



WELCOME TO THE NORTH EAST SCHOOL DISTRICT

NEW STUDENT REGISTRATION REQUIREMENTS

The following items are required for the registration and entry of a student 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: _____ Grade to be enrolled in: _____

School student is leaving: _____ School Phone #: _____

School City: _____ School State: _____ School Fax #: _____

Grades 7-12 Only: Please list previous PIAA Extracurricular participation (i.e., sport, band, etc.) _____

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"/> Elementary School Grades K-5 50 E. Division St. North East, PA 16428 Fax: 814-725-8643 (K-2) Carol Komorowski – Ext. 3052 ckomorowski@nesd1.org (3-5) Sue Beardsley – Ext. 3000 sbeardsley@nesd1.org	<input type="checkbox"/> Middle School Grades 6-8 1903 Freeport Rd. North East, PA 16428 Fax: 814-725-1086 Michele Seth – Ext. 2003 mseth@nesd1.org	<input type="checkbox"/> High School Grades 9-12 1901 Freeport Rd. North East, PA 16428 Fax: 814-725-3357 Amy Bement – Ext. 1006 abement@nesd1.org	<input type="checkbox"/> Special Education Grades K-12 50 E. Division St. North East, PA 16428 ATTN: Special Education Dept. Fax: 814-347-0043 Taylor Teel – Ext. 3027 tteel@nesd1.org
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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

NEW STUDENT EMERGENCY INFORMATION

STUDENT # _____

HOMEROOM _____

LOCKER # _____

STUDENT NAME _____ DOB _____ GRADE _____

N.E. STREET ADDRESS _____ PRIMARY PHONE# _____

Primary Custodial Parent/Guardian(s) – Primary Contacts that the student lives with:

Parent/Guardian #1 Name:			
Email		Cell Phone #	
Employer		Work Phone #	
Parent/Guardian #2 Name:			
Email		Cell Phone #	
Employer		Work Phone #	

Non-Custodial Parent – Parent that the student does NOT live with full time, if applicable:

Name	Phone #		
Address			
May Pick Up :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

LOCAL emergency contacts (persons not living in the student's household):**To be contacted if parent/guardian(s) are unable to be reached**

	Name	Relationship to student	Phone #	May Pick up Student in case of Emergency	
E1				Yes <input type="checkbox"/>	No <input type="checkbox"/>
E2				Yes <input type="checkbox"/>	No <input type="checkbox"/>
E3				Yes <input type="checkbox"/>	No <input type="checkbox"/>

AUTOMATED MASS MESSAGING SYSTEM

Please designate at least one phone number to receive automated messages from the mass messaging system in event of weather-related school closings or delays, or similar mass notifications.

This is normally the parent/guardian and/or home number. Please do NOT list student names or phone numbers. Student cell phones will not be entered for messages.

Adult Contact Name (Please Print)	Phone Number with Area Code	*Text Messages?	
		Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

For High School Students Only:

In the event that my high school student listed above has a personal mode of transportation (such as a motor vehicle or bike) at school when an evacuation is necessary, I authorize him/her to use the personal mode of transportation for evacuation travel purposes and also to transport other immediate family members if feasible: ☐ YES ☐ NO

SIGNATURE OF PARENT/GUARDIAN

DATE

PRIMARY PHONE NUMBER

**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
_____Teacher

_____Counselor
_____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 (6th-12th grade ONLY)

Tylenol (6th-12th 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 30th 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 COMPLETEDRules 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 _____

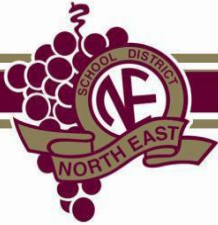
Parent Signature _____

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 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 30th 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 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: <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. FEMALES ONLY: 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 ☐ No ☐

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

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

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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
<div> <div>_____</div> <div>_____</div> <div>_____</div> </div> <div>LastFirstMiddle</div>				<input type="checkbox"/> <input type="checkbox"/> M F			

ADDRESS

No. and StreetCity or Post OfficeBorough or TownshipCountyStateZip

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