2013-14 Kindergarten or First Grade Registration

Site based registration dates are 8:00 AM – 5:00 PM as follows:

Monday, March 4, 2013	Penn Lincoln, Washington-Jefferson, Juniata Gap
Tuesday, March 5, 2013	Baker, Juniata, Wright
Wednesday, March 6, 2013	Logan and Pleasant Valley
Thursday, March 7, 2013	McAuliffe Heights and Ebner

Please note that children living in the former Irving School attendance area are now in the Juniata Gap attendance area.

WHAT THE PARENT NEEDS TO BRING – (THE PARENT OR LEGAL GUARDIAN MUST REGISTER THE CHILD)

A. **Proof of age** is required by State Law and this must be presented at time of registration. An official certificate of birth is preferred. If this is not available, please bring a hospital certificate, baptismal certificate or the ORIGINAL notarized statement indicating name, date of birth, and place of birth.

B. Parent or Guardian **Photo I.D**.

C. If an adult other than the parent is registering the child, a copy of the **guardianship papers** or a sworn affidavit must be presented at registration. This copy will be kept by the school district.

CHILDREN WILL NOT BE REGISTERED WITHOUT PROPER AUTHORIZED FORMS.

D. **Current custody papers**, if applicable.

E. **Proof of Residency** – Current lease, utility bill or photo I.D. with correct address.

F. It is MANDATORY that all children starting school have their **immunizations** of:

*Diptheria and Tetanus (4 or more doses of DPT, Td, or DT, or any combination of these with the last dose given after the age of four (4) years).

*Poliomyelitis (3 doses of oral vaccine or 4 doses of inactivated vaccine).

*Measles, Rubella, and Mumps (two doses of measles vaccine preferably given as a second dose of Measles, Mumps, and Rubella (MMR). The Measles, Rubella and Mumps inoculations must be given at age 12 months or older.

*Hepatitis B vaccine (three properly spaced doses)

*Chickenpox vaccine (2 doses as per Dept. of Health requirement) or date of disease

Please contact the Pa. Dept. of Health, Cricket Field Plaza, at 946-7300. Immunizations are given there by appointment only or contact your child's pediatrician.

PARENTS MUST BRING THE CHILD'S SHOT RECORD WITH THEM AT THE TIME OF REGISTRATION

G. **Social security numbers** are helpful.

ALTOONA AREA SCHOOL DISTRICT
Student Health Services
STUDENT HEALTH HISTORY

Child's Full Name:_____ Birthday: _____/ _____/ _____
Last First Middle Month Day Year

Address:_____ Telephone#:_____
_____ Place of Birth:_____

Father's Name:_____ Occupation:_____
Mother's Name:_____ Occupation:_____
Guardian's Name:_____ Occupation:_____

Give names and birth date of other children in the family:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents are: ___Married ___Single ___Divorced ___Separated ___Widowed
Child is living with: ___Mother ___Father ___Both ___Guardian (Name please): _____
If living with guardian, what is relationship to the child?_____
Have any members of the immediate family died? (Do not include miscarriages.) ___Yes ___No
How many people live in the same household as the child?_____
Are there any problems such as housing, employment, food, etc…?_____
Has this child attended: ___Headstart ___Pre-School (where)_____

Child's Physician:_____ Child's Dentist:_____

Does your child have any special health needs or problems that will require attention or assistance in school?
_____

Does your child need a special diet or have any food problems? (Give details):_____
_____

Is there any reason why your child should not participate in physical education classes? (Give details)_____
_____

Is your child taking any medications other than vitamins, regularly? Give name of medication/s and reason._____
_____

Is your child presently being treated for any health problems? (Give details):_____
_____

MEDICAL HISTORY: (Check any of the following your child has had and appropriate age.)

___Chickenpox_____
___Measles (Regular)_____
___Rubella (German Measles)_____
___Mumps_____
___Whooping Cough_____
___Scarlet Fever_____
___Rheumatic Fever_____
___Lead Poisoning (Highest Level)_____
___Pneumonia_____
___Seizures (Epilepsy)_____
___Convulsion (High Fever)_____
___Head Injury_____
___Eye Surgery_____
___Tubes in ears_____
___Tonsils removed_____

Does your child have complete bowel and bladder control?_____
Has your child ever been hospitalized or had an operation? (If Yes, When, where, for what?)_____
_____
Has your child had any serious illness, accident, or broken bones? (If Yes, when, where, what?)_____

---CONTINUED ON REVERSE SIDE---

Check any of the following your child has had:

___Frequent colds/sore throats_____
___Frequent ear infections_____
___Visual problems/glasses_____
___Dental problems_____
___Frequent headaches_____
___Frequent "belly aches"_____
___Swelling of joints_____
___Pain in arms or legs_____
___Fainting spells_____
___Urinary/Bladder problems_____
___Bowel problems_____
___Other_____

___Speech problems_____
___Trouble breathing thru nose_____
___Snores at night_____
___Trouble sleeping_____
___Skin problems_____
___Eczema_____
___Asthma/wheezing_____
___Allergies (note type below)_____
Food_____
Medicine_____
Insects_____
Other_____

Does child fall, stumble or bump into things frequently?_____

PRE-NATAL HEALTH HISTORY:

Did mother have any illnesses during pregnancy?:_____
Did mother take any medications or drugs (other than iron or vitamins) during pregnancy?_____
Was the mother hospitalized for any problems during pregnancy?_____

BIRTH OF CHILD: (Check any that apply)

Number of hours in active labor:_____

___Instrument delivery
___Caesarean (C-Section)
___Premature (how much?)_____
___Breech birth
___Jaundice
___Overdue (how much?)_____
___Oxygen after birth
___In incubator

DEVELOPMENTAL HISTORY:

Birth weight:_____
Did your baby have any trouble while in the hospital?_____
Did your baby have any problems during the first six months?_____

Approximate age:
_____sat alone without support
_____ walked alone without support
_____dressed self
_____stopped wetting the bed at night
_____stood alone without support
_____ spoke two to three words together
_____toilet training was complete

How do you feel your child's development compares with other children such as brothers or sisters?
____Same ____Slower ____Faster

FAMILY HISTORY: (Place an "X" in the box next to any problems the child's parents, grandparents, aunts, uncles, sisters, or brothers have had and indicate the relationship in the space provided.)

❒Allergies_____
❒Anemia_____
❒Asthma_____
❒Cancer_____
❒Diabetes_____
❒Epilepsy/siezures_____
❒Drug/Alcohol Addiction_____
❒Eye disease_____
❒Hearing problems_____
❒Heart disease_____
❒High blood pressure_____
❒Kidney problems_____
❒Lead poisoning_____
❒Learning problems_____
❒Multiple sclerosis_____
❒Muscular dystrophy_____
❒Nervous breakdown_____
❒Sickle cell_____
❒Tuberculosis_____
❒Other_____

Is there anything else you would like us to know about your child?_____
_____

_____ Date:_____
Signature of Parent or Guardian

IT IS ACKNOWLEDGED AND AGREED THAT ANY NAME OR ADDRESS INFORMATION PROVIDED ON THIS FORM MAY BE SHARED AND DISCLOSED WITH ANY MUNICIPAL, COUNTY, STATE, OR FEDERAL AGENCY.

ALTOONA AREA SCHOOL DISTRICT

STUDENT REGISTRATION FORM

Date:_____

STUDENT INFORMATION:

(1) Last_____ **First**_____ **Middle**_____

Home Address_____

Grade Level Entering_____ Date of Birth_____ S.S.N._____

Male___ Female___ Phone Number_____

Has the student previously registered with Altoona Area School District? ☐ Yes ☐ No

Does the student have an IEP for speech, OT, PT, or any other Special Education area?_____

Student Race (optional): ___Hispanic ___Asian/Pacific Islander ___White/Non-Hispanic

___American Indian/Alaskan Native ___Black/African American/Non-Hispanic

(2) Last_____ **First**_____ **Middle**_____

Home Address_____

Grade Level Entering_____ Date of Birth_____ S.S.N._____

Male___ Female___ Phone Number_____

Has the student previously registered with Altoona Area School District? ☐ Yes ☐ No

Does the student have an IEP for speech, OT, PT, or any other Special Education area?_____

Student Race (optional): ___Hispanic ___Asian/Pacific Islander ___White/Non-Hispanic

___American Indian/Alaskan Native ___Black/African American/Non-Hispanic

(3) Last_____ **First**_____ **Middle**_____

Home Address_____

Grade Level Entering_____ Date of Birth_____ S.S.N._____

Male___ Female___ Phone Number_____

Has the student previously registered with Altoona Area School District? ☐ Yes ☐ No

Does the student have an IEP for speech, OT, PT, or any other Special Education area?_____

Student Race (optional): ___Hispanic ___Asian/Pacific Islander ___White/Non-Hispanic

___American Indian/Alaskan Native ___Black/African American/Non-Hispanic

PARENT INFORMATION

(1) Parents are:

__Married __Widowed __Divorced __Separated __Unmarried

(2) Student(s) live with:

___ Both parents ___ Natural Mother only ___ Natural Father only
___ Guardian ___ Step Parent ___ Self

(3) Father's Name: First_____ (M)_____ Last_____

Place of employment:_____ Occupation_____
Home Phone_____ Work Phone_____ Cell/Pager_____

Address (if different than student's):_____

_____

(4) Mother's Name: First_____ (M)_____ Last_____

Mother's Maiden Name:_____
Place of employment:_____ Occupation_____
Home Phone_____ Work Phone_____ Cell/Pager_____

Address (if different than student's):_____

_____

(5) Guardian's Name: First_____ (M)_____ Last_____

Place of employment:_____ Occupation_____
Home Phone_____ Work Phone_____ Cell/Pager_____

Address (if different than student's):_____

_____

(6) Step Parent's Name: First_____ (M)_____ Last_____

Place of employment:_____ Occupation_____
Home Phone_____ Work Phone_____ Cell/Pager_____

Address (if different than student's):_____

_____

(7) Do you have custody papers? ___No ___Yes
(If yes, the official papers <u>MUST</u> be presented at time of registration.)

(8) Emergency number and person to contact if parent is not at home:

Phone No._____ Name_____
Relationship to student(s)_____

Complete the following information for brothers and/or sisters not already listed:

BROTHER(S):

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

SISTER(S):

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

Last_____ First_____ Middle_____ Date of Birth_____

This form was completed by:

Print Full Name:_____

Signature:_____

Date:_____

E-Mail Address:_____

COMPLETE FOR KINDERGARTEN REGISTRATION ONLY:

Is the child attending preschool or a daycare center? ____No ____Yes, where: _____

Has the child attended first grade in another school district? ____No ____Yes

If yes, where: _____

ALTOONA AREA SCHOOL DISTRICT - ACT 26 QUESTIONNAIRE

STUDENT NAME:_____

PARENTS/GUARDIANS ARE REQUIRED, BY PENNSYLVANIA STATE LAW, TO RESPOND TO THE FOLLOWING STATEMENTS:

Please check either "YES" or "NO" next to each statement.

(1) __Yes __No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for an act or offense involving weapons, defined as any type of firearm, cutting tool, nunchaku, or implement capable of inflicting serious bodily injury.

(2) __Yes __No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for an act or offense involving weapons, defined as any type of firearm, cutting tool, nunchaku, or implement capable of inflicting serious bodily injury.

(3) __Yes __No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for an act or offense involving drugs or alcohol.

(4) __Yes __No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for an act or offense involving drugs or alcohol.

(5) __Yes __No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for the willful infliction of injury to another person and/or any act of violence committed on school property.

(6) __Yes __No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for the willful infliction of injury to another person and/or any act of violence committed on school property.

IF ANY OF THE ABOVE STATEMENTS ARE MARKED "YES", INDICATE THE QUESTION NUMBER, THE APPROXIMATE DATE OF SUSPENSION/EXPULSION, AND A BRIEF EXPLANATION OF THE INCIDENT WHICH LED TO THE SUSPENSION/EXPULSION.

_____
_____
_____
_____
_____
_____
_____
_____
_____

I/WE UNDERSTAND THAT ANY WILLFUL FALSE STATEMENT MADE TO ANY OF THE SIX QUESTIONS ABOVE WOULD BE A MISDEMEANOR OF THE THIRD DEGREE, PUNISHABLE PURSUANT TO 24 PS 13-1304-A. I/WE ALSO UNDERSTAND THAT ANY FALSE STATEMENTS HEREIN ARE MADE SUBJECT TO THE PENALTIES OF THE 18 PA C.S. 4904 RELATING TO UNSWORN FALSIFICATIONS TO AUTHORITIES.

PARENT/GUARDIAN_____ DATE_____

HOME LANGUAGE SURVEY*

ALTOONA AREA SCHOOL DISTRICT

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 identification.

School District: Altoona Area School District

Name of Child: _____ **Date:** _____

Address: _____ **Grade:** _____

School: _____

1. What is/was the student's first language? _____

2. Does the student speak a language(s) other than English? ☐ Yes ☐ No
   (Do not include languages learned in school.)

   If yes, specify the language(s):

3. What language(s) is/are spoken in your home? _____

4. Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No

   If yes, complete the following:

Name of School	State	Dates Attended

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

Parent/Guardian Signature: _____

*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.

NCLB-B1 – Home Language Survey – (09/05)

ALTOONA AREA SCHOOL DISTRICT

District Attendance Office
1415 Sixth Avenue
Altoona, PA 16602
814-946-8230

Kindergarten children DO NOT report on the first day of school. Sometime around the middle of August, you will be notified by mail when to go into the school for your appointment. The appointment usually takes place during the first couple of days that school is in session. The teacher will tell you to bring your child to school.

PLEASE NOTIFY THE BUILDING WHERE YOUR CHILD WILL BE ATTENDING KINDERGARTEN IMMEDIATELY IF YOU DO ANY OF THE FOLLOWING:

Move out of the city
Move to another address in the city
Change any information that was obtained at registration
Decide not to send your child to kindergarten

Preschool Survey

The Learning Express Preschool 2914 W. Chestnut Ave. Altoona, PA 16601 946-8465

Dear Parents:

The Altoona Area School District and The Learning Express Preschool are conducting a survey regarding Preschool services. Families of children registering for kindergarten are asked to fill out this survey and return it at kindergarten registration.

Child's Name:_____ School:_____
Parent(s) Name:_____
Address:_____
_____
Phone:_____

Please check off all that apply to your family.

__ My child attended _____ Preschool before kindergarten.
__ My child attended _____ Daycare or went to a private sitter instead of a separate preschool.
__My child was involved in Early Intervention Birth to Three through Easter Seals, Home Nursing and North Star Support Services.
__My child was involved with Preschool Early Intervention through The Learning Express or the Appalachia Intermediate Unit 08.
__ My child did not attend preschool, or only attended preschool for a short time.

Reasons my child did not attend preschool:

__ My family could not find free/low-cost preschool, and could not afford preschool.
__ Preschool(s) that I called were full or had a waiting list.
__ I did not know of any preschools in the area.
__ Transportation – I did not have a way to get my child to and from preschool.
__ I did not feel my child was ready for preschool.
__ I did not feel it was necessary for my child to go to preschool before kindergarten.
__ Other reasons:_____

If you would like to be called about this survey:

__Please call me–I have questions about this survey.
__Please call me–I have younger children at home and would like information about preschools in the area.
__Please call me – I have concerns about my younger child's readiness for preschool.

I hereby give my permission for the Altoona Area School District to share data and information about my child's academic progress with my child's pre-school program. The intent of sharing this information is to facilitate the transition of children entering kindergarten.

Child's Name_____ Birth Date_____

Pre-School Program_____

_____ _____

Parent Signature Date

ALTOONA AREA SCHOOL DISTRICT

CONFIDENTIAL INFORMATION FOR COUNSELORS –
(KINDERGARTEN/FIRST GRADE STUDENTS ENROLLING FOR THE FIRST TIME)

Date:_____ For School Year:_____

Child's Name:_____

Parent(s) Name:_____

School:_____

(1) Do you have any concerns about your child's behavior, discipline or development?
No___ Yes___ (If yes, please explain below.)

_____

_____

_____

_____

(2) Has your child received help from any community agency or resource? If Yes, check all that apply and complete the information for "Other", if applicable.

_____Family Resource Center
_____Altoona Hospital - Mental Health Center
_____Canal Ways
_____WRAP Around
_____Blair County Children & Youth Services
_____Learning Express
_____Early Intervention
_____Easter Seals
_____Headstart
_____Other (specify)_____

(3) Do you believe that these concerns will influence your child's learning?
No___ Yes___ (If yes, please explain below.)

_____

_____

_____

_____

(4) Would you like to talk with a school counselor about your child?
No___ Yes___ (If yes, daytime phone number:_____)

ALTOONA AREA SCHOOL DISTRICT

AFFIDAVIT OF PARENT(S)
Parent(s) living in Altoona Area School District

COMMONWEALTH OF PENNSYLVANIA)
) SS:
COUNTY OF BLAIR)

Before me, the undersigned Notary Public, this day personally appeared _____ _____, residing at_____ _____, to me known, who being duly sworn according to law, depose(s) and say(s) the following:

I (We) am (are) the parent(s) of _____, and I (we) hereby confirm and consent to the fact that my (our) child will be kept in the home of _____, residing at _____, who will support my child gratis, assuming all personal obligations for the child relative to school requirements and intending to keep and support the child continuously and not merely throughout the school term.

_____
PARENT

_____
PARENT

Subscribed and sworn to before me this
____ day of _____, 20___.

_____
NOTARY PUBLIC

My Commission Expires:

ALTOONA AREA SCHOOL DISTRICT
GUARDIANSHIP PACKET
Parent(s) **DO NOT** live in the Altoona Area School District

Information from an applicant who is requesting resident school privileges (under Section 1302 of the Pennsylvania School Code) for a student(s) **(NOT HIS/HER OWN)** kept in his/her home.

I/WE UNDERSTAND THAT ANY WILLFUL ***FALSE STATEMENT*** MADE TO ANY OF THE QUESTIONS WOULD BE MISDEMEANORS OF THE THIRD DEGREE, PUNISHABLE PURSUANT TO 24 PS 13-1304-A.

I/WE ALSO UNDERSTAND THAT ANY ***FALSE STATEMENTS*** HEREIN ARE MADE SUBJECT TO THE PENALTIES OF 18 PA C.S. 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

By signing this, I fully understand the consequences of this packet:

Signature _____ Date _____

ALTOONA AREA SCHOOL DISTRICT
GUARDIANSHIP PACKET

Parent(s) **DO NOT** live in the Altoona Area School District

Information from an applicant who is requesting resident school privileges (under Section 1302 of the Pennsylvania School Code) for a student(s) **(NOT HIS/HER OWN)** kept in his/her home.

In order to be given consideration the applicant must:

A. *Complete and sign **Part I** of the questionnaire.*
B. *Have the parent(s) of the student(s) complete and sign **Part II** of the questionnaire.*
C. *Return the completed questionnaire and affidavit to the **Student Registration Office or the Home School**.*

The admission of a student(s) by the school authorities will be tentative and subject to final approval of the Superintendent or his/her designees. Altoona Area School District reserves the right to verify any and all information contained within the Guardianship Packet with law enforcement agencies. By executing this form, the applicant and student authorize Altoona Area School District to retrieve any information necessary in making a determination with respect to enrollment applications. By submitting this request, the parent(s), guardians and student hereby waive the right to privacy guaranteed by FERPA so that the District can gather the information necessary to make the enrollment decision.

PART I – APPLICANT INFORMATION

1. *Name of Applicant:* _____
   Spouse of Applicant (if applicable): _____
   Home Address: _____
   _____
   Home Telephone No.: _____
   Work Telephone No.: _____

2. *Name of Student:* _____
   Date of Birth: _____
   Grade of Student: _____
   Last School Attended: _____

3. *The date student(s) began residing in the Applicant's home:* _____

4. *Are you related to the student(s)?* YES____ NO_____

5. *How are you related to the student(s)?*_____

6. *Please explain why the student(s) is(are) residing with you and not with the parent(s).*

_____
_____
_____

7. *Is the father living?* YES_____ NO_____
NAME*:*_____
HIS ADDRESS*:*_____
_____
SOCIAL SECURITY NUMBER*:*_____

8. *Is the mother living?* YES_____ NO_____
NAME*:*_____
HER ADDRESS*:*_____
_____
SOCIAL SECURITY NUMBER*:*_____

9. *Will the **parent(s)** contribute anything for the student's support:*

MONEY	YES_____	NO_____
FOOD, CLOTHING	YES_____	NO_____
HEALTH INSURANCE	YES_____	NO_____

10. *Will you receive welfare, public assistance or any other form of aid or payment for this child?*

YES_____ NO_____

11. *Will the **parent(s)** claim the student(s) as a dependent(s) for income tax reporting purposes? **(The School District reserves the right to review your income tax return.)***

YES_____ NO_____ If **NO**, who will claim?_____

12. *What is the anticipated length of time that the applicant plans to keep the student(s)?*

_____

13. Will the student(s) customarily return to the parent(s) during vacations?

YES_____ NO_____

14. Will the student(s) continuously sleep overnight at the applicant's residence?

YES_____ NO_____

ALTOONA AREA SCHOOL DISTRICT RESERVES THE RIGHT TO REVOKE ADMISSION IF THE APPLICATION CONTAINS FALSE INFORMATION ON WHICH THE SCHOOL DISTRICT RELIED IN MAKING ITS DECISION TO ENROLL THE STUDENT.

(FOR ADMINISTRATIVE USE ONLY)

Applicant Interviewed by:_____ Date:_____

Action Recommended:_____

_____

Final Administrative Action: **APPROVED**_____**DENIED**_____

Signature:_____ Date:_____

COMMENTS:

ALTOONA AREA SCHOOL DISTRICT
Certification of Applicant – Part I

*I certify that I am a **legal resident** of the Altoona Area School District and that I have paid all my taxes for the last 12 months. I further certify that the information submitted in response to the above questions is correct and that I will submit the necessary affidavit (sworn statement) in support of this application after carefully reading it and finding that it is consistent with the facts. I UNDERSTAND THAT IF THE INFORMATION FURNISHED IS **UNTRUE**, **I WILL BE LIABLE FOR THE PERSONAL TUITION PAYMENTS** in accordance with School District Policy #5003R.*

I understand that any willful false statement made to any of the questions would be a misdemeanor of the third degree, punishable pursuant to 24 PS 13-1304-A. I also understand that any false statements herein are made subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities.

*Date:*_____ *Signature of Applicant:*_____

*Telephone Number:*_____ *Address:* _____

_____

Verification of Parent(s) – Part II

*I/We certify that I/we have read the above information in Part I submitted by the applicant and also the affidavit necessary to be submitted by the applicant and find that the information contained therein is correct and the I/we give my(our) permission for **[Name of Student(s)]**_____ to be placed under the responsibility of the above applicant as though said student(s) was his or her own, agreeing that he or she assumes all personal obligation for the said student(s) relative to the school requirements and with the understanding that it is his or her intention of supporting the student(s) continuously and not merely throughout the school term.*

I/We understand that any willful false statement made to any of the questions would be misdemeanors of the third degree, punishable pursuant to 24 PS 13-1304-A. I/We also understand that any false statements herein are made subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities.

*Date:*_____ *Signature of Father:*_____

*Signature of Mother:*_____

*Telephone Number:*_____ *Address:* _____

_____

ALTOONA AREA SCHOOL DISTRICT

AFFIDAVIT OF GUARDIAN

COMMONWEALTH OF PENNSYLVANIA)
) SS:
COUNTY OF BLAIR)

Before me, the undersigned Notary Public, this day personally appeared _____ _____, residing at_____ _____, to me known, who being duly sworn according to law, depose(s) and say(s) the following:

I (we) am (are) keeping and supporting_____, _____, gratis, and that I (we) will be responsible for this person for school attendance and all personal requirements, and that I (we) intend to so keep and support this individual continuously and not merely throughout the school term. In addition, I (we) fully understand that the School District may make an independent investigation to make certain that the guardianship I (we) am (are) claiming is a legitimate one.

_____
GUARDIAN

_____
GUARDIAN

Subscribed and sworn to before me this _____ day of _____, 20___.

_____
NOTARY PUBLIC

My Commission Expires:

Student Birth Information:

Name: _____

Date of Birth: _____

Place of Birth: _____

ALTOONA AREA SCHOOL DISTRICT

AFFIDAVIT OF PARENT(S)
Parent(s) living in Altoona Area School District

COMMONWEALTH OF PENNSYLVANIA)
) SS:
COUNTY OF BLAIR)

Before me, the undersigned Notary Public, this day personally appeared _____ _____, residing at_____ _____, to me known, who being duly sworn according to law, depose(s) and say(s) the following:

I (We) am (are) the parent(s) of _____, and I (we) hereby confirm and consent to the fact that my (our) child will be kept in the home of _____, residing at _____, who will support my child gratis, assuming all personal obligations for the child relative to school requirements and intending to keep and support the child continuously and not merely throughout the school term.

_____
PARENT

_____
PARENT

Subscribed and sworn to before me this
____ day of _____, 20___.

_____
NOTARY PUBLIC

My Commission Expires:

ALTOONA AREA SCHOOL DISTRICT
Student Health Services
STUDENT HEALTH HISTORY

Child's Full Name:_____ Birthday: _____/ _____/ _____
Last First Middle Month Day Year

Address:_____ Telephone#:_____
_____ Place of Birth:_____

Father's Name:_____ Occupation:_____
Mother's Name:_____ Occupation:_____
Guardian's Name:_____ Occupation:_____

Give names and birth date of other children in the family:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents are: ___Married ___Single ___Divorced ___Separated ___Widowed
Child is living with: ___Mother ___Father ___Both ___Guardian (Name please): _____
If living with guardian, what is relationship to the child?_____
Have any members of the immediate family died? (Do not include miscarriages.) ___Yes ___No
How many people live in the same household as the child?_____
Are there any problems such as housing, employment, food, etc…?_____
Has this child attended: ___Headstart ___Pre-School (where)_____

Child's Physician:_____ Child's Dentist:_____

Does your child have any special health needs or problems that will require attention or assistance in school?
_____

Does your child need a special diet or have any food problems? (Give details):_____
_____

Is there any reason why your child should not participate in physical education classes? (Give details)_____
_____

Is your child taking any medications other than vitamins, regularly? Give name of medication/s and reason._____
_____

Is your child presently being treated for any health problems? (Give details):_____
_____

MEDICAL HISTORY: (Check any of the following your child has had and appropriate age.)

___Chickenpox_____
___Measles (Regular)_____
___Rubella (German Measles)_____
___Mumps_____
___Whooping Cough_____
___Scarlet Fever_____
___Rheumatic Fever_____
___Lead Poisoning (Highest Level)_____
___Pneumonia_____
___Seizures (Epilepsy)_____
___Convulsion (High Fever)_____
___Head Injury_____
___Eye Surgery_____
___Tubes in ears_____
___Tonsils removed_____

Does your child have complete bowel and bladder control?_____
Has your child ever been hospitalized or had an operation? (If Yes, When, where, for what?)_____
_____
Has your child had any serious illness, accident, or broken bones? (If Yes, when, where, what?)_____

---CONTINUED ON REVERSE SIDE---

Check any of the following your child has had:

___Frequent colds/sore throats_____
___Frequent ear infections_____
___Visual problems/glasses_____
___Dental problems_____
___Frequent headaches_____
___Frequent "belly aches"_____
___Swelling of joints_____
___Pain in arms or legs_____
___Fainting spells_____
___Urinary/Bladder problems_____
___Bowel problems_____
___Other_____

___Speech problems_____
___Trouble breathing thru nose_____
___Snores at night_____
___Trouble sleeping_____
___Skin problems_____
___Eczema_____
___Asthma/wheezing_____
___Allergies (note type below)_____
Food_____
Medicine_____
Insects_____
Other_____

Does child fall, stumble or bump into things frequently?_____

PRE-NATAL HEALTH HISTORY:

Did mother have any illnesses during pregnancy?:_____
Did mother take any medications or drugs (other than iron or vitamins) during pregnancy?_____
Was the mother hospitalized for any problems during pregnancy?_____

BIRTH OF CHILD: (Check any that apply)

Number of hours in active labor:_____

___Instrument delivery
___Caesarean (C-Section)
___Premature (how much?)_____
___Breech birth
___Jaundice
___Overdue (how much?)_____
___Oxygen after birth
___In incubator

DEVELOPMENTAL HISTORY:

Birth weight:_____
Did your baby have any trouble while in the hospital?_____
Did your baby have any problems during the first six months?_____

Approximate age:
_____sat alone without support
_____ walked alone without support
_____dressed self
_____stopped wetting the bed at night
_____stood alone without support
_____ spoke two to three words together
_____toilet training was complete

How do you feel your child's development compares with other children such as brothers or sisters?
____Same ____Slower ____Faster

FAMILY HISTORY: (Place an "X" in the box next to any problems the child's parents, grandparents, aunts, uncles, sisters, or brothers have had and indicate the relationship in the space provided.)

❒Allergies_____
❒Anemia_____
❒Asthma_____
❒Cancer_____
❒Diabetes_____
❒Epilepsy/siezures_____
❒Drug/Alcohol Addiction_____
❒Eye disease_____
❒Hearing problems_____
❒Heart disease_____
❒High blood pressure_____
❒Kidney problems_____
❒Lead poisoning_____
❒Learning problems_____
❒Multiple sclerosis_____
❒Muscular dystrophy_____
❒Nervous breakdown_____
❒Sickle cell_____
❒Tuberculosis_____
❒Other_____

Is there anything else you would like us to know about your child?_____
_____

_____ Date:_____
Signature of Parent or Guardian

ALTOONA AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
PHYSICAL EXAMINATION

Dear Parent/Guardian:

The Pennsylvania School Law requires all school age children to have periodic physical examinations as follows: kindergarten or grade one, grade six and grade eleven. Transfer students, as well as students with incomplete health records, shall be required to have a physical examination as the need arises.

I am recommending the examination is completed by your family physician since he/she can best evaluate your child's health. The private physician's report form needs to be completed by your family physician and returned to the school nurse by:

Completed private examination forms must be returned prior to the date the school examinations are scheduled or your child will be scheduled for a medical examination at school. If you wish to be present for the examination, please submit your request in writing before the scheduled physical exam.

If you have any questions regarding this health program requirement, please contact me at or email me at .

Sincerely,

School Nurse

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 ☐**

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)

ALTOONA AREA SCHOOL DISTRICT
STUDENT HEALTH SERVICES
DENTAL EXAMINATION

Dear Parent or Guardian:

Pennsylvania School Law requires a dental examination on all children entering school, kindergarten or 1st grade, 3rd grade and 7th grade. The examination may be done in school or by your family dentist.

We recommend your family dentist do this examination since he/she can best evaluate your child's dental health and assist you in obtaining the necessary treatments and corrections.

Please return the dental forms by _____ , 20_____.

According to STATE LAW, if a private dentist's form is not returned, the examination will be scheduled and done by the school dentist. If you wish to be present while the examination occurs, please submit your request in writing prior to the scheduled date.

School Dental Examination Scheduled: _____

Respectfully,

School Nurse

H514.027

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 or 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

ALTOONA AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
IMMUNIZATION REQUEST

Dear Parent/Guardian:

The immunization record that was submitted at the time of registration indicates your child needs one or more immunizations to complete the Pennsylvania State requirements. ***It is recommended that you have the following highlighted immunizations completed prior to the start of school***. Please contact your Physician or the State Health Center at 946-7300 for an appointment as soon as possible.

Immunizations needed:

DtaP
1st dose, 2nd dose, 3rd dose, 4th dose, 5th dose

(**Tetanus & Diphtheria – 1 dose must occur on or after the child's 4th birthday.)**

Polio
1st dose, 2nd dose, 3rd dose, 4th dose

MMR
1st dose, 2nd dose

Hepatitis B
1st dose, 2nd dose, 3rd dose

Varicella
(Chickenpox) 1st dose _____ 2nd dose _____
or History of Chickenpox disease (date/age) _____

It is common to receive these immunizations during your child's well check-up exam around age five. Please ensure that the school your child is attending receives a copy of the updated immunizations that were given.

Respectfully,

School Nurse