

Date: \_\_\_\_\_



STUDENT ENROLLMENT			
Weisenberg Elementary 2665 Golden Key Road Kutztown, PA 19530 (610) 285-6169 Fax: (610) 285-2677	Northwestern Elementary 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8573	Northwestern Lehigh Middle School 6636 Northwest Road New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8178	Northwestern Lehigh High School 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: 610-298-2063

### Who may enroll?

Parents or court-appointed guardians may enroll a student new to the Northwestern Lehigh School District

### When may registration take place?

Monday to Friday, 9:00 a.m. - 2:00 p.m. **Appointments are necessary.** Please contact the appropriate school, at the phone number listed above, to make an appointment.

### What is included in the registration packet?

- Student Registration
- Residency Verification
- Release of Information Form
- Home Language Survey
- Discipline Verification Parent Form
- Emergency Contact Information
- New Student Health History Form
- Child Custody Information

### In addition to the completed registration materials, you will need to bring the following to your appointment:

- Verification of date of birth by any of the following:
  - Original Birth Certificate
  - Passport
  - Hospital Birth Record
  - Adoption Papers
  - Residency Verification—Must provide TWO forms of current documentation:
  - Department of Transportation identification or driver's license, or
  - Department of Transportation vehicle registration, or
  - A utility bill, or
  - Medical Insurance Information with address, or
  - Federal, State, and Local Income Tax Forms, or
  - Moving Permit, or
  - Bank statement with address, or
  - Paycheck stub with name and address of employee and employer, or
  - A signed, current property lease agreement or sales contract, or
  - Voter's registration card, or
  - Residency affidavit

**Residency is subject to investigation and verification by the school district**

Date: \_\_\_\_\_



- Physical examination within the past year or consent for a physical examination to be conducted by the school physician
- Immunizations with dates (a list of required vaccines and number of doses are provided in the registration packet)
- Legal documents designating parent or legal guardian with educational rights if other than biological parents (court order or notarized District Guardianship Form)
- School Records
  - Transfer card from last school attended
  - Proof of withdraw from previous school, including grades at time of withdrawal
  - Academic transcript or report card from the former school
- Other information:
  - For Special Education Students, most recent ER and IEP
  - For Gifted Students, most recent GWR and GIEP

STUDENT ENROLLMENT CHECKLIST	
<input type="checkbox"/>	Date of Birth Verification (i.e. Birth Certificate)
<input type="checkbox"/>	Residency Verification – 2 forms for proof of residency
<input type="checkbox"/>	Physical Examination Records
<input type="checkbox"/>	Immunization Records
<input type="checkbox"/>	Transfer card from previous school
<input type="checkbox"/>	Proof of withdraw from previous school, including grades at time of withdrawal
<input type="checkbox"/>	Transcripts or Report Card from previous school
<input type="checkbox"/>	Most recent ER/RR/IEP (if applicable)
<input type="checkbox"/>	Most recent GWR/GIEP (if applicable)
<input type="checkbox"/>	Court Order, Custody, or District Guardianship Form (if applicable)



**Northwestern Lehigh School District**  
**Student Registration**

**Student ID #**

**Grade:**

**Additional Information**

Northwestern District Entry Date:

Pennsylvania School Entry Date:

US Entry Date:

Date First Entered US School:

Document for Birthdate Identification:

Birth City/State:

**Student Information (Please Print)**

Last Name:

First name:

Middle Name:

Suffix:

Gender: ☐ Female ☐ Male

Birth date:

Phone #:

Unlisted: ☐

**Student Physical Address**

Address 1:

Address 2:

City:

State:

Zip + 4

Township

County:

**Ethnicity**

☐ 1. American Indian/Alaskan Native

☐ 3. Black

☐ 4. Hispanic

☐ 5. White

☐ 6. Multiracial

☐ 9. Asian

☐ 10. Native Hawaiian/Other Pacific Islander

**Parent/Guardian Contact information**

Relation to Child:

Lives With: ☐ Yes ☐ No

Same Address ☐ Yes

Release to: ☐ Yes ☐ No

Title:

Last Name:

First Name:

Address 1:

Address 2:

City & State:

Zip + 4:

Home Phone # :

Cell Phone # :

Work Phone :

Email:

Occupation

Employer:

Active Duty in Military: ☐ Yes ☐ No

If yes, what branch of military:

Receive Mailers: ☐ Yes ☐ No

Custody Papers: ☐ Yes ☐ No

**Parent/Guardian Contact information**

Relation to Child:

Lives With: ☐ Yes ☐ No

Same Address ☐ Yes

Release to: ☐ Yes ☐ No

Title:

Last Name:

First Name:

Address 1:

Address 2:

City & State:

Zip + 4:

Home Phone # :

Cell Phone # :

Work Phone :

Email:

Occupation

Employer:

Active Duty in Military: ☐ Yes ☐ No

If yes, what branch of military:

Receive Mailers: ☐ Yes ☐ No

Custody Papers: ☐ Yes ☐ No

**Other Than Parent/Guardian  
Emergency Contact #1**

Relation to Child:

Release to: ☐ Yes ☐ No

Title:

Last Name:

First Name:

Address 1:

Address 2:

City:

State:

Zip + 4:

Home Phone # :

Cell Phone # :

Work Phone :

**Other Than Parent/Guardian  
Emergency Contact #2**

Relation to Child:

Release to: ☐ Yes ☐ No

Title:

Last Name:

First Name:

Address 1:

Address 2:

City:

State:

Zip + 4:

Home Phone # :

Cell Phone # :

Work Phone :

**Siblings**

Last Name:

First Name:

Date of Birth:

Last Name:

First Name:

Date of Birth:

Last Name:

First Name:

Date of Birth:

Last Name:

First Name:

Date of Birth:

**Prior School Information**

School Name:

Address:

City:

State:

Phone # :

Contact:

**Programs**Special Ed (IEP): ☐ Yes ☐ No

Type:

ELL Student: ☐ Yes ☐ NoVOTECH: ☐ Yes ☐ No*For School Personnel Use Only*

Date Registered: \_\_\_\_\_

Entry Date: \_\_\_\_\_ Entry Code: \_\_\_\_\_

Withdrawal Date: \_\_\_\_\_ W. Code: \_\_\_\_\_

Re-Entry Date: \_\_\_\_\_ R-Entry Code: \_\_\_\_\_

Building : \_\_\_\_\_ Room # : \_\_\_\_\_

Locker # : \_\_\_\_\_

Pre-Resident Agreement: ☐ Yes ☐ NoHomeless: ☐ Yes ☐ NoFoster: ☐ Yes ☐ No**Document Copies - For School Personnel Use Only**Birth Certificate ☐ Transfer Card ☐Proof of Residence/Moving Permit ☐Immunization Record ☐ Report Card ☐Affidavit for Guardianship ☐**Additional Comments**

I give consent for the Northwestern Lehigh School District to add the Parent/Guardian email addresses and/or phone numbers listed above to the Blackboard Connect system to receive messages from the Northwestern Lehigh School District.

\_\_\_\_\_  
Parent/Guardian Signature\_\_\_\_\_  
Date

Date: \_\_\_\_\_



### Residency Verification

Weisenberg Elementary 2665 Golden Key Road Kutztown, PA 19530 (610) 285-6169 Fax: (610) 285-2677	Northwestern Elementary 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8573	Northwestern Lehigh Middle School 6636 Northwest Road New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8178	Northwestern Lehigh High School 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: 610-298-2063
--	---	--	---

Name of Parent(s) \_\_\_\_\_

Current Address \_\_\_\_\_

Phone number \_\_\_\_\_

I am requesting enrollment of my child(ren), \_\_\_\_\_, at Northwestern Lehigh School District. The Northwestern Lehigh School District requires TWO forms of proof for residency within the District. I am providing the following document(s) to establish that I reside at the above listed address.

The following documents will be provided to the Northwestern Lehigh School District for verification of your address:

- |  |   |
|--|---|
| <input type="checkbox"/> PA Driver's License           | <input type="checkbox"/> Moving Permit                              |
| <input type="checkbox"/> PA vehicle registration       | <input type="checkbox"/> Current Lease or Sales Contract            |
| <input type="checkbox"/> Utility Bills                 | <input type="checkbox"/> Current Bank Statement                     |
| <input type="checkbox"/> Medical Insurance Information | <input type="checkbox"/> Federal, State and Local, Income Tax Forms |
| <input type="checkbox"/> Pay stub                      | <input type="checkbox"/> Voter's Registration Card                  |

I/We have read this form and understand that I/we will be required to provide the above documents to Northwestern Lehigh School District. The Northwestern Lehigh School District's administration routinely investigates the accuracy of residencies within Northwestern Lehigh School District.

\_\_\_\_\_  
Signature of Parent or Guardian  
Date:

\_\_\_\_\_  
Witness  
Date:

-Copies of TWO FORMS of residency on file with the Northwestern Lehigh School District.

Date: \_\_\_\_\_



### Authorization for Release of Records

Weisenberg Elementary 2665 Golden Key Road Kutztown, PA 19530 (610) 285-6169 Fax: (610) 285-2677	Northwestern Elementary 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8573	Northwestern Lehigh Middle School 6636 Northwest Road New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8178	Northwestern Lehigh High School 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: 610-298-2063
--	---	--	---

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**I hereby authorize the below-listed person/entity to release educational, medical, and health information/records regarding my son/daughter to the Northwestern Lehigh School District.**

TO: (School/Physician, or Entity from whom records are being requested)

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

The specific educational, medical, health information/records to be released include the following (as circled):

- |  |  |
|--|--|
| <input type="checkbox"/> Health Records/Immunizations      | <input type="checkbox"/> Multidisciplinary Reports                   |
| <input type="checkbox"/> Transcripts/Report cards          | <input type="checkbox"/> ER, IEP, NOREP                              |
| <input type="checkbox"/> Academic records                  | <input type="checkbox"/> GWR, GIEP, NORA                             |
| <input type="checkbox"/> Attendance/Enrollment Records     | <input type="checkbox"/> Speech/Language Reports                     |
| <input type="checkbox"/> Discipline Records                | <input type="checkbox"/> 504 Agreement                               |
| <input type="checkbox"/> Team Action Plan (IST, SAP, etc.) | <input type="checkbox"/> Physical Therapy/Occupation Therapy Reports |
| <input type="checkbox"/> Standardized Test Scores          | <input type="checkbox"/> Other pertinent educational records         |
| <input type="checkbox"/> Psychological/Psychiatric records |  |
| <input type="checkbox"/> Social History Records            |  |

OTHER RECORDS (Specify): \_\_\_\_\_

I also authorize the employees of the Northwestern Lehigh School District to verbally discuss and exchange educational or /health record information, about my child, with the above named person/entity. I formally request written confirmation of any physician's instructions regarding the school setting.

I understand and acknowledge the following:

- all records and information exchanged shall be considered confidential;
- (if applicable) the use of these medical/health records and information is limited to the reasonable and necessary use in the school setting;
- any records and information received may be placed in the child's education record if used as a source of information to provide the child with appropriate educational programming, and/or be of clear importance to protect the child or others;
- if the above information does become part of the child's educational record, the Family Educational Rights and Privacy Act and the Confidentiality Sections of the Education of the Handicapped Acts grant the parent, guardian or surrogate the right to review and/or receive a copy of said report(s);
- the duration and effectiveness of this release shall continue for 365 days from the date written below unless it is revoked in writing before that time. I understand that I may revoke this release at any time by providing written notice to the Northwestern Lehigh School District.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_



### PARENTAL REGISTRATION STATEMENT

Weisenberg Elementary  
2665 Golden Key Road  
Kutztown, PA 19530  
(610) 285-6169  
Fax: (610) 285-2677

Northwestern Elementary  
6493 Route 309  
New Tripoli, PA 18066  
(610) 298-8661  
Fax: (610) 298-8573

Northwestern Lehigh Middle School  
6636 Northwest Road  
New Tripoli, PA 18066  
(610) 298-8661  
Fax: (610) 298-8178

Northwestern Lehigh High School  
6493 Route 309  
New Tripoli, PA 18066  
(610) 298-8661  
Fax: 610-298-2063

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Phone No. \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ PA \_\_\_\_\_  
(street/city/zip)

Pennsylvania School Code Section 13-1304-A states in part "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 of 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."

Please complete the following:

I hereby swear or affirm that my child was \_\_\_\_\_ was not \_\_\_\_\_ previously suspended or expelled from any public or private school of this Commonwealth or any other state for an act of 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.\* I make this statement subject to the penalties of 24 P.S. Section 13-1304-410A(b) and 18 PA C.S.A. Section 4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\*Name of the school from which student was suspended or expelled, reason for suspension/expulsion and dates of suspension or expulsion

\_\_\_\_\_  
Any willful false statement made above shall be a misdemeanor of the third degree. This form shall be maintained as part of the student's disciplinary record.

(Ref. Policy # 608)

11/96

Date: \_\_\_\_\_



### HOME LANGUAGE SURVEY

Weisenberg Elementary 2665 Golden Key Road Kutztown, PA 19530 (610) 285-6169 Fax: (610) 285-2677	Northwestern Elementary 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8573	Northwestern Lehigh Middle School 6636 Northwest Road New Tripoli, PA 18066 (610) 298-8661 Fax: (610) 298-8178	Northwestern Lehigh High School 6493 Route 309 New Tripoli, PA 18066 (610) 298-8661 Fax: 610-298-2063
--	---	--	---

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS 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 method for the identification.

School District:  
School:

Date:

Student's Name:

Grade:

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

2. Does the student speak a language(s) other than English?  
(Do not include languages learned in school.)

☐ Yes ☐ No

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: \_\_\_\_\_

\*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.

Date: \_\_\_\_\_



## RACE AND ETHNICITY IDENTIFICATION FORM

To Parents/Guardians:

Please complete Parts 1 AND 2 of this form for each of your children in our schools, and return this form to your student's school.  
**You must complete a separate form for each child.**

Name of Student \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### Part 1: Ethnicity Designation

**Directions:** Read the definition below and check the box that indicates this student's heritage.

**Is this student Hispanic or Latino? (Select one answer)**

Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered **Hispanic** or **Latino**.

☐ Yes

☐ No

### Part 2: Race Designation

**Directions:** Read the descriptions below and check the box or boxes that indicate this student's race. You must select at least one race, regardless of ethnicity designation. More than one response can be selected.

**Indicate this student's race (Select all that apply)**

- ☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North or South America (including Central America), and who maintains a tribal affiliation or community attachment.
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.
- ☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

I verify the information on this form is accurate.

I refuse to re-identify the race and ethnicity of this student.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature, Parent/Guardian      Date

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature, Parent/Guardian      Date

### FOR SCHOOL USE ONLY

Observations used to complete this form due to parent/guardian refusal to re-identify.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature, Observer      Date



Date: \_\_\_\_\_



## NORTHWESTERN LEHIGH SCHOOL DISTRICT CHILD CUSTODY INFORMATION

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. It is the responsibility of the custodial parent to provide the school with any limiting court order.

1. Child's Name: \_\_\_\_\_
2. Name of custodial parent with whom the child resides: \_\_\_\_\_
3. Name of non-custodial parent: \_\_\_\_\_
4. Do you as custodial parent have **legal** custody through a court order?

☐ Yes      ☐ No

If **Yes**, a copy of the court order **MUST** be supplied to the school office to be kept on file.

If pending, the date to be finalized: \_\_\_\_\_

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

☐ Yes      ☐ No

If **Yes**, a copy of the court order **MUST** be supplied to the school office to be kept on file.

6. 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.

7. Will you provide routine information such as report cards, parent bulletins, conference reports, etc. to the non-custodial parent?

☐ Yes      ☐ No

If **No**, please inform him/her that information may be provided with a written request.

8. Please provide any additional information (on the back of this sheet) regarding custody of which the school should be aware.

Signature of Custodial Parent: \_\_\_\_\_

Date: \_\_\_\_\_



Name of non-custodial parent: \_\_\_\_\_

**PLEASE BE AWARE OF THE FOLLOWING:**

Date: \_\_\_\_\_

**Northwestern Lehigh School District  
Health History**

**Student:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**CONTACT INFORMATION**

**Parent(s)/Guardian(s):**

**Primary contact name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Lives with student:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Type:** \_\_\_\_\_

**Alternate Phone:** \_\_\_\_\_ **Type:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Secondary contact name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Lives with student:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Type:** \_\_\_\_\_

**Alternate Phone:** \_\_\_\_\_ **Type:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Physician name/Location:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist name/Location:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**MEDICAL INFORMATION**

**Please circle YES or NO. Describe any YES answers and provide dates if applicable.**

**ALLERGIES:**

**Food:** YES / NO \_\_\_\_\_

**Medication:** YES / NO \_\_\_\_\_

**Other:** YES / NO \_\_\_\_\_

**ASTHMA:** YES / NO \_\_\_\_\_

**FOOD OR DIETARY RESTRICTIONS:** YES / NO \_\_\_\_\_

**SEIZURE DISORDER:** YES / NO \_\_\_\_\_

**HEART PROBLEMS:** YES / NO \_\_\_\_\_

**DIABETES:** YES / NO \_\_\_\_\_

**CONTINUED ON BACK >>>**

EARS:

Frequent earaches or ear infections: YES / NO \_\_\_\_\_

Ear surgery: YES / NO \_\_\_\_\_

Hearing loss: YES / NO \_\_\_\_\_

SPEECH PROBLEMS: YES / NO \_\_\_\_\_

EYES:

Wears glasses or contact lenses: YES / NO \_\_\_\_\_

Eye surgery: YES / NO \_\_\_\_\_

URINARY/BLADDER PROBLEMS: YES / NO \_\_\_\_\_

INTESTINAL/BOWEL PROBLEMS: YES / NO \_\_\_\_\_

ECZEMA/SKIN PROBLEMS: YES / NO \_\_\_\_\_

ATTENTION DEFICIT/HYPERACTIVITY DISORDER: YES / NO \_\_\_\_\_

PSYCHOLOGICAL/EMOTIONAL PROBLEMS: YES / NO \_\_\_\_\_

HISTORY OF HOSPITALIZATION: YES / NO \_\_\_\_\_

EVER HAD SURGERY: YES / NO \_\_\_\_\_

FRACTURED BONES: YES / NO \_\_\_\_\_

CONCUSSION/SEVERE HEAD INJURY: YES / NO \_\_\_\_\_

CHICKEN POX DISEASE: YES / NO \_\_\_\_\_

CURRENT MEDICATIONS: YES / NO Please list all medication(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any medications to be kept at school: YES / NO \_\_\_\_\_

ANY PHYSICAL RESTRICTIONS: YES / NO \_\_\_\_\_

ANY OTHER HEALTH CONDITIONS OR CONCERNS: YES / NO \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does/will your child attend daycare? : YES / NO

Before School: YES / NO

After School: YES / NO

Where: \_\_\_\_\_ Phone: \_\_\_\_\_

*Thank you for taking the time to fill out this Health History as accurately as possible. This will help us to care for your child during the school day.*

\_\_\_\_\_  
**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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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?		
<b>HEAD/NECK/SPINE: <i>Has the student...</i></b>	<b>YES</b>	<b>NO</b>
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?		
<b>HEART/LUNGS: <i>Has the student...</i></b>	<b>YES</b>	<b>NO</b>
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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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?		
<b>BONE/JOINT: <i>Has the student...</i></b>	<b>YES</b>	<b>NO</b>
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?		
<b>SKIN: <i>Has the student...</i></b>	<b>YES</b>	<b>NO</b>
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____		
<b>DENTAL:</b>	<b>YES</b>	<b>NO</b>
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
<b>SOCIAL/LEARNING: <i>Has the student...</i></b>	<b>YES</b>	<b>NO</b>
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?		
<b>FAMILY HEALTH:</b>	<b>YES</b>	<b>NO</b>
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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)?		
<b>QUESTIONS OR CONCERNS</b>	<b>YES</b>	<b>NO</b>
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 PERFORMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	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 <input type="checkbox"/>				
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 ☐

**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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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
<b>Other Vaccines: (Type and Date)</b>					



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
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

ADDRESS

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

**REPORT OF EXAMINATION**

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

Is The Child Under Treatment

Yes ☐No ☐

Treatment Completed

Yes ☐No ☐\_\_\_\_\_  
Date of Dental Examination\_\_\_\_\_  
Signature of Dental Examiner\_\_\_\_\_  
Print Name of Dental Examiner\_\_\_\_\_  
Address