Information for Student Registration Appointment

Required Information

To enroll a student, school districts must request proof of the child's age; proof that the child is immunized; and proof that the child is a resident. We ask that in addition to the registration packet (if not completed on-line), that you bring the following to your registration appointment:

- Proof of Age: Examples are a child's birth certificate or passport, baptismal certificate, a legal statement by a parent or prior school records.
- Proof of Immunization Status: Typically, a physician's statement/record of immunizations is provided. If this information is not available, a prior school district or physician can confirm by telephone that the child is immunized with records to follow.
- Two Proofs of Residency: Acceptable documents to establish residency include, but are not limited to a deed, a lease, utility bills, vehicle registration, driver's license or Dept. of Transportation identification card.

Other Helpful Information to Bring to your Registration Appointment

For administrative purposes and to assist with the education of your child, we also request that you bring the following, if applicable:

- Transcripts from previous school (to assist with timely and appropriate scheduling of classes)
- Current Physical and Dental Forms (if not in the student's school records)
- Custody Papers
- Any student-specific plans such as IEP, 504 Plan, GIEP

Updated March 2022

South Eastern School District

Fawn Grove, Pennsylvania 17321

Student Registration/Census Form

For Internal Use Only

Grade: _____ **Enrollment Date:** ____/____/____ **Enrollment Code:** _____

Student ID #: _____ **Date of Withdrawal:** ____/____/____ **Date of Graduation:** ____/____/____

STUDENT INFORMATION

I am interested in (check all that apply): _____Brick & Mortar _____ SESD Online Academy _____SESD Virtual

Student's Name: _____
(Last) (First) (Middle) (Jr., III, IV)

Address: _____
(Street) (City) (State) (Zip)

Township/Borough: _____ *Home Phone _____ *Cell Phone _____

Birth Date: ____/____/____ Place of Birth: _____ Gender: M F

Attendance Notification _____ Attendance Notification (#2) _____

District Residence Date: ____/____/____ **PA Residence Date:** ____/____/____ **School Entry Date:** ____/____/____

Initial US Entry Date: ____/____/____ **(if ELL)**

School Last Attended (if applicable): _____

Address: _____

Phone: _____ **Fax:** _____

PARENT/GUARDIAN INFORMATION

1st CONTACT	2nd CONTACT	3rd CONTACT
Legal Relationship to Student (ex. Father, Mother, Stepparent, Grandparent, Foster Parent, Significant Other, etc.)	**Legal Relationship to Student** (ex. Father, Mother, Stepparent, Grandparent, Foster Parent, Significant Other, etc.)	**Legal Relationship to Student** (ex. Father, Mother, Stepparent, Grandparent, Foster Parent, Significant Other, etc.)
Name:	**Name:**	**Name:**
Address:	**Address:**	**Address:**
***Home Phone:**	***Home Phone:**	***Home Phone:**
***Cell Phone:**	***Cell Phone:**	***Cell Phone:**
E-Mail Address:	**E-Mail Address:**	**E-Mail Address:**
Employer:	**Employer:**	**Employer:**
Address:	**Address:**	**Address:**
Occupation:	**Occupation:**	**Occupation:**
***Work Phone:**	***Work Phone:**	***Work Phone:**
Access to Student Info: Y N	**Access to Student Info: Y N**	**Access to Student Info: Y N**

Military Family: Y N (indicates parent/guardian is active duty military or full-time member of Reserves or Nat'l Guard)

***Enter "NA" after a telephone number to exclude it from the district's phone notification system.**

TRANSPORTATION INFORMATION

If Parent(s) Work, Babysitter's Name: _____

Babysitter's Address: _____

Babysitter's Telephone Number: _____

Provide location where child will board bus: _____

Bus Assigned: _____ **Bus Stop:** _____

LIST OTHER CHILDREN RESIDING AT PARENT/GUARDIAN ADDRESSES:

LAST NAME, FIRST NAME, MIDDLE NAME	DATE OF BIRTH	RELATIONSHIP TO PARENT/GUARDIAN	GENDER	RESIDES WITH	LAST SCHOOL ATTENDED	GRADE

IN ADDITION TO THOSE LISTED ABOVE, LIST OTHER INDIVIDUALS OVER THE AGE OF 18 RESIDING AT PARENT/ GUARDIAN ADDRESSES:

LAST NAME, FIRST NAME, MIDDLE NAME	RELATIONSHIP TO PARENT/GUARDIAN	OCCUPATION	PLACE OF EMPLOYMENT

TWO EMERGENCY CONTACTS (non-parent/guardian who may pick up the student if the legal parent/guardian cannot be reached)

NAME and RELATIONSHIP	ADDRESS	PHONE

Family Physician _____ **Phone** _____

Family Dentist _____ **Phone** _____

Part 1: Ethnicity (choose one) Hispanic/Latino Not Hispanic/Latino

Part 2: Race: (choose one or more, regardless of ethnicity)

American Indian/Alaskan Asian Black or African American Native Hawaiian or Other Pacific Islander White

Student resides with: (Circle all that apply) Both parents Mother Father Joint Custody Parent & Stepparent Foster Parent Grandparent Agency Relative Children's Home Other*_____

***If student resides with other, indicate name and relation to the child:** _____

Status of adult with whom student resides: Single Married Separated Divorced Widowed Living Together

Date of most current Court Orders/Custody Decrees: _____

PLEASE PROVIDE A COPY OF ANY COURT ORDERS/CUSTODY DECREES THAT PERTAIN TO STUDENT OR RESTRICT ACCESS TO STUDENT.

Immigrant: Yes_____ No____ **Education in US School since _____ grade.**

(Not attend US schools more than 3 full years)

Has your child ever received remedial tutoring or special education services? Yes_____ No _____
If yes, please circle the type(s) below and provide dates of service: From: ____/____/____ To: ____/____/____

IEP:

Autistic	**Learning Support (LS)**	**Occupational Therapy (OT)**
Emotional Support (ES)	**Life Skills Support (LSS)**	**Physical Therapy (PT)**
Gifted Support (GIEP)	**Multiple Disabilities Support (MDS)**	**Hearing-Impaired Support (HIS)**
Vision Impaired Support (VIS)	**Speech/Language Support (SLS)**	**Neurologically Impaired Support (NI)**

Each student will have access to an iPad or Chromebook. If the school allows devices to be taken home, will the student have reliable access to the Internet?
Yes_____ No____

_____
Parent/Guardian Signature

BIRTH RECORD VERIFICATION
BIRTHDATE:_____
BIRTHPLACE:_____
CERTIFICATE NO.:_____

STUDENT RESIDENCE VERIFICATION
TYPE OF VERIFICATION:_____
_____

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

Revised February 2017

SOUTH EASTERN SCHOOL DISTRICT

377 Main Street
Fawn Grove, PA 17321

Permission to Release Student Information

PLEASE FORWARD THIS FORM OR A COPY WITH THE STUDENT RECORDS

For disciplinary records, please check the appropriate box:

☐ Certified disciplinary record enclosed ☐ Student has no disciplinary record

The signature of the following individual certifies the disciplinary records enclosed are the true and accurate discipline records of the student indicated below.

_____ _____ _____
School Official Position Date

PSC 1305-A: Requires the receiving school district in the state of Pennsylvania to request certified disciplinary records from a student's former school district. Please accept this form as a request for certified disciplinary records.

1. Student's Name _____ Grade _____ Date of Birth _____

Date enrolled at South Eastern School District _____

2. I hereby give permission for _____
(Name of Previous School)

to release the following information to South Eastern School District, for above-named student(s). It is my understanding that all information will be utilized only by professional personnel to aid my child in his/her education program.

_____ Title I
_____ Reading Recovery
_____ IST
_____ 504 Plan
_____ Other
_____ **Pa Secure ID #**
_____ Psychological/Psychiatric Evaluations
_____ Comprehensive Evaluation Report (ER)
_____ Individual Educational Program (IEP)
_____ Notice of Recommended Educational Placement (NOREP)
_____ Cumulative File Date
_____ Health/Dental/Immunization Records
_____ Discipline Records (weapons, drugs/ drug/alcohol, violence)
_____ Standardized Test Scores
_____ Report Cards or Grades to Date
_____ Mutual Exchange of Information (including school counselors, school nurse, teachers, and administrators)

_____ _____
Signature of Parent/Guardian/Surrogate Parent Date

IT IS NOT NECESSARY FOR PARENTS TO SIGN A RELEASE WHEN RECORDS ARE BEING PASSED FROM PUBLIC SCHOOL TO PUBLIC SCHOOL.
Note Federal Register, Part II HEW—Privacy Rights of Parents and Students. Vol: 41,#118-24673

"99.31 prior consent for disclosure not required"
(a) An educational agency or institution may disclose personally identifiable information from the education records of a student without the written consent of the parent of the student or the eligible student if the disclosure is (1) to other school officials, including teachers, within the educational institution or local educational agency who have been determined by the agency or institution to have legitimate educational interests; (2) to officials of another school or school system in which the student seeks or intends to enroll, subject to the requirements set forth in 99.34.

The above information is to be sent to:

☐ Delta-Peach Bottom Elementary School
1081 Atom Road
Delta, PA 17314
Fax - 717-456-6042

☐ Fawn Area Elementary School
504 Main Street
Fawn Grove, PA 17321
Fax - 717-382-1326

☐ Stewartstown Elementary School
17945 Barrens Road North
Stewartstown, PA 17363
Fax – 717-993-5256

☐ South Eastern Intermediate School
417 Main Street
Fawn Grove, Pa 17321
Fax 717-382-4786

☐ South Eastern Middle School
375 Main Street
Fawn Grove, PA 17321
Fax – 717-382-9033

☐ Kennard-Dale High School
393 Main Street
Fawn Grove, PA 17321
Fax – 717-382-4258

PLEASE FORWARD THIS FORM OR A COPY WITH THE STUDENT RECORDS

SESD: 45 (06/15)

SOUTH EASTERN SCHOOL DISTRICT

STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren), and further help us determine if we have additional resources we can offer you and your family. 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 box below –

SECTION A	SECTION B
☐ In an emergency or transitional shelter, or awaiting foster care placement ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ☐ In a car, park, campground, temporary trailer, abandoned building or substandard housing ☐ In a hotel/motel CONTINUE to Section C if you checked any box in this section.	☐ 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, after signing the reverse side.

SECTION C

- What was the event that caused your family to move?

_____

- Do you consider this living situation to be a temporary situation, or something more long term?

Please
Explain:_____

_____

● When was the last day your son/daughter was enrolled in school?_____

3. Contact Number for the person completing this form:_____

4. The student lives with:

   Check all that apply
   □ Parent(s) or legal guardian
   □ Relative, friend(s), or other adult(s)
   □ Alone
   □ Other:_____

5. Contact person at school last attended (if known):_____

_____ _____

Signature of Parent/Legal Guardian ~ or individual enrolling child: Date

SOUTH EASTERN SCHOOL DISTRICT
Verification Under 24 P.S. 13-1304-A
Parental Registration Statement

I. Sworn Statement

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

_____ Telephone # _____

I hereby verify that my child has _____ or has not _____ been previously suspended or expelled from any public or private school in Pennsylvania or elsewhere 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 acknowledge that the foregoing statements are true and that the statements are made subject to the penalties of 18 Pa. C. S. §4904 (b) relating to penalties for unsworn falsifications to authorities.

_____ _____
(Signature of Parent or Guardian) (Date)

II. Supporting Information Complete this section if the child was previously Suspended or expelled for any offenses listed in Section I.

Name of School _____

Reason(s) for Suspension/Expulsion _____

_____

_____

Date of Suspension/Expulsion _____

_____

_____

SOUTH EASTERN SCHOOL DISTRICT
MEDIA RELEASE FORM

The South Eastern School District has numerous opportunities throughout the year to release pictures and/or news information about our students to the local newspapers, radio, television stations, and social media. The purpose of the pictures and information is to promote our District's programs and goals. If parents prefer that pictures of or information about their student not be used for these purposes, please complete this form and return to your student's school office. Videotaping and photographing of students by parents, guardians and school visitors during the school day is prohibited.

Please, do not include pictures of or information about _____
In any school media release. *(Print student's full name)*

School student attends:
___Delta-Peach Bottom Elementary
___Fawn Area Elementary
___Kennard-Dale High School
___South Eastern Intermediate School
___South Eastern Middle School
___Stewartstown Elementary

Parent Signature:_____ Date:_____

South Eastern School District - New Registrant Health Requirements

Dear Families:

We welcome you to the South Eastern School District. You will need to complete the following health requirements ***prior*** to your registration appointment.

- I**mmunization Record:**Your child's immunization record ***MUST*** be presented at (or before) your registration appointment; even if the record is incomplete. **ALL immunizations are required to be completed prior to the first day of school.** A complete list of the required immunizations can be found at the end of this packet.

- **Physical Exam-**required for students entering:
  Grades Pre-K/K, 6th and 11th or upon transfer from another school if there is no record of a physical exam.
  page 1- must be completed by parent/guardian prior to or at the registration appointment.
  page 2-4 must be completed by your healthcare provider

- **Dental Exam**-required for students entering:
  Grades Pre-K/K, 3rd and 7th or upon transfer from another school if there is no record of a dental exam.
  This form is to be completed by the family dentist. If your child does not have a dentist, we offer the opportunity to be examined by the school dentist (Family First Health) during the school day.

- **New Entrant Health Information**
  This form discusses important information about medication administration at school.

- **Checklist/Completion Plan**
  For upcoming appointments, please provide the required information on this form and submit it to the school nurse at registration.

Any physical or dental exam done after August 22, 2023, will meet Pennsylvania State requirements. **For appointments scheduled after registration, you will need to provide the date the exam is scheduled, and physician's name.** You may request that your child be examined by the school physician and/ or school dentist at your registration appointment.

Please submit the required documentation in one of the following ways:

1. Drop off, mail, email or fax to the appropriate school nurse as soon as possible.
2. Provide a copy at the registration appointment.

We look forward to working with you and your child. Please contact your child's School Nurse if you have any questions or concerns.

Sincerely,
SESD Certified School Nurses

Delta-Peach Bottom Elementary
Mrs. Amy Kinley
(717) 456-5313 ext. 5820
Fax: (717) 456-6042
kinleya@sesd.k12.pa.us

Fawn Area Elementary
Mrs. Beth Riale
(717) 382-4220 ext. 4820
Fax: (717) 382-1326
rialeb@sesd.k12.pa.us

Stewartstown Elementary
TBD
(717) 993-2725 ext. 8820
Fax: (717) 993-5256
gantzj@sesd.k12.pa.us

SEIS 5th/6th Grades
Mrs. Heather Miller
(717) 382-4851 ext. 3820
Fax:(717) 382-4786
millerh@sesd.k12.pa.us

SEMS 7th/8th Grades
Mrs. Lynn Keeny
(717) 382-4851 ext. 2820
Fax:(717) 382-9033
keenyl@sesd.k12.pa.us

Kennard-Dale HS
Mrs. Julie Beaver
(717) 382-4871 ext. 1820
Fax:(717) 382-4869
beaverj@sesd.k12.pa.us

South Eastern School District
New Entrant Student Health Information

Student Name: _____

Medical Insurance:

Is your student covered by
Health insurance? __*Yes*__ *No*
Dental insurance? __*Yes*__ *No*
Vision insurance? __*Yes*__ *No*

Sunscreen

Parents/guardians may choose to supply their child with non-aerosol topical sunscreen for use during school activities. Teachers and staff are ***not permitted to provide or apply sunscreen to students***. A school may cancel or restrict the possession, application or use of sunscreen if the student fails to comply with the appropriate use of the product. Please indicate below if your child has permission to use sunscreen during the school day or at school events.

_____ Yes, my student has permission to use non-aerosol sunscreen

_____ No, my student does NOT have permission to use non-aerosol sunscreen

Permission for non-prescription medications to be administered during the school day:

School personnel have my permission to administer the non-prescription medications I have checked below. If applicable, non-prescription medications will be administered by appropriate weight or age.

	Cough Drops		Antacid (liquid or tablet)
	Generic Advil/Motrin		Generic Tylenol
	Generic Zyrtec (to treat allergy symptoms)		Generic Benadryl (to treat allergy symptoms)

Transportation for Emergency Medical Care

Please note that in the event of a medical emergency, if parents or persons listed as emergency contacts cannot be reached, school personnel may need to arrange transportation for emergency medical care.

NOTE: PARENTS ARE RESPONSIBLE TO NOTIFY THE SCHOOL AS SOON AS POSSIBLE OF ANY CHANGES IN HEALTH, IMMUNIZATION STATUS OR CONTACT INFORMATION.

(2 page form - please complete both pages)

HEALTH HISTORY

Student Name: _____

TO THE PARENT OR GUARDIAN: The information requested on this form will be of help to the school nurse in determining the health status of your child. The information provided will be kept confidential and shared with school staff and bus drivers only when the school nurse and/or school physician believes that it is in the best interest of your child's health, safety and education. Please feel free to contact the school nurse if you have any questions or information you wish to share.	***Circle YES NO***
1. DOES YOUR CHILD *a) have any significant medical history (such as severe illness, injury, hospitalization, concussion, etc.)?* *If yes, please describe*_____	*YES NO*
b) currently receive treatment for any illness, injury, or operation? *If yes, please describe*_____	*YES NO*
2. SHOULD YOUR CHILD BE RESTRICTED FROM PARTICIPATION IN SCHOOL SPORTS OR GYM? *If yes, please provide recommendations from your physician, in writing.*	*YES NO*
3. DOES YOUR CHILD REQUIRE A SPECIAL DIET? *If yes, please specify*_____	*YES NO*
4. DOES YOUR CHILD HAVE ANY ALLERGIES WHICH REQUIRE ATTENTION AT SCHOOL? *If yes, prescription and nonprescription medication will be given in compliance with the school district's Medication Policy. A physician and parent will need to complete the Authorization for Medication Form. This form may also be obtained from the Nurse's Office.*	*YES NO*
5. IS YOUR CHILD PRESENTLY TAKING MEDICATION? (Please update as needed throughout the school year) *a) what kind*_____ *b) dosage required*_____ *c) for what reason*_____ *d) how long has child been taking medication*_____ *WILL HE/SHE NEED TO RECEIVE MEDICATION AT SCHOOL?* *If yes, medication will only be given in compliance with the school district's Medication Policy. Forms are available from the Health Room and should be completed and returned when medication is to begin.*	*YES NO* *YES NO*
6. HAS YOUR CHILD HAD ANY IMMUNIZATIONS DURING THE PAST YEAR? *If yes, please forward a copy to the school nurse.*	*YES NO*
7. HAVE THERE BEEN ANY CHANGES IN YOUR FAMILY DURING THE PAST YEAR WHICH MAY AFFECT YOUR CHILD? *If yes, please explain*_____	*YES NO*
8. DOES YOUR CHILD *a) have trouble seeing?* *b) need to wear glasses/contacts lenses?* *If yes please X all that apply: Needed for Constant Wear_____ Near Vision_____ Distant Vision____* *c) have trouble with ears or hearing?* *d) need to wear hearing aids/amplification system?* *e) is preferential seating required?*	*YES NO* *YES NO* *YES NO* *YES NO* *YES NO*
9. DO YOU HAVE ANY CONCERNS REGARDING YOUR CHILD TO DISCUSS WITH THE SCHOOL NURSE? *If yes, please call to set up an appointment.*	*YES NO*

My signature below indicates that I have read and understand the information on both sides of this form.

_____ _____

Date ***Signature of Parent / Guardian***

On behalf of the SESD School Health Services, thank you for taking time to complete this important information.

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

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

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

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) 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 (2/2023)

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 STUDENT			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	6C	7 D	8 E	9 F	10 G	11 H	12 I	13J	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
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

_____
Date of Dental Examination

_____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address of Dental Examiner

FAMILYFIRST
HEALTH

Dear Parent or Guardian,

Dentists from Family First Health will be coming to your child's school to provide the following services:

- Dental exams
- X-rays
- Dental cleaning
- Fluoride treatment
- Sealants
- Oral hygiene education

Please complete the attached consent form and return to the school nurse giving permission for your child to participate in the 2024-25 school year oral health program. Our dental staff plans to return to your child's school 3 to 4 times a year to provide the above listed services. This is all an effort to support your child's oral health.

For more information about these, and other Family First Health services, please contact us at (717) 845-8617. We look forward to seeing you!

FAMILYFIRST
HEALTH

Estimado Padre o Guardián,

Los profesionales de la salud dental de Family First Health estarán visitando la escuela de su niño(a) con el motivo de brindar los siguientes servicios:

- Exámenes
- Radiografias (Rayos X)
- Limpiezas dentales
- Tratamientos de Fluoruro
- Sellantes/Empastes
- Educación sobre la higiene dental

Por favor, complete el formulario adjunto y entrégueselo a la enfermera de la escuela. En esta forma usted estará autorizándonos a su niño(a) a participar en el programa de salud oral en el año escolar 2024-25. El personal dental volverá de 3 a 4 veces al año para ofrecer los servicios prestados. Esto es todo un esfuerzo para apoyar la salud oral de tu niño(a).

Para obtener más información sobre este y otros servicios de Family First Health, por favor comuníquese con nosotros al (717) 845-8617. ¡Con gusto le atenderemos en nuestro centro!

FAMILYFIRST HEALTH

Homeroom: _____

Dental Outreach Program Registration Form 2024-2025 School Year

Please print clearly in ink

Student's Legal Name: _____

Student's Date of Birth: _____

Student's Age: _____

Student's Social Security #: _____

Student's Gender at Birth (circle): Male / Female

Parent/Guardian Name: _____

(please circle) Mother / Father / Guardian

Address: _____

_____

Phone #: _____

☐ I consent to receive information about my child's dental care via text

Email Address: _____

Insurance Information

Dental Insurance Name: _____

Subscriber/Member ID: _____

Group # (if private insurance): _____

***If insurance is through parent:**

Member's Name: _____

Members Date of Birth:_____

Member's Social Security #: _____

Employer's Name: _____

Health History

When was your child's last dental exam: _____

Physician Name: _____

Please list health history and problems, including allergies (check all that apply):

- o Heart murmur
- o Asthma
- o Hemophilia
- o Allergies
- o Hepatitis A, B, C
- o Diabetes
- o HIV/AIDS
- o Seizures
- o ADHD/ADD or behavior problems
- o Sinus/nasal problems
- o Vision, hearing, or speech problems
- o Other: _____

_____

_____

Medications (circle): Yes / No

Please List: _____

_____

_____

At each visit we will ask if there are any changes to your child's health.

IMPORTANT

My child has permission to receive the following dental services during the 2024-2025 school year, offered by Family First Health dental staff: Dental exam, X-rays, dental cleaning, fluoride treatment, sealant, and dental hygiene education. The insurance card information provided for services rendered is my current insurance carrier. I authorize Family First Health to bill my insurance carrier for all services provided. If insurance does not cover the service, Family First Health will **not** bill the patient.

I have completed the registration form with all necessary information. I understand all services are provided in a caring and confidential manner. I agree to allow staff to share my child's medical history with Family First Health.

Parent/Guardian Signature: _____ Date: _____

Family First Health Dental Center Locations:

George Street Center, 116 S. George Street, York, PA - 717.845.8617
Hanover Center, 1230 High Street, Hanover, PA - 717.632.9052
Gettysburg Center, 1275 York Road, Gettysburg, PA - 717.337.9400
Columbia Center, 430 Walnut St, Columbia, PA - 717.356.2233

FAMILYFIRST HEALTH

Salon de clase:_____

Formulario de Inscripción del Programa Dental 2024-2025

Escriba en letra de molde con tinta

Nombre del Estudiante:_____

Fecha de Nacimiento: _____

Edad: _____

Número de Seguro Social: _____

Sexo al nacer (circule): Masculino / Femenino

Nombre del Padre/Guardián: _____

(Circule) Madre / Padre / Guardián

Dirección: _____

_____

Número de Teléfono: _____

☐ Doy consentimiento a recibir información sobre el cuidado dental de mi hijo a través de mensaje de texto

Método de Pago

Nombre del Seguro Dental: _____

Subscriptor/ID de Miembro: _____

Número de Grupo (Seguro Privado): _____

***Si el seguro es a través del padre/guardián:**

Nombre del Miembro: _____

Fecha de Nacimiento:_____

Número de Seguro Social: _____

Historial de Salud

Cuando fue el último examen dental del niño: _____

Nombre del médico: _____

Por favor indique el historial de salud incluyendo problemas médicos y alergias (marque todos los que apliquen):

o Soplo (Corazón)
o Asma
o Hemofilia
o Alergias
o Hepatitis A, B, C
o Diabetes
o VIH/SIDA
o Convulsiones
o ADHD/ADD* o problemas del comportamiento/salud mental
o Sinusitis/problemas nasales
o Problemas de la vista, audición, o el habla
o Otros: _____

_____

_____

Medicamentos (circule): Si / No

Por favor, enumere sus medicamentos:

_____

En cada visita le preguntaremos sobre cambios en la salud de su nino/niño(a).

IMPORTANTE

Mi niño(a) permiso de recibir los siguiente servicios dentales durante el año escolar 2024-2025, ofrecidos por el personal de la salud dental de Family First Health: exámenes dentales, radiografias(rayos X), limpieza dental, tratamiento de fluoruro, sellantes, y educación sobre la higiene dental. La tarjeta de seguro proveida para los servicios prestados representa mi compania de seguro actual. Autorizo a Family First Health a que facture mi compania de seguro por todos los servicios prestados. Si la compania de seguro no cubre los servicio, el paciente **no recibira** una facture.

He completado el formulario de registración con toda la información necesaria. Entiendo que todos los servicios se proporcionarán de manera confidencial. Estoy de acuerdo en permitir al personal que comparta el historial de salud de mi niño(a) con Family First Health.

Firma del Padre/Guardián: _____ Fecha: _____

Family First Health Dental Center Locations:

George Street Center, 116 S. George Street, York, PA - 717.845.8617
Hanover Center, 1230 High Street, Hanover, PA - 717.632.9052
Gettysburg Center, 1275 York Road, Gettysburg, PA - 717.337.9400
Columbia Center, 430 Walnut St, Columbia, PA - 717.356.2233