | | |
| Behavioral Problems | Yes | No | | | | |
| Vision Problems | Yes | No | | | | |

Explain all *Yes* answers:_____

_____

_____

Abnormal Birth History:_____

List all operations:_____

List all major illnesses:_____

List all current daily medications, include dose:_____

_____

List all as needed medications, include dose:_____

_____

Is your child presently under medical treatment (if yes, explain):_____

_____

_____

## Family History

(Please check those that apply to your family)

| | | | | |
|---|---|---|---|---|
| Allergies | Epilepsy | Tuberculosis | Heart Disease | Kidney Disease |
| Asthma | Deafness | Diabetes | Psychiatric Depression | |

_____ _____

Parent/Guardian Signature Date

Rev. 12/11

**Jersey Shore Area School District**
**175 A&P Drive, Jersey Shore, PA 17740**

**Med. Form**
**B**

# ***Medical Screening Acknowledgment***

In order to eliminate the need to send home numerous permission slips for the various phases of our school health programs, we are offering this form as an overall coverage for this program.

Student Name _____ Date of Birth _____

I understand my child will participate in the following Pennsylvania State mandated health programs:

- Annual Vision Screening, Grades K-12
- Annual Height and Weight Screening, Grades K-12
- Hearing Screening, Grades, K, 1, 2, 3, 7, and 11
- Scoliosis Screening, Grades 6, and 7
- Physical examinations upon entry into school (Grades K or 1) and Grades 6 and 11*

If you have any questions regarding the school health program, please feel free to call your school nurse.

_____ _____
Signature of parent/guardian Date

*You may have the routine school health examination performed by your family physician at your expense. A private physician's form is enclosed in this packet. If your child is be examined by the school physician, you will be informed when and where the exam will occur. If you wish to attend, contact the school nurse.

**Jersey Shore Area School District**
**175 A&P Drive, Jersey Shore, PA 17740**

**Form**
**9**

# ***Medical Forms Cover Letter***

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- Private Dentist's Form of Dental Examination (Form D)
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Please return the completed form(s) to the nurse at your child's school. If you have any questions please contact the school nurse and/or if you prefer to have the form faxed, use the appropriate numbers below:

| | | | |
|---|---|---|---|
| Senior High | Judy Morlock RN/CSN | Ph: 570-398-7170 | Fax: 570-398-5612 |
| Middle School | Judy Morlock RN/CSN | Ph: 570-398-7400 | Fax: 570-398-5618 |
| JS ES | Hillary Leonard RN/CSN | Ph: 570-398-7120 | Fax: 570-398-5624 |
| Avis ES | Hillary Leonard RN/CSN | Ph: 570-753-5220 | Fax: 570-753-3469 |

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:<br>☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection<br>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:<br>☐ Heart murmur or heart infection<br>☐ High blood pressure ☐ Kawasaki disease<br>☐ 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<br>If yes: At what age was her first menstrual period? _____<br>How many periods has she had in the last 12 months? _____<br>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: _____<br>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:<br>☐ Anemia/blood disorders ☐ Inherited disease/syndrome<br>☐ Asthma/lung problems ☐ Kidney problems<br>☐ Behavioral health issue ☐ Seizure disorder<br>☐ Diabetes ☐ Sickle cell trait or disease<br>Other_____ | | |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:<br>☐ Brugada syndrome ☐ QT syndrome<br>☐ Cardiomyopathy ☐ Marfan syndrome<br>☐ High blood pressure ☐ Ventricular tachycardia<br>☐ 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_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**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)<br>Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio<br>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)<br>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)<br>Type: HPV2 or HPV4 | 1 | 2 | 3 | 4 | 5 |
| Influenza<br>Type: TIV (injected)<br>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)<br>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 (08/2011-under review)

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/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