HEMPFIELD AREA SCHOOL DISTRICT
4347 Route 136, Greensburg, PA 15601-9315
(724) 834-2590

Dr. Barbara J. Marin
Superintendent
Dr. Mark A. Gross
Assistant Superintendent
Secondary

Dr. Tammy S. Wolicki
Assistant Superintendent
Elementary
Mr. Wayne J. Wismar
Business Manager

Committed to Educational Excellence

Dear Parent/Guardian:

The Hempfield Area School District will conduct kindergarten and first grade registration for the 2016-2017 school year during the month of February. Children entering kindergarten must be five (5) years old and children entering first grade must be six (6) years old, by August 31, 2016 in order to qualify for enrollment. Children who currently attend kindergarten in the Hempfield Area School District have already been registered for first grade.

Registration will take place at each elementary school. If you are unable to attend on the date scheduled for the school in your attendance area, you may register at an alternate location and your child's records will be forwarded to his/her home school. For your convenience, each school will host both a daytime and early evening registration. Below is the kindergarten registration schedule.

You are reminded to bring your child's birth certificate, a record of current immunizations, and <u>two</u> proofs of residency. Please bring two of the following: your photo driver's licenses, current utility bill, a residence lease or sales agreement, insurance card, wage tax statement, pay check stub. We strongly urge you to register your child in February, since it aids the school district with our enrollment and staffing projections.

School	Daytime Registration	Evening Registration
Fort Allen Elementary Principal: Mrs. Marty Rovedatti-Jackson rovedattim@hasdpa.net (724) 850-2501	February 19, 2016 9:30 AM-3:00 PM	February 18, 2016 4:30 PM-6:30 PM
Maxwell Elementary Principal: Mrs. Alene Mancini mancinia@hasdpa.net (724) 850-3500	February 17, 2016 9:30 AM-3:00 PM	February 16, 2016 4:30 PM-6:30 PM
Stanwood Elementary Principal: Dr. Raymond Burk burkr@hasdpa.net (724) 838-4000	February 26, 2016 9:30 AM-3:00 PM	February 25, 2016 4:30 PM-6:30 PM
West Hempfield Elementary Principal: Mr. Randall Sarnelli sarnellir@hasdpa.net (724) 850-2780	February 17, 2016 9:30 AM-3:00 PM	February 18, 2016 4:30 PM-6:30 PM
West Point Elementary Principal: Mrs. Audrey Dell della@hasdpa.net (724) 850-2270	February 23, 2016 9:30 AM-3:00 PM	February 24, 2016 4:30 PM-6:30 PM

It will not be necessary for you to bring your child to registration. Kindergarten transition activities will be held in early March through August and will be held at each individual school. Building principals will provide you with more detailed information about these activities at a later date. If you have questions, please don't hesitate to contact your child's principal at the phone number listed above.

Sincerely,

Tammy S. Wolicki, Ed.D.
Assistant Superintendent for Elementary Education

School Board

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Solicitor

STUDENT ENROLLMENT FORM

Child's Legal Name (*Last, First, Middle*) _____ Birth Date _____ ☐ M ☐ F Gender _____ Grade _____

Address (House Number, Street, City, Zip Code) _____ List PO Box (if used for mailing) _____

Home Phone _____ Cell Phone _____ ☐ Yes ☐No Web Access Email _____

Ethnicity: Hispanic/Latino ☐ Yes ☐ No **Check if applicable**: ☐ Migrant ☐ Refugee ☐ Foreign Exchange

Race: ☐ White/Caucasian ☐ Black/African American ☐Asian ☐American Indian/Alaskan ☐ Multi Racial
☐ Native Hawaiian/other Pacific Islander

NATIVE LANGUAGE: ☐ English ☐ Spanish ☐ Japanese ☐ Chinese ☐Hindi ☐Other _____

FAMILY INFORMATION: (provide address if different from above)

Father	**Work #**	**✓ if lives w/child**	**✓ if deceased**
		☐	☐
Mother			
		☐	☐
Step Parent / Foster Parent / Guardian(s)			
		☐	☐
Other Caretaker or Adult in the home 18 and above			
		☐	☐

Has child ever attended this District before? ☐ Yes ☐ No If Yes, what year and school? _____

Previous School/District: _____ Date Entered 9th Grade: _____

CHECK ALL THAT APPLY

☐ Remedial Reading ☐Remedial Math ☐Speech ☐Special Education/IEP ☐Gifted ☐ 504 Agreement

Legal Custody/Court Document/Special Arrangements (Please list): _____

Special Health Issues/Concerns/Medical Instructions (be specific): _____

If Foster Child, list Agency Name and Telephone Number: _____

LIST OTHER PRE-SCHOOL OR SCHOOL AGE CHILDREN NOT ATTENDING HEMPFIELD SCHOOLS:

Name (l*ast, first, middle*)	Relationship to Child	Birth Date	Gender	Grade	School Attending

Signature of Parent or Guardian: _____ ***Date***: _____

OFFICE USE

☐ Affidavit of Guardianship ☐ Affidavit of Multiple Occupancy ☐ Non-Resident or Foster

Student Number: _____ Code: E ___ R ___ Grade Assigned _____ Building Assigned _____ Room_____

Verification of Birth _____ Immunization Verification _____ Act 26 Sworn Parent Statement _____

Previous School/District: _____

Phone _____ Fax _____ Withdraw Date _____

New Enrollment Date: _____ Entry Date: _____ Records Requested: _____ Received: _____

Bus Stop:_____ Bus Number: _____ AM _____PM

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HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

School District: Hempfield Area School District **Date**:_____

School: Maxwell Elementary

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

1. What is/was the student's first language? _____
2. Does the student speak a language(s) other than English?
   (Do not include languages learned in school.)

   ☐ Yes ☐ No

   If yes, specify the language(s): _____
3. What language(s) is/are spoken in your home? _____
4. Has the student attended any United States school in any 3 years during his/her lifetime?

   ☐ Yes ☐ No

   If yes, complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Parent/Guardian signature: _____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.

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HEMPFIELD AREA SCHOOL DISTRICT

Preschool Information Summary

Child's Name _____

Does your child have preschool or daycare experience?

☐Yes ☐No

Period of time your child attended preschool or day care:

☐6 months ☐1 year ☐2 years ☐3years ☐Other

Preschool or daycare your child attended:
Preschool Name _____
Street _____
City, State & Zip_____

I hereby give permission for the Hempfield Area School District to contact the preschool or agency designated above to request the following school-related information:

☐ School Records including grades, progress reports, grade level completed attendance record, etc.

☐ Achievement tests results

☐ Special education records including speech & language, hearing, vision etc.

☐ Immunization and other health records

These reports are to be used only for professional purposes and are to be kept strictly confidential in accordance with the Hempfield Area School District's Student Record Procedures.

Parent/Guardian Signature: _____ Date: _____

Mail records to: Maxwell Elementary School
1101 Old Salem Road
Greensburg, PA 15601

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Dear Parent/Guardian:

Welcome to the Hempfield Area School District. The law requires that a parent or guardian show duly certified evidence of age, 2 proofs of residency, and immunization for all children entering school. This applies to both kindergarten and first grade students who are entering the Hempfield Area School District for the first time.

DOCUMENTATION OF AGE MAY BE SATISFIED BY:

- Birth Certificate
- Baptismal Certificate
- Notarized statement from parent indicating date of birth
- Certified transcript of birth which appears satisfactory to the local school --- if none of the above proofs are obtainable

If you do not have an official birth certificate, one may be secured from the Division of Vital Statistics, P.O. Box 1528, South Mercer Street, New Castle, PA 16101.

2 PROOFS OF RESIDENCY MAY BE SATISFIED BY:

- Driver's License
- Mortgage agreement or deed (or mortgage book) in your name
- Current lease for rental property in your name
- Wage tax statement
- Utility bill (within 30 days) in your name with current address
- Pay check stub (within 30 days) with your address

VERIFICATION OF THE FOLLOWING IMMUNIZATIONS MUST BE PRESENTED:

- 4 doses of Tetanus and Diptheria (DTP, DTaP, DT, or Td) -properly spaced with 1 dose on or after the fourth birthday
- 3 doses of Polio (OPV, E-IPV) -properly spaced
- 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella (preferably given as MMR) -first dose at twelve months of age or older, or Measles and/or Rubella immunity proved by laboratory test or a physician's written diagnosis of Mumps
- 3 doses of Hepatitis B (Hep B) -properly spaced
- 2 doses of Varicella (Var) Chickenpox -or Chickenpox immunity proven by laboratory test, or a written statement of history of Chickenpox disease from a parent, guardian, or physician

If your child has not been protected, please make arrangements with your family physician to have this done as soon as possible. **If there is any medical reason why your child should not be fully immunized, please bring a certificate from your physician stating the reason.** If you object to immunizations for religious reasons, the state requires that you sign a form that can be provided to you by the school nurse.

If you have any questions about these guidelines, please do not hesitate to contact the school nurse or building principal.

Sincerely

Tammy S. Wolicki, Ed.D.
Assistant Superintendent for Elementary Education

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For Office Use Only

_____

Student Number

HEMPFIELD AREA SCHOOL DISTRICT
STUDENT TRANSPORTATION REGISTRATION FORM

Please check the appropriate level: Kindergarten ☐ First Grade ☐

Child _____ _____
(Last Name) (First Name)

Birthdate _____ Sex _____

School your child will attend _____

Parent _____ _____
(Last Name) (First Name)

Telephone _____

Address _____

Please be aware that Hempfield Township has eliminated all RD addresses. The address that you provide must contain a house number and street name. If you do not know your new address, please contact the Hempfield Township Supervisor's office at 724-834-7232.

Location of your residence: _____
(Examples: Foxtown, Swede Hill, Middletown, Placid Manor, Farmbrook, etc.)

My child will (check one): Ride the bus ☐ Carpool ☐

List any special transportation concerns/needs such as: (special vans, daycare centers, sitters, etc.):

_____

On the back of this sheet, please circle the bus stop closest to your home, even if your child will not be taking the bus.

MAXWELL

ACADEMY HEIGHTS X BLANKSCHOOL RD
515 AMBERSON PL
AMBERSON X SOUTHFIELD
23 BARNHART
80 BARNHART RD
113 BASHFORTH
BASHFORTH DR X WHEATRIDGE DR (PUMP)
916 BEACON VALLEY RD
BEECH HILLS RD X CLEMENS DR
BEECH HILLS RD X DALLAS DR
BEECH HILLS RD X LAKEVIEW AVE
BEECH HILLS RD X TODD
BEECHWOOD DR X Shutt Rd X Sarver Rd
BLANK SCHOOL RD X BEACON VALLEY RD
BOQUET ST X COURTVIEW (TOP)
598 Bovard Luxor Rd
636 BOVARD LUXOR RD
708 BOVARD LUXOR RD
851 BOVARD LUXOR RD
BOVARD RD X LAURENTZ LA (PINEVIEW)
223 BRAVEHEART DR
BROOKVIEW DR X FOREST HILLS DR
BURAK X JEFFERSON ST (BOVARD STORE)
1214 BUSINESS ROUTE 66
CARE BEAR DAY CARE
908 CASTLEGATE CIR
929 CASTLEGATE CIR
CASTLEGATE CROSSROADS
119 CHAPEL VIEW DR
CHAPEL VIEW DR X CHURCHHILL DR
713 COURTVIEW DR
732 COURTVIEW DR
133 CRAIG DR
Crest View Dr X Union Cemetery Rd
Deerfield Dr X Franconia Dr
DEERFIELD X MARLBORO
338 Downes Rd
DOWNES RD X ECHO VALLEY RD
DOWNES X WILLOWOOD
ECHO VALLEY X LOCUST VALLEY
ESSEX DR X CADDY DR
EVERGREEN RD X NORTH DR
FINK LN X RT 66
335 FORBES RD
FORBES RD X RT 1055
125 FORBES TRAIL RD
299 FORBES TRAIL RD
597 FORBES TRAIL RD
603 FORBES TRAIL RD
740 FORBES TRAIL RD
FOREST HILLS DR X TERRACE VIEW DR
FOXBORO X TIMBER TRAIL DR
FRANCONIA DR X DEERFIELD DR (NEAR RT 66)
168 FRONT ST
258 Front St
GAELIC X BRODIE
439 Glenmeade Rd
295 GLENN AVE
GLENN AVE @ 3RD HOUSE
GLENN AVE X HARROLD ST
GOODRIDGE X POPLAR
HAMPSHIRE DR X DARTMOUTH DR
HANNASTOWN DR X CADDY
HANNASTOWN POST OFFICE
735 HARVEY AVE
751 Harvey Ave
HORSEHOE TRAIL X TIMBER TRAIL
KEMERER DR X LEJUNE DR
KEMMERER X McCABE
338 LEJEUNE DR
728 LINDWOOD DR
LINWOOD X GATEWAY
218 LOCUST VALLEY
439 LOCUST VALLEY RD
MATHEWS X TIMBER TRAIL (FOX RIDGE)
McDonald LN X RT 66
224 MCILVAINE RD
337 MCILVAINE RD
MEADOW LANE DR X HUNTING RIDGE DR
MEADOWOOD DR X WILLOWOOD RD
212 MURDOCK WAY
222 MURDOCK WAY
312 MURDOCK WAY
MURDOCK WAY X SOUTHFIELD DR
MURDOCK X RALEIGH
122 N LOCUST DR
308 NORTH DR
120 Oakford Park Rd
OAKFORD PARK RD X MOLLICK LN
547 Old Route 66
657 OLD ROUTE 66
Old Route 66 X MEADOW LARK LN
586 Old RT 66
729 OLD RT 66
737 Old RT 66
OLD RT 66 X ALBERTA LN
Oxford Dr X Union Cemetery Rd
47 Peters Rd
53 PETERS RD
318 PLEASANT VALLEY RD
PLEASANT VALLEY RD X KENTWOOD DR
PLEASANT VALLEY RD X WEBER RD
PLEASANT VALLEY RD X WOODHAVEN DR
551 POPLAR DR
PRISANI ST X JEFFERSON ST
606 RIDGEWOOD DR
621 RIDGEWOOD DR
1762 Route 119
1902 ROUTE 119 (O'BROCHTA)
ROUTE 66 X FAWN LN
RT 119 X VICTORY
751 SAGAMORE DR
SAGAMORE X Kettering
228 Shutt Rd
297 SHUTT RD
SHUTT RD X FORBES
434 SOUTHFIELD
SOUTHFIELD X MURDOCK WAY
1740 State Route 66
STIRRUP DR @ CORNER
STIRRUP DR X TIMBER TRAIL
STIRRUP RD X TALLY HO DR
STIRRUP X FOXBORO
173 STONEY SPRING RD
311 STONEY SPRINGS RD
STONEY SPRINGS RD X HIMLER RD
10 SURREY DR
24 SURREY DR
SURREY DR X HUNTING RIDGE DR
110 TARTAN
104 TARTAN DR
120 TARTAN DR
TARTAN DR X BRAVEHEART DR
THIRD ST X CHIPPY LN
17 TIMBER TRAIL DR
720 UNION CEMETARY (MURPHY)
972 UNION CEMETERY RD
UNION CEMETERY RD X CADDY DR
Union Cemetery Rd X KETTERING ST
VAN AVE X LEJEUNE DR
VAN AVE X LOCUST VALLEY
WEDGEWOOD CT X WOODHAVEN DR
10 WINDIHILL
18 WINDIHILL
23 WINDIHILL
WOODHAVEN DR X SARAH CT
WOODLAWN RD X LOCKWOOD DR
Woodlawn Rd X UNDERWOOD AVE

HEMPFIELD AREA SCHOOL DISTRICT
STUDENT TRANSPORTATION DEPARTMENT
4347 Route 136, Greensburg, PA 15601
PHONE: 724-523-8600 FAX: 724-523-8675

LONG TERM REQUEST FOR SPECIAL TRANSPORTATION ARRANGEMENTS

- **ALL REQUEST FOR SPECIAL TRANSPORTATION ARRANGEMENTS** must be submitted to Mr. Leonard Coniglio at the Transportation **Office no later than August 1, 2016**. The form to make this special request is available in the school office or at the Transportation Department
- **Arrangements previously in effect for the 2015-2016 school year will not be continued unless the Student Transportation Office has been notified in writing, prior to the start of the 2016-2017 School Year.**
- If a change in childcare arrangements occurs during the school year, a request for a change in student transportation **MUST BE SUBMITTED IN WRITING** at least (3) days in advance of the date of the requested change to the Transportation Office.
- **Childcare providers must be located within the attendance boundaries of the school to which your child is enrolled and they must be located on an established bus route.**
- You may have the option of having the bus deliver your child to a different location from where he/she was picked up; however this location must remain the same for every day of the week.
- Emergency situations will be handled on a case by case basis. The student will be required to obtain a bus pass for changes in bus assignment or stop locations. Parents should contact the building principal in order for the student to obtain the pass.
- If you have any questions about this procedure, please contact Mr. Leonard Coniglio at the Transportation Office at (724) 523-8600.

(over)

HEMPFIELD AREA SCHOOL DISTRICT

LONG TERM REQUEST FOR SPECIAL TRANSPORTATION ARRANGEMENTS

Please complete the information on the form below and forward it to:

HEMPFIELD AREA SCHOOL DISTRICT
4347 ROUTE 136, GREENSBURG, PA 15601
ATTN: STUDENT TRANSPORTATION DEPARTMENT

Student's Name: _____

School: _____

Grade _____ School Year: _____

Home Address: _____

_____

Parent/Guardian's Name: _____

Phone Number: _____ _____

Home _____ Work _____

Child Care Provider's Name: _____

Child Care Provider's Address: _____

Child Care Provider's Phone Number(s): _____

I request special transportation arrangements for child care purposes based on the information below:

❑ Morning Transportation Only

Pick-up at _____

Bus Stop Location: _____

❑ Afternoon Transportation Only _____

Drop-off at _____

Bus Stop Location: _____

❑ Transportation to same address both morning and afternoon

Pick-up and drop-off at _____

Bus Stop Location: _____

Starting Date: _____

Action Taken:

❑ Approved: Child will ride Bus _____AM Pick Up Time: _____ Bus Stop: _____

Child will ride Bus _____PM Drop Off Time: _____ Bus Stop: _____

❑ Request Denied

Copies to: Transportation, Parent, Principal

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_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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 ☐**

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

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

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

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

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

HEMPFIELD AREA SCHOOL DISTRICT
STUDENT HEALTH HISTORY

Student's Name (Last, First, Middle)	Date of Birth	Sex M☐ F☐	
		Grade	Homeroom

To the best of your knowledge, does your child have a history, a need, or a concern with the following:

Health Item	Yes	No	Please Comment
Hospitalizations			
Surgery			
Concussion (Head Injury)			
Fractures			
Lead Poisoning			
Eye or Vision Problems			
Ear or Hearing Problems			
Speech Problems			
Cerebral Palsy			
Meningitis			
Heart Problems/Heart Murmur			
Serious Allergic Reactions (food, insects, medications, etc.)			If yes, what type of reaction & treatment:_____
Behavior or Emotional Problems			
Attention Deficit Disorder			
Asthma			If yes, does your child have/use an inhaler?_____
Sickle Cell Anemia			
Diabetes			
Cancer			
Seizure Disorder			
Bleeding Problem (i.e. hemophilia, nosebleeds)			
Limits on Activity			
Bladder or Urinary Problems			
Currently taking medication			Please give name of medication: _____
Medication needed during school hours/school activities			Please give name of medication: _____
Other health concerns/needs			

_____ _____

Parent's Signature Date

Hempfield Area School District
Emergency Cards

HR: _____ Grade: _____ Sex: _____
Bus #: AM_____ PM _____
Custody Issue_____

Student Name: _____ Date of Birth: _____
Home Address_____
Home Phone_____

Guardian 1: Parent Name	Home Phone	Cell Phone

Employer	Employer's Phone

Email Address

	Guardian 1 Lives at the same address
	Yes☐ No☐

Guardian 2: Parent Name	Home Phone	Cell Phone

Employer	Employer's Phone

Email Address

	Guardian 2 Lives at the same address
	Yes☐ No☐

Custody Agreement: Yes ☐ No ☐ Custody Agreement on File: Yes ☐ No ☐
Special Custody Considerations:

Emergency Contacts:

Name	Phone	Relationship

Name	Phone	Relationship

Medical Alert Information

Medical Conditions: _____

Other existing conditions: _____

My Child is on medication for: _____
Name of Medication: _____ Required during school hours: Yes ☐ No ☐

Physician: _____ Phone: _____
Dentist: _____Phone: _____

I have read the attached standing orders for my first aid and student care to be followed by the school nurse, assistant school nurse or designated school personnel.

1. ☐ I approve for my child
2. ☐ I do not approve
3. ☐ I approve with these exceptions _____

Signature of Parent_____ Date: _____

HEMPFIELD AREA SCHOOL DISTRICT
POLICY REGULATING ADMINISTRATION OF MEDICATIONS AND TREATMENTS BY SCHOOL NURSE

STANDING ORDERS FOR FIRST AID AND STUDENT CARE

PROBLEM (Condition)	TREATMENT
Pain: Mouth Ulcer	Orastat or Orabase with benzocaine to affected area
Minor Sore Throat	Warm saline gargle,1/2 tsp of salt per. 8 ounces of water
Burns: First degree, minor second degree	Bacitracin ointment or Bacitracin Zinc, apply topically
Skin: Irritation: poison ivy, mosquito bites, etc.	*Calamine, apply topically to affected area *Clear Caladryl, apply topically to affected area
Abrasions, minor lacerations	Bacitracin ointment ,apply topically, sterile dry dressing after cleansing with Dial antibacterial soap – hydrogen peroxide
Dry skin	Vaseline Intensive Care Lotion, apply topically to affected area Eucerin, apply topically to affected area
Mouth: Toothache/Pain	Orajel or Orastat with benzocaine, apply to affected area
Canker sores/cold sores	Orabase or Orastat with benzocaine, apply to affected area
Eye Irritation: Soft contact lenses	Water irrigation Saline Solution for rinsing soft lenses
Allergic reaction: Localized reaction to insect sting, food, or medication	*Sting-Kill swabs, apply topically to sting sites *Benadryl orally (age/weight appropriate dose)
Systemic Reaction	Epipen/Epipen Jr - following directions. Epipen Jr if wt. < 70 lb. Transport to hospital via ambulance
Infectious Process: Temperature (oral) >= 102.5 F. Parent will be requested to take student home.	*Tylenol—orally--every 4-6 hours 36 – 47 lbs. 240 mg. 48 – 59 lbs. 320 mg. 60 - 71 lbs. 400 mg. 72 – 95 lbs. 480 mg. 96 lbs and over 650 mg.
Parents will be notified if their child requires medication and/or ambulance transport to a hospital.	

The above standing orders are in addition to treatment as outlined by American Red Cross Standard First Aid. If symptoms persist, physician follow-up is suggested.

*Generic equivalent may be used.

6/9/15

Dr. James Mastersen, 724-689-1070 Date
School Physician for Hempfield Area School District