



## WELCOME TO THE NORTH EAST SCHOOL DISTRICT

### **NEW STUDENT REGISTRATION REQUIREMENTS**

The following items are required for the registration and entry of a student(s) into the North East School District:

1. **PROOF OF RESIDENCY (TWO FORMS)** – Provide any two of the following documents with your current North East, PA address:
  - a. Current utility bill or confirmation of new utility service
  - b. Lease Agreement or Mortgage Statement/Sales Agreement**NOTE:** Wireless bills are not accepted.
2. **PARENT/GUARDIAN VALID PHOTO ID** – Provide a valid photo ID such as a Driver's License or state issued ID.
3. **STUDENT'S ORIGINAL BIRTH CERTIFICATE** – Provide the original copy to the school district and a copy will be made for the student's file.
4. **STUDENT'S CURRENT IMMUNIZATION RECORDS** – Students will not be permitted to attend school until all required immunizations are provided to the school.
5. **CUSTODY ORDER** – If a custody order is in effect for the student(s) being registered, the district will need to make a copy of the most recent order.
6. **FOSTER CARE** – If applicable, provide placement documentation.

If you have any questions, please call the Administration office at (814) 725-8671 ext. 3900.



# North East School District

50 E. Division Street, North East, PA 16428 814-725-8671

## REQUEST FOR SCHOOL RECORDS

Enrollment of the following student has been initiated at the North East School District:

Student's Name: \_\_\_\_\_ Current/Last Completed Grade: \_\_\_\_\_

School student is leaving: \_\_\_\_\_ School Phone #: \_\_\_\_\_

School City: \_\_\_\_\_ School State: \_\_\_\_\_ School Fax #: \_\_\_\_\_

Please check "Yes" or "No" to indicate if student is currently receiving the following services:

Special Education	Yes	No	Alternative Education	Yes	No
Gifted Education	Yes	No	Student Assistance Program	Yes	No
504 Accommodations	Yes	No	On-Site Counseling	Yes	No
Title One Reading or Math	Yes	No	Building Level Team Support	Yes	No
Speech Services	Yes	No	Case Management Support	Yes	No
ESL Services	Yes	No	Agency Visitations	Yes	No
Vocational Education	Yes	No	Other (please explain) _____		

I hereby request the above named school district, RELEASE the following information to the North East School District:

- **Grades to Date** (numerical and letter) by marking period or final grades. Please include grading code.
- **Test Scores**
- **Birth Certificate**
- **Health Records** including immunization records

\_\_\_\_\_  
Parent/Guardian Name (Printed) Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Address: Phone #: \_\_\_\_\_

**Please forward records to the following school office as appropriate:**

<input type="checkbox"/> <b>Davis Primary Elementary</b> <i>Grades K-2</i> 50 E. Division St. North East, PA 16428 Fax: 814-725-0821 Carol Komorowski – Ext. 3052 ckomorowski@nesd1.org	<input type="checkbox"/> <b>Intermediate Elementary</b> <i>Grades 3-5</i> 50 E. Division St. North East, PA 16428 Fax: 814-725-8643 Sue Beardsley – Ext. 3000 sbeardsley@nesd1.org	<input type="checkbox"/> <b>Middle School</b> <i>Grades 6-8</i> 1903 Freeport Rd. North East, PA 16428 Fax: 814-725-1086 Michele Seth – Ext. 2003 mseth@nesd1.org	<input type="checkbox"/> <b>High School</b> <i>Grades 9-12</i> 1901 Freeport Rd. North East, PA 16428 Fax: 814-725-3357 Chrissy Kirsch – Ext. 1006 ckirsch@nesd1.org
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**Please forward Special Education records to:**

50 E. Division St.  
North East, PA 16428  
ATTN: Special Education Dept.  
Fax: 814-347-0043  
Nancy Bifulco – Ext. 3027  
nbifulco@nesd1.org

Information received by the North East School District will be placed in a file which parents have access to and have the capacity to release to a third party independent agency. The professional staff of the North East School District monitors this access. Information will be destroyed when it is no longer useful for educational purposes. Equal Opportunity Employer





NORTH EAST SCHOOL DISTRICT  
HEALTH HISTORY

**THIS FORM MUST BE COMPLETED**  
**(ONE FORM PER STUDENT)**

STUDENT NAME \_\_\_\_\_ Gender  Male  Female

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

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

Parent's/Guardian's Names \_\_\_\_\_

Grade \_\_\_\_\_ School Last Attended \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Is your water supply from the North East Borough? Yes  No

If NO, has your child had fluoride treatments? \_\_\_\_\_

**HEALTH HISTORY:** Please list any serious illnesses or communicable diseases: \_\_\_\_\_

\_\_\_\_\_

Allergies? \_\_\_\_\_

**IMMUNIZATION HISTORY:** Please list dates or attach Doctor's print out.

DPT (Combination Diphtheria-Pertussis-Tetanus) – 4 Required

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ Booster \_\_\_\_\_

MCV 1) \_\_\_\_\_ TDAP 1) \_\_\_\_\_

POLIO-SABIN VACCINE – 4 Required

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ Booster \_\_\_\_\_

MMR (Combination Measles-Mumps-Rubella) – Required 1) \_\_\_\_\_ 2) \_\_\_\_\_

HEPATITIS A 1) \_\_\_\_\_ 2) \_\_\_\_\_

HEPATITIS B – 3 Required 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

HIB VACCINE – 3 Required 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

If applicable:

CHICKEN POX (Date child had chicken pox) \_\_\_\_\_ OR

VACCINE 1) \_\_\_\_\_ 2) \_\_\_\_\_

(Continued on back)

**MEDICAL INFORMATION**

1. Is your child’s vision or hearing impaired? .....Yes No  
If yes, is he/she under a doctor’s care?.....Yes No  
What is the problem?

2. Is your child toilet trained? ..... Yes No Does  
he/she have bowel or bladder accidents? ..... Yes No If yes,  
can you be specific regarding what the issues are?

3. Does your child have a speech or language problem? .....Yes No  
If yes, is he/she being treated for the problem?.....Yes No  
What is the problem?

4. Does your child have any other physical illness or handicap which might affect  
normal progress or participation in the usual school program?.....Yes No  
If yes, please explain:

5. Does your child have any emotional or behavioral problem which might affect  
school performance or participation?.....Yes No  
If yes, please explain:

6. Is your child on any long-term medication? .....Yes No  
If yes, please specify:

7. Has your child been restricted by a doctor as far as physical activity in school  
is concerned?.....Yes No  
If yes, please submit a statement from your doctor specifying the nature and  
duration of the restriction.

8. Does your child have any health condition which might require emergency action  
when he/she is at school? (i.e. seizures, bee sting allergy, bleeding problem, diabetes,  
heart problem, etc).....Yes No  
If yes, please specify:

9. Do you have: \_\_\_\_\_Medical Insurance \_\_\_\_\_Medical Card  
\_\_\_\_\_ Other (please explain) \_\_\_\_\_

10. Would you like to discuss this information with any of the following:  
\_\_\_\_\_School Nurse \_\_\_\_\_Counselor  
\_\_\_\_\_Teacher \_\_\_\_\_Principal

\_\_\_\_\_  
Signature of Parent/Guardian

# North East School District

## HEALTH ROOM EMERGENCY INFORMATION

NAME: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ GRADE \_\_\_\_\_

Address \_\_\_\_\_ Primary Phone # \_\_\_\_\_

Preferred Hospital in case of an emergency: \_\_\_\_\_

Students Health Care Provider: \_\_\_\_\_ Recent appointment date: \_\_\_\_\_

Students Dental Care Provider: \_\_\_\_\_ Recent appointment date: \_\_\_\_\_

Please read the following and CIRCLE any health concerns.

**Any Routine Medication?** YES NO If Yes, please list: \_\_\_\_\_

**LIFE THREATENING ALLERGIES/REACTIONS?** YES NO

If yes, to what? \_\_\_\_\_ Is an Epi-Pen prescribed? YES NO

**ASTHMA:** YES NO Is an inhaler prescribed for school? YES NO

**EPILEPSY/SEIZURE DISORDER:** YES NO Date of last seizure: \_\_\_\_\_

Emergency seizure medication prescribed? YES NO Medication Name: \_\_\_\_\_

**Please describe any additional health conditions or home concerns below:**

\_\_\_\_\_

The school has standing orders, which includes a list of approved treatments and medications recommended by our physician. The list of approved medications is provided online and on the back of this page.

Please circle the following items that you give permission to the school nurses to administer to your student while in school:

**Ibuprofen ( 6<sup>th</sup>-12<sup>th</sup> grade ONLY)**

**Tylenol ( 6<sup>th</sup>-12<sup>th</sup> grade ONLY)**

I hereby give my permission for my child to receive a **physical exam** as per PA Public Health Code section 1402, which requires all students receive a health exam upon entry into school, in the 6th grade and again in the 11th grade years.

Signature: \_\_\_\_\_

I hereby give my permission for my child to receive a **dental exam** as per PA School Health Code section 1403, which requires all students to receive a dental exam upon entry into school, in the 3rd grade and again in the 7th grade years.

Signature: \_\_\_\_\_

I hereby give my permission for my child to have his/her back screened for **scoliosis** per PA School Health Code Chapter 23, section 10. This screening is required during the 6th and 7th grade years, which are during the period of critical developmental growth.

Signature \_\_\_\_\_

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

## **Over the Counter Medications approved by Standing Orders**

*Analgesics Topical (Anbesol, Bactine, Biofreeze, Blistex, Burn Spray, Caladryl, Carmex, Chloraseptic, Throat Spray, Sting Swabs)*

*Analgesics Oral (Acetaminophen, Ibuprofen, Midol) Middle and High School Students only.*

*Antibiotics Topical (Bacitracin, Neosporin)*

*Antihistamine (Benadryl, Epinephrine) Dosage by age/weight with Parental notification prior to administration required except in the event of an emergency.*

*Anti-inflammatory (Hydrocortisone Cream, Ibuprofen)*

*Gastrointestinal (Lactose intolerance medications, Tums)*

*Ophthalmic (Contact lens solution, Eye wash, Visine)*

*Other (Narcan, Albuterol) Emergency administration only.*

## **Health Services Include**

- *Immunization record review and maintenance*
- *Annual vision screening grades K-12*
- *Annual height/weight measurement grades K-12*
- *Annual hearing screening grades K,1,2,3,7,11 and special education students*
- *Blood pressure checked on all students grades 6-12*
- *Dental exams are provided for grades K, 3, 7*
- *Medical exams are provided for grades K, 6, 11*
- *Scoliosis screening done in grades 6 and 7*
- *Assisting with obtaining health insurance for uninsured children through the CHIPS program*

**NORTH EAST SCHOOL DISTRICT**  
**PUBLISHING OF DOCUMENTS and IMAGES ON THE INTERNET/WORLD WIDE WEB**  
**PARENT/GUARDIAN and STUDENT SIGNATURES REQUIRED on Page 2**

The North East School District ("District") has created a website for each school within the District. This policy shall apply to schools and individual students who publish on the Internet where the information being published originates from a school or district-maintained web server or from any server currently in use by the school system. This policy should be followed in conjunction with the District's Computer/Internet Acceptable Use Policy for Students.

**I. Online Images of Adults on District-owned or maintained websites**

Pictures and identifying information of Board members, District employees or any other adult, such as parents or volunteers, may be published on District-owned or controlled websites provided the permission of the adult is obtained prior to the publication of his/her image and/or information on the Internet.

**II. Online Images of Students of the District**

Pictures and identifying information of students of the North East School District may be published on District-owned or controlled websites provided the permission of the student's parent/guardian and/or the student is not disallowed prior to the publication of his/her image and/or information on the Internet.

Parents and/or legal guardians who do not wish to allow the photograph, name(s) or work of their student(s) to be published in any written District publication and/or posted on any District maintained online format must notify the student's school in writing no later than September 30<sup>th</sup> of each school year, denying permission for such publication. In the absence of a written letter, the District shall assume that publication is granted for the current school year.

**III. Publication Of Student Names**

The District May Publish Students' Names on the Internet, provided that permission for such publication has not been previously disallowed in writing by the student's parent/guardian and/or the student for the current school year.

**IV. Publication Of Student-Produced Work.**

The District may publish student-produced work on the Internet, provided that permission for such publication has not been previously disallowed in writing by the student's parent/guardian and/or the student for the current school year.

Prior to the posting of student-generated work, schools within the District must take reasonable care that the content of the work is owned solely by the student. Plagiarism in any form is not permitted.

The District may require that student publications meet a variety of standards related to adequacy of research, spelling, grammar and appropriateness of material.

Administrative Regulation



**THIS FORM MUST BE COMPLETED**Rules for North East School District Computer Users

As a user of computers owned or controlled by the North East School District, I agree to follow the District's rules relative to computer and Internet use, including the District's Computer/Internet Acceptable Use Policies, and the District's policy on the Publishing of Documents and Images on the Internet/Internet, in all of my work with computers while at the North East School District.

I will not play games or use the computer resources for non-academic activities and will not attempt to access materials which would be inappropriate in the educational setting.

I will follow the directions given at the lab site. When I am in a computer lab, I will work in ways that will not disturb others.

I will not waste or take supplies that are provided by the North East School District.

I recognize that software is protected by copyright laws; therefore, I will not make unauthorized copies of software found on the North East School District computers, either by copying them onto my own discs or onto other computers through electronic mail or bulletin boards or other electronic pathways; and I will not give, lend, or sell copies of software to others unless I have the written permission of the copyright owner or the original software is clearly identified as shareware or in the public domain.

I recognize also that the work of all users is valuable; therefore, I will protect the privacy of others by not trying to learn their passwords; I will not copy, change, read, or use files in another user's area without that user's prior permission; I will not attempt to gain unauthorized access to system programs or equipment; I will not use computer systems to disturb or harass other computer users by sending unwanted mail or by other means; and I will not download personal files onto the hard drives of any North East School District computers for permanent storage.

Violations of the District's rules and policies regarding the use of District computers and the Internet will be addressed in accordance with the discipline policies of the North East School District. Violators will lose computer privileges.

As the parent or guardian of this student, I have read the terms and conditions for Internet access. I understand that this access is designed for educational purposes. I also recognize it is impossible for the North East School District to restrict access to all controversial materials, and I will not hold them responsible for materials acquired on the network. I hereby give permission for my child to use the Internet and certify that the information contained on this form is correct. **I understand, further, that if I do not sign, my child will not be permitted access to the Internet through the school's computers.**

Student Name \_\_\_\_\_  
Please Print

Parent(s) Name \_\_\_\_\_  
Please Print

Student Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

Valid through the end of September of the following school year.



## NORTH EAST SCHOOL DISTRICT

50 EAST DIVISION STREET • NORTH EAST, PENNSYLVANIA 16428  
 TELEPHONE (814) 725-8671 • FAX (814) 725-9380

### PARENT OR GUARDIAN NOTIFICATION

#### FOR PUBLICATION OF STUDENT IMAGES, NAMES, AND/OR STUDENT WORK

North East School District Board Policy 815 outlines the school district's position regarding the publishing of documents and images on the Internet/World Wide Web. This policy is readily available for your review in its entirety on the district's website at [www.nesd1.org](http://www.nesd1.org) by clicking on the Resource tab and scrolling down to Policies.

North East School District currently maintains a website at this address and also a district social media (Face Book) page and publishes newsletters where, from time to time, images of students, student-produced work and/or student names may be posted, either in order to promote positive activities happening on campus or to showcase and recognize the achievements and talents of our students.

Please be aware that permission is assumed to be granted for the District to publish images and/or student-produced work and to reference students by name on District owned or maintained online sites and in such written publications as the school district newsletters and local/community newspapers.

If you **DO NOT** wish to allow your student's photograph, name or work to be posted in any online format (such as the district's website) or in any written publication (such as district or school newsletters), please send a written letter to your child's school no later than September 30<sup>th</sup> of the current school year, stating that you deny permission for such publication.

If you have any questions regarding publication of student images, names and/or student work, either in electronic or written format, you are invited to contact the Superintendent's office at (814) 725-8671 extension 3904 or any of the building administrators.

If you do not have internet access at home and would like to review the District's policy on publications, you are invited request a printed copy of this policy from any school office.

We anticipate an exciting school year and look forward to honoring the exceptional student accomplishments which take place throughout the year.



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?		
HEAD/NECK/SPINE: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <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 <b>DURING</b> or <b>AFTER</b> exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
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: _____		
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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <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)?		
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 PERFORMING EXAMINATION: Yes <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>
Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20____
Print name of examiner _____
Print examiner's office address _____ Phone _____
Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>

**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								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	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