IROQUOIS SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

OFFICE USE ONLY

State ID _____ Student No. _____ Current Grade Level _____

School: ❑ 2052 IES ❑ 4817 IHS ❑ New Entry ❑ Re-enrollment Homeroom (IES Only) _____ Entry Code _____

School Entry Date _____ Birth Date Verification Code _____

STUDENT INFORMATION

Student's Full Legal Name _____
Last Name First Name Middle Name Suffix

Date of Birth _____ Birthplace _____
City, State, Country

Gender _____ Student's Cell Phone Number (Optional) _____

Student Ethnic Code: (Please check one)
- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African American (Not Hispanic)
- ❑ Hispanic (Any Race)
- ❑ White/Caucasian (Not Hispanic)
- ❑ Native Hawaiian/Pacific Islander
- ❑ Multi-racial/ethnic

School previously attended _____

School Address _____

Does the student have an IEP (Individualized Education Program)? ❑ No ❑ Yes If yes, please indicate which program: ❑ Learning Support ❑ Life Skills ❑ Emotional Support ❑ Gifted ❑ Other _____

Most recent date that the student entered the State of PA _____

If applicable, school year in which the student entered 9th grade for the first time _____

PARENT/GUARDIAN INFORMATION

Student resides with: ❑ Both Natural Parents ❑ Father ❑ Mother ❑ Guardian ❑ Foster Parent

In the case of joint parental custody, guardianship, or foster placements, the district of residence should be the location the child resides for the majority of each week throughout the entire calendar year.
Appropriate legal and/or custody documents are required at time of registration. This documentation will be required annually, within the first week of each school year.

Custody documents provided: ❑ Court Order documentation provided: ❑

Father: _____
Last Name First Name Employer Work/Cell Phone

Mother: _____
Last Name First Name Employer Work/Cell Phone

Guardian/Foster Parent: _____
Last Name First Name Employer Work/Cell Phone

EMERGENCY CONTACT INFORMATION

Contact 1 _____
Last Name First Name Relationship Phone

Contact 2 _____
Last Name First Name Relationship Phone

Contact 3 _____
Last Name First Name Relationship Phone

IROQUOIS SCHOOL DISTRICT

STUDENT SCHOOL ENROLLMENT FORM

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY [1]

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

School District: IROQUOIS SCHOOL DISTRICT **Date:** _____

School: _____

Student's Name: _____ **Grade:** _____

1. **What is/was the student's first language?** _____
2. **Does the student speak a language(s) other than English?** _____ Yes _____ No
   (Do not include languages learned in school.)

   If yes, specify the language(s)? _____
3. **What language(s) is/are spoken in your home?** _____
4. **Has the student attended any United States school in any 3 years during his/her lifetime?** _____ Yes _____ No

   If yes, complete the following:

Name of School	State	Dates Attended

Person completing this form (if other than parent/guardian): _____

Parent/Guardian signature: _____

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

I acknowledge that the information noted above is true and accurate, and that the student being registered is a resident of the Iroquois School District, and as such, spend at least half or more of each school week residing with a parent or legal guardian within the boundaries of the Iroquois School District. I understand that false statements made herein are made subject to the penalties of 18 Pa. C.S. 4904, relating to unsworn falsification to authorities.

_____ _____

Signature of Parent/Legal Guardian Date

IROQUOIS SCHOOL DISTRICT

FAMILY/HOUSEHOLD CENSUS FORM

Street Address _____
House Number, Street, Lot or Apt. No., City, State, Zip Code

Mailing Address _____
If Different from Above (Example: P.O. Box)

Township/Boro _____ Home Phone Number _____

HEAD OF HOUSEHOLD INFORMATION

Head of Household Name _____

Relationship to Child(ren) in Household _____

Place of Employment _____ Work Phone Number _____

E-Mail Address _____ Cell Phone Number _____

OTHER ADULTS LIVING IN HOUSEHOLD

1. Name _____

   Relationship to Child(ren) in Household _____

   Place of Employment _____ Work Phone Number _____

   E-Mail Address _____ Cell Phone Number _____

2. Name _____

   Relationship to Child(ren) in Household _____

   Place of Employment _____ Work Phone Number _____

   E-Mail Address _____ Cell Phone Number _____

3. Name _____

   Relationship to Child(ren) in Household _____

   Place of Employment _____ Work Phone Number _____

   E-Mail Address _____ Cell Phone Number _____

4. Name _____

   Relationship to Child(ren) in Household _____

   Place of Employment _____ Work Phone Number _____

   E-Mail Address _____ Cell Phone Number _____

CHILDREN LIVING IN HOUSEHOLD

1. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

2. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

3. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

4. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

5. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

6. Name _____

   Birthdate _____ Gender _____ Grade/Age _____ School _____

RESIDENCY VERIFICATION REQUIREMENTS

The following documents **MUST** be provided to demonstrate residency within the Iroquois School District in order to complete enrollment of a student.

1, Deed or Lease Agreement indicating residency of the parent/guardian AND the student(s) to be enrolled.

2. Copy of current utility bill, voter registration, vehicle registration or other documentation as approved by ISD Administration.

NOTE: ISD may request additional documentation to demonstrate residency.

SIGNATURE

AN ADULT HOUSEHOLD MEMBER MUST SIGN THIS FORM.

I certify (promise) that all information provided on this form is true and accurate at this time.

Sign Here _____

Print Name _____ Date _____

IROQUOIS SCHOOL DISTRICT

STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian:

The McKinney-Vento Act, as amended by the No Child Left Behind Act of 2001, defines homelessness and outlines the rights of homeless students. Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren). Thank you for your cooperation.

1. Student name: _____ **Birth Date:** _____

   Person completing form: _____ Relationship to child: _____

2. **In what type of setting is the student living now?**
   Check one option below:

SECTION A	SECTION B
☐ In an emergency or transitional shelter ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason. ☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations. ☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings. ☐ Other places not designed for, or ordinarily used as, regular sleeping accommodations for human beings. CONTINUE to Question 3 if you checked any box in SECTION A.	☐ None of the choices in Section A apply.  If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.

3. Contact number for person completing this form: _____

   Address where student is now living: _____

   _____

4. The student lives with:
   Check all that apply:

   ☐ Parent(s) or legal guardian

   ☐ Relative, friend(s), or other adult(s)

   ☐ Alone

   ☐ Other: _____.

IROQUOIS SCHOOL DISTRICT

800 Tyndall Avenue • Erie, PA 16511

PARENTAL REGISTRATION STATEMENT

Student Name _____

Date of Birth _____ Grade _____ Telephone No. _____

Parent/Guardian Name _____

Address _____

Pennsylvania School Code §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 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".

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 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.* I make this statement subject to the penalties of 24P.S. §13-1304-A(b) and 18 Pa. C.S.A.§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/Guardian Date

If prior suspension or expulsion was indicated in signed statement above, please complete the following:

Name of School_____

Date of Suspension or Expulsion_____

Reason for 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.

IROQUOIS ELEMENTARY SCHOOL
4231 Morse Street
Erie, PA 16511
(814) 899-7643

Jennifer L. Foutz, Elementary School Principal
Veronica E. Will, Elementary School Assistant Principal
ies.iroquoissd.org

SPEECH/LANGUAGE DEVELOPMENTAL QUESTIONNAIRE

Date: _____

Child's Name: _____ Birth Date: ___/___/____ Grade: _____

Parent Name(s): _____

Address: _____

_____ Phone: _____

1.	Do family members and other people frequently have difficulty understanding your child's speech?	Yes	No
2.	Does your child ever become frustrated because of his/her speech or language?	Yes	No
3.	When your child talks, are his/her sentences always less than five words in length?	Yes	No
4.	Does your child have difficulty understanding directions?	Yes	No
5.	Does your child have difficulty with any of the following:		
	a. Carrying on a conversation with you by telling you what s/he is doing?	Yes	No
	b. Asking questions such as why, when and how?	Yes	No
6.	Are you concerned about your child's hearing?	Yes	No
7.	Do you feel your child stutters?	Yes	No
8.	Do you have any questions or comments about your child's speech and language development?	Yes	No

_____

_____

_____

Please return this form to the school secretary with your enrollment packet.

Revised: 7/2023 bkt

IROQUOIS SCHOOL DISTRICT
800 Tyndall Avenue • Erie, PA 16511

REQUEST FOR RECORDS

Student Name _____ Grade _____

Date of Birth _____ Previous School _____

The above-named student has enrolled in the Iroquois School District. In order to determine an appropriate placement, it is necessary to have the following documents released to the school selected below:

Student's PA Secure ID (for Pennsylvania School Districts) _____

We are requesting the ENTIRE permanent records file including but not limited to the following records:

- Cumulative Academic Records including test results
- Special Education Records (IEP, ER)
- Psychological
- Birth Certificate
- Attendance Records
- Discipline Records
- Health Records
- Community/Outside Services, Social Work Reports

Please return records to:

☐ Iroquois Junior-Senior High School
Attn: Pupil Services Secretary
4301 Main Street
Erie, PA 16511
814-899-7643 ext. 1000
FAX - (814) 897-2410
jlarocca@iroquois.iu5.org

☐ Iroquois Elementary School
Attn: Principal's Secretary
4231 Morse Street
Erie, PA 16511
814-899-7643 ext. 2001
FAX – (814) 897-2414
hwoodring@iroquois.iu5.org

Parent/Guardian Signature _____ Date _____

IROQUOIS SCHOOL DISTRICT

800 Tyndall Avenue
Erie, PA 16511
(814) 899-7643

Shane S. Murray, Superintendent
Kimberly A. Smith, CPA, CGMA, Business Manager
Dr. Thad Urban, Asst. to the Superintendent
iroquoissd.org

An Equal Rights & Opportunities School District

The Iroquois School District hereby notifies parents and guardians of special education services available to eligible students ages 3–21. All services are at no cost to the parents and are in place to meet the eligible child's unique needs. The Iroquois School District has a screening and evaluation process to identify students who may require special education services. If parents or guardians think their child might need special education services, they can refer their child by contacting the principal of the school in which the child attends or the school district's Pupil Services Office.

For preschool children, ages 3 to 5, parents/guardians should contact the Early Intervention Project at the Northwest Tri-County Intermediate Unit #5 at (814)734-5610 or (800)677-5610. Screenings and evaluation occur throughout the year.

If your child is eligible for special education services, there is help through the Iroquois School District with a variety of services available. Some services are in the District while others are in districts within our region, depending on the individual needs of the student. The types of support include:

- **Autistic Support** – for students diagnosed along the Autism Spectrum.
- **Early Intervention** – for children 3 to 5 years of age with developmental delays or disabilities; supports are provided in conjunction with the Northwest Tri-County Intermediate Unit #5
- **Learning Support** – for students with learning problems in academic areas associated with learning disabilities or mild intellectual disabilities.
- **Emotional Support** – for students with emotional or behavioral mental health problems.
- **Speech/Language Support** – for students with speech and language communication problems affecting their learning.
- **Life Skills Support** – for students who require instruction in daily living skills and readiness for basic skills associated with moderate to severe intellectual disabilities.
- **Sensory Support** – for students who are deaf, hard of hearing, blind or have visual impairments.
- **Physical Support** – for students with cerebral palsy, muscular dystrophy or other physical disabilities.
- **Multiple Disabilities Support** – for students who have a combination of two or more disabilities such as intellectual disability and physical disability.

Parents are also advised that in Pennsylvania special education for students who are mentally gifted is also available. Parental rights of access to these programs are governed by regulations found in Chapter 16 of the School Code. If parents feel their child is gifted, they should contact the principal of the school in which their child attends to initiate the evaluation process. Parents are also advised that in Pennsylvania, children with disabilities who do not require special education are protected by the regulations of Chapter 15 of the School Code. Parents who feel their child may be a "protected handicapped student" should contact the principal of the school in which their child attends for information.

Notice is also given to parents/guardians regarding confidentiality requirements for students who are referred for special education services. These requirements are found in both federal and state regulations. Records generated by the identification, evaluation and programming process are confidential and cannot be released outside the school district or intermediate unit without written parent consent. District Policy 113.4: Confidentiality of Special Education Student Information describes the District's system of safeguards to protect the confidentiality of personally identifiable information in the education records of students with disabilities.

For more information or for learning more about your child's rights for a Free Appropriate Public Education (FAPE), please call or write:

Maria Modzelewski
Director of Special Education
Iroquois School District
800 Tyndall Avenue
Erie, PA 16511
(814) 899-7643 ext. 4010

OR

CHILD FIND
Northwest Tri-County Intermediate Unit #5
252 Waterford Street
Edinboro, PA 16412
(814) 734-5610
1(800) 677-5610 Toll Free

IROQUOIS SCHOOL DISTRICT

STUDENT ENROLLMENT HEALTH HISTORY

To assist us in providing the best health care for your child, please complete ALL questions on this form to the best of your knowledge. All information is kept confidential in the School Health Room.

Student Name:			**Grade Level:**
Gender: ☐ M ☐ F	**DOB:**	**Previous School:**	
Father's Name:			
Mother's Name:			

CHILD'S HEALTH HISTORY

Does your child have any ongoing medical conditions? If so, please identify:

☐ ADHD	☐ Diabetes	☐ Seizure Disorder
☐ Asthma	☐ Mental Health Diagnosis	☐ Severe Allergy
☐ Other:		

Does your child have any allergies?

☐ Animals	☐ Dust	☐ Plants
☐ Bee Sting	☐ Foods	☐ Pollen
☐ Drugs	☐ Other:	

Explain reaction:

Is your child frequently troubled by any of the following?

☐ Bladder/Bowel Problems/Incontinence	☐ Fainting Spells	☐ Persistent Cough
☐ Dizziness	☐ Headaches	☐ Tires Easily
☐ Earaches/Frequent Infections	☐ Nosebleeds	☐ Wheezing
☐ Emotional Problems	☐ Painful Joints	

☐ Other – Please explain:

Is this condition under the care of a doctor?	☐ Yes ☐ No	Name of Doctor:

Is your child currently taking medication? ☐ Yes ☐ No	Inhaler? ☐ Yes ☐ No

List all medications currently taken, including dosage for each and doctor prescribing each.

Will the child need medication during school hours? ☐ Yes ☐ No

Depending on what type of medication your child may need, the appropriate form listed below will be required:

• Authorization for Medication at School Form • Parent Consent for Standing Order Medications Form	• Student Contract to Carry Asthma Inhaler/Epipen Form • Authorization For Self-Administration of Medication at School Form

Does your child require a special diet?	☐ Yes ☐ No
If yes, note restrictions:	
Depending on type of diet needed, the form listed may be required: **Medical Plan of Care for School Food Services Form**	

Does your child experience any difficulty with:	☐ Hearing	☐ Vision
Please explain:		

Does your child wear glasses/contacts?	☐ Yes ☐ No
Does your child wear hearing aids?	☐ Yes ☐ No

Has your child had any serious injuries, accidents or operations?	☐ Yes ☐ No
If yes, please list and give dates:	

Family physician, pediatrician, dentist and/or other doctor caring for your child:		
Name:	Phone:	Date child was last seen?
Address:		
Name:	Phone:	Date child was last seen?
Address:		
Name:	Phone:	Date child was last seen?
Address:		

List your child's type of insurance coverage:	
Indicate if no coverage: ☐	*We may be able to assist you in obtaining health insurance for your child.*

Additional Comments:

Parent/Guardian Signature _____ Date _____

Iroquois School District
Authorization for Medication at School

School _____ Year _____

Name of Student _____ GR/HR _____

Diagnosis for which medication is given _____

Dates medication to be given _____ to _____

Medication _____

Dosage _____ Route _____ Time to be given _____

Can this medication be adjusted to accommodate class schedules? YES NO

If so, by how much?_____

If medication is to be given "PRN", describe indications and intervals _____

_____

List significant side effects or limitations of school activities _____

_____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name Printed Physician's Office Phone Number

I understand this medication MUST be in a container clearly labeled by the pharmacy with the name of the medication, the amount to be given, the time of day to be given and the prescribing healthcare provider. I, the parent, am responsible for taking a supply to the school to be dispensed by a licensed nurse as designated by the Iroquois School District policy. The medication is to be given in school because the medication must be taken at a time when the child is in school and another time is not feasible.

With the intent to be legally bound, we hereby release, discharge, hold harmless, and indemnify the Iroquois School District, its Board, employees, and agents from any liability whatsoever for any personal injury, damages, or expenses to student or to parent/guardian caused or occasioned by the administration of this medication.

_____ _____ _____
Parent/Guardian Signature Date Daytime Phone Number

IROQUOIS SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

School_____ Year_____

Students requiring Albuterol for asthma and Epi-Pen for life-threatening allergies will be allowed to carry the medication on their person while in the school setting, provided the following conditions are met.

- Before allowing a student to self-carry medication, the CSN will ensure that the student is competent in self-care through demonstration of administration skills and responsible behavior.
- The student must notify the CSN immediately following each use.
- If the school policies are abused or ignored, the immediate confiscation of the medication and loss of self-administration privileges will occur.

I certify that (student) _____ in Grade _____ is

diagnosed with _____(list asthma or type of life threatening allergy)

Medication _____Dosage _____ Route _____

Describe indications and intervals for self-administration _____++_____

_____

This order will be in effect for the _____ school year, and must be renewed annually.

☐ I have trained the student in self-administration and it is medically necessary that this medication be carried on the student at all times while in school.

_____ _____
Physician's Signature Date

_____ _____
Physician's Name Printed Physician's Office Phone Number

☐ I, the parent, am responsible for ensuring my child has a supply of the above prescribed medication on their person.

With the intent to be legally bound, we hereby release, discharge, hold harmless, and indemnify the Iroquois School District, its Board, employees, and agents from any liability whatsoever for any personal injury, damages, or expenses to student or to parent/guardian caused or occasioned by the administration of this medication.

_____ _____ _____
Parent/Guardian Signature Date Daytime Phone Number

IROQUOIS SCHOOL DISTRICT

STUDENT CONTRACT TO CARRY ASTHMA INHALER/EPINEPHRINE AUTO INJECTOR

School_____ Year_____

Student_____ Grade _____

Parent/Guardian _____

It is important that your child has access to the medication necessary for controlling the symptoms of asthma/anaphylaxis as quickly as possible. In order to maintain the safety of all students in the Iroquois School District, students who have medical orders to carry medication on their person during the school day must abide by the following student rules.

Name of medication_____

What steps should be taken if the expected results of the medication are not obtained?

_____

_____

_____

After the school nurse has verified proper technique, my child may carry his/her medication and will be responsible for having it with him/her at all times. I understand that necessary school personnel will be informed of my child's authorization to carry medication. If my child does not follow any of the student rules for medication use listed below, I am aware that disciplinary action will result including confiscation of the medication and loss of the privilege to carry an inhaler. I hereby release, discharge, and hold harmless the Iroquois School District, its agents and its employees from any and all liability if my child fails to self-medicate as prescribed by the physician.

Parent Signature_____Date_____

Student Rules on Medication Use

- I am responsible for taking my medication as prescribed by my physician.
- I will notify the school nurse immediately after each time I use my medication in school.
- I am responsible for bringing my medication to school.
- I will never touch anyone else's medication.
- I will never loan my medication to anyone else or invite anyone to try my medication.
- If I do not follow all of the above rules, I am aware that I may face disciplinary action.

Student Signature_____Date_____

School Nurse Signature_____Date_____

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*

ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

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

_____

_____

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

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

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

Signature of parent / guardian / emancipated student_____ Date_____

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

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: 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 ☐

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)

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