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	
☐	Date of Birth Verification (i.e. Birth Certificate)
☐	Residency Verification – 2 forms for proof of residency
☐	Physical Examination Records
☐	Immunization Records
☐	Transfer card from previous school
☐	Proof of withdraw from previous school, including grades at time of withdrawal
☐	Transcripts or Report Card from previous school
☐	Most recent ER/RR/IEP (if applicable)
☐	Most recent GWR/GIEP (if applicable)
☐	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	☐ No
VOTECH:	☐ 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	☐ No
Homeless:	☐ Yes	☐ No
Foster:	☐ 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:

___ PA Driver's License

_____PA vehicle registration

_____Utility Bills

_____Medical Insurance Information

_____Pay stub

___Moving Permit

___Current Lease or Sales Contract

___Current Bank Statement

___Federal, State and Local, Income Tax Forms

___ 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: _____

PARENTAL REGISTRATION STATEMENT

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

_____ ___/___/___

Signature, Parent/Guardian *Date*

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

_____ ___/___/___

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*

Northwestern Lehigh Transportation Department
6493 Route 309
New Tripoli PA 18066

Kindergarten Registration Form

Student's Name: _____

Address: _____

Birth Date: _____ Gender: _____ Daytime Phone: _____

Siblings in school: _____

Younger siblings and ages: _____

Work Phone: _____

Township (Circle): Heid Lowhl Lynn Weis Other Phone: _____

Notes: _____

_____

_____

_____

_____

_____

_____

Kindergarten Parents: It is Northwestern Lehigh District practice that kindergarten students not met at the bus stop by an adult or older sibling be returned to school or to the bus garage if the school office is closed. Older children will be dropped off regardless of supervision unless specifically requested by the guardian to maintain this practice. Parents who submit a waiver to this practice may have their student dropped at the stop without an escort. Please fill out the form below if that is your intention regarding the delivery of your child:

I authorize my kindergarten child be permitted to get off at his/her stop without the visible presence of an adult or sibling.

Signature of parent: _____ Date: _____

I authorize the following people to accept my child at the stop: _____

_____

_____

Other information: _____

OFFICE USE ONLY: WEIS	NWE
HOME CK-S LilCC ALC OTHER	HOME CK-N NWCC OTHER
	STUDENT ID:

NORTHWESTERN LEHIGH ELEMENTARY SCHOOLS
Developmental History Record for Kindergarten

Child's name _____ Birthdate _____

The following information will assist us in understanding your child, and will help him/her adjust to school. Replies will be considered confidential.

Father's Name _____ Occupation _____ Employer _____

Mother's Name _____ Occupation _____ Employer _____

Siblings (please include birthdates)_____

_____

_____

_____

Age when child started to walk _____ talk _____

Toilet trained at age _____ Can child care for self at toilet _____

Does child wet bed or self now _____

Does your child:

bite nails	_____	button/zip coat	_____
suck thumb	_____	right handed	_____
		or	
dress self	_____	left handed	_____
tie shoes	_____	use scissors	_____
put on boots	_____	have ear problems	_____

Nickname _____ Has she/he attended pre-school _____

If so, where_____ length of time _____

Does your child play with neighborhood children _____ age group _____

Will your child attend day care/go to babysitter _____ If so, where _____

Are other languages (other than English) spoken in the home _____

Usual bedtime hour _____

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: _____

Date: _____

NORTHWESTERN LEHIGH SCHOOL DISTRICT
CHILD CUSTODY INFORMATION

Child's Name: _____

Name of custodial parent with whom the child resides: _____

Name of non-custodial parent: _____

PLEASE BE AWARE OF THE FOLLOWING:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Custodial Parent: _____ 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: ***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 NAME:

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

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____ 20_____

Print name of examiner _____

Print examiner's office address _____ **Phone** _____

Signature of examiner _____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

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

ADDRESS

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

REPORT OF EXAMINATION

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

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address