

In addition to these documents we will need: a copy of the child's birth certificate, a copy of the child's immunization records, and proof that the parent/guardian resides in Pennsylvania (drivers license, utility bill, etc.). Most doctors' offices will fax the immunization records to us with your permission. Our fax number is (814)842-6246.

Should you have any questions please feel free to email Mrs. Heiple at sheiple@hyndmancharterschool.org or Brigette Emerick at bemerick@hyndmancharterschool.org

We look forward to seeing your child at HHCS!



Charter School Student Enrollment Form

For School Year 2022-23

Warning: A child enrolled in another public school or a nonpublic or private school cannot, at the same time, enroll in a charter school.

Name of Charter School: HOPE for Hyndman Charter School
School Address: 130 School Drive
Hyndman, PA 15545
Charter School Contact Person: Mrs. Stephene Heiple
Telephone: 814-842-3918 Email Address: sheiple@hyndmancharterschool.org

I. Student Information:

Last Name: _____ First Name: _____ MI: _____
Home Address: _____ State: _____ Zip Code: _____
City: _____ Telephone: _____
County: _____
Mailing Address (If Different From Home Address): _____ State: _____ Zip Code: _____
City: _____ Age: _____
Date Of Birth: _____

II. School District of Residence and Former School Information

School District of Residence: _____
Former School Information (Other Than Pre-School):
 Public School Charter School Home School Nonpublic School
Student Not Enrolled in School Preceding Enrollment in Charter School Because:
 Entering Kindergarten Re-Enrolling Dropout Other
Name of Former School: _____
Address of Former School: _____
Previous Grade: _____ Withdrawal Date From Former School: _____

III. Parent/Guardian Information:

Child Lives With: _____ Both Parents _____ Both Parents Alternately _____ Mother Only _____ Father Only
_____ Legal Guardian _____ Foster Parents _____ Other Adult _____
_____ Yes _____ No _____

Special Custodial Court Instructions:
(If Yes, Please Provide a Copy of Court Order.)

Complete Parent/Guardian Name and Address Information As Applicable

Father's Name _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work Telephone: _____

Mother's Name _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work Telephone: _____

If The Student Is Not Living With Parents, Please Complete This Section.

_____ Guardian's Name Or _____ Foster Parent's Name Or _____ Other Adult Name
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

My signature on this form indicates my decision to have my child attend the charter school named on page 1 of this form and signifies my request that appropriate school records be forwarded from the school district to the charter school. My signature also certifies that my child is not, and will not be, enrolled in another public school, a nonpublic school or a private school at the same time he or she is enrolled in this charter school.

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

IV. To Be Completed By Charter School:

Verification of Date of Birth: _____ Birth Certificate _____ Other _____
Proof of Residency _____ Mortgage Statement _____ Lease _____ Utility Bill _____ Other _____
Official Enrollment Date: _____ Anticipated Date of Attendance: _____
Grade Student Is Entering: _____

Signature of Charter School Representative: _____



HOPE for Hyndman Charter School
130 School Drive, Hyndman, PA15545
(814)842-3918



Student Name: _____

Date of birth: _____ Grade: _____

Parent or Guardian Name: _____

Address: _____

Home phone: _____ Cell phone: _____

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an action of offense involving a weapon, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child was _____ was not _____ previously suspended or expelled, or is _____ is not _____ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

Dates of suspension or expulsion:

(Please provide additional schools and dates of expulsion or suspension on back of this sheet.) Reason for

suspension/expulsion (optional) _____

 (Signature of Parent or Guardian)

 (Date)



HOME LANGUAGE SURVEY

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

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

Child's first name: _____

Child's family name: _____

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

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? No Yes (language) _____
2. Does your child communicate in a language other than English? No Yes (language) _____
3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided No Yes

HOPE FOR HYNDMAN CHARTER SCHOOL

ACT 110 VERIFICATION

I/We _____ being duly sworn to law

Dispose and say: THAT I/We am/are the Parent(s)/Legal Guardian(s) of

_____ (the pupil);

THAT The pupil has NOT previously been expelled under the provisions of 24 P.S. § 13-1318.1 entitled: "Students Convicted or Adjudicated Delinquent of Sexual Assault."

THAT The pupil is NOT currently expelled under the provisions of 24 P.S. § 13-1318.1 entitled: "Students Convicted or Adjudicated Delinquent of Sexual Assault."

Any willful false statement made above shall be a misdemeanor of the third degree.

This form shall be maintained as part of the student's disciplinary record.

THAT I/We recognize the following:

NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, A PERSON WHO KNOWINGLY PROVIDES FALSE INFORMATION IN A SWORN STATEMENT FOR THE PURPOSE OF ENROLLING A CHILD IN A SCHOOL DISTRICT (OR CHARTER SCHOOL TO THE EXTENT PERMITTED BY LAW) FOR WHICH THE CHILD IS NOT ELIGIBLE COMMITS A SUMMARY OFFENSE AND SHALL, UPON CONVICTION FOR SUCH VIOLATION, BE SENTENCED TO PAY A FINE OF NO MORE THAN THREE HUNDRED DOLLARS (\$300) FOR THE BENEFIT OF THE SCHOOL DISTRICT (OR CHARTER SCHOOL TO THE EXTENT PERMITTED BY LAW) IN WHICH THE PERSON RESIDES OR TO PERFORM UP TO TWO HUNDRED FORTY (240) HOURS OF COMMUNITY SERVICE, OR BOTH. IN ADDITION, THE PERSON

SHALL PAY ALL COSTS AND SHALL BE LIABLE TO THE SCHOOL DISTRICT (OR CHARTER SCHOOL TO THE EXTENT PERMITTED BY LAW) FOR AN AMOUNT EQUAL TO THE COST OF TUITION CALCULATED IN ACCORDANCE WITH SECTION 2561 OF THE PUBLIC SCHOOL CODE DURING THE PERIOD OF ENROLLMENT.

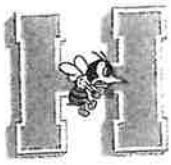
I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

PARENT/GUARDIAN: _____

Address: _____ Phone: _____

PARENT/GUARDIAN: _____

Address: _____ Phone: _____



2022-23 EMERGENCY CONTACT FORM

*Please list all students in your home:

Student's Name: _____ Grade: _____
First Name Last Name

Student's Name: _____ Grade: _____
First Name Last Name

Student's Name: _____ Grade: _____
First Name Last Name

Student's Name: _____ Grade: _____
First Name Last Name

Student's Name: _____ Grade: _____
First Name Last Name

➤ 911 / Street Address: _____

Mailing Address: _____

Home # and/or Cell #: _____

➤ Primary Contact's Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____ Ext: _____

➤ Secondary Contact's Name: _____ Relationship: _____

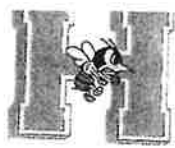
Home #: _____ Cell #: _____

Employer: _____ Work #: _____ Ext: _____

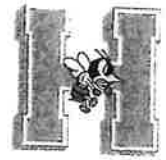
➤ Please list any additional contacts your child(ren) may be released to during an emergency.

Name of Designated Guardian	Relationship	Phone #s
_____	_____	_____
_____	_____	_____
_____	_____	_____

➤ I, _____, authorize HOPE for Hyndman Charter School to
Name of Parent/Guardian
 release my child(ren), whose names are stated above, to the contact(s) listed on this form.



HOPE for Hyndman Charter School



130 School Drive
Hyndman, PA 15545
hopeforhyndmancs.org

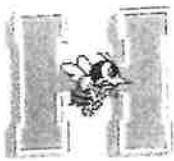
In order provide the Pennsylvania Department of Education with required data, and to better serve our community, we ask that you please complete the following questionnaire. Thank you.

Student's Full Name: _____ Grade (2022-23) _____

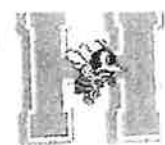
1. How did you hear about HHCS? _____
2. Do you have other children attending HHCS? If yes, please list each child's name and date of birth:

3. Is your child Hispanic or Latino? Yes No
4. Please indicate your child's race:
 (A) Asian (B) Black or African American (I) American Indian or Alaska Native
 (P) Native Hawaiian / Other Pacific Islander (W) White
5. Please indicate your child's ethnicity:
 American Indian or Alaska Native (1)
 Asian or Pacific Islander (2)
 Black (Non-Hispanic) (3)
 Hispanic (4)
 White (Non-Hispanic) (5)
 Multi-Racial (6)
 Unknown (7)
6. Please indicate your child's gender: Male Female
7. Has your child been enrolled in a PA school before? Yes No
If yes, please indicate their 10-digit PA Secure ID, if you know it.

8. If your child is in entering grades 9 through 12, please indicate the school year he/she first entered 9th grade.
 2018-19 2019-20 2020-21 2021-22
9. Did your child receive Free/Reduced Meals at previous school?
 Yes No
10. Are any of the Parent(s) or Guardian(s) active or retired military?
 Yes No



HOPE for Hyndman Charter School



130 School Drive
 Hyndman, PA 15545
 Tel: (814)842-3918
 Fax: (814)842-6246
hopeforhyndmancs.org
**Transfer / Release
 Data Form**

PRIOR SCHOOL INFORMATION

Name of Prior School: _____
 Street Address: _____ Suite/Floor No: _____
 City: _____ State: _____ Zip Code: _____
 School Phone: _____ School Fax: _____

STUDENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
 Street Address: _____ Suite/Floor No: _____
 City: _____ State: _____ Zip Code: _____
 Grade Assignment: _____ Date of Birth: _____

Student will begin attending HHCS on _____

Upon receipt of this form, please forward:

- Student's PA Secure ID
- Health and Dental Records
- Official Student Records/Transcripts
- Special Education Records, IEP, ER, NOREP, Permission to Evaluate/Reevaluate, IEP invitations, Psychological Reports, SAP Records, etc.
- Most Recent Report Card
- Discipline Referrals
- Career Readiness Portfolio

Permission is granted to forward all official school records to the above named school except:

Parent/Guardian Signature

Date

HOPE for Hyndman Charter School
Student/Family Residence Questionnaire

Your child may be eligible for additional educational services through Title I Part A, Title I Part C-Migrant, and/or Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Presently, are you and/or your family living in any of the following situations? Check all that apply.

- A. Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer B. Waiting for foster care placement
- C. Sharing the housing of others due to loss of housing, economic hardship or similar reason
- D. Living in a car, park, campground, abandoned building, or other inadequate accommodation
- E. Temporarily living in a motel or hotel due to loss of housing, economic hardship or similar reason
- F. Living alone as a minor student(s) without an adult (unaccompanied youth)

If you checked any box above please complete the remainder of this form and submit it to school personnel.
 If you did not check any box above, you do not need to complete or submit this form.

2. Please list all children currently living with you.

First	Middle	Last	M/F	Birthdate	Grade	School Name

The undersigned parent/guardian certifies that the information provided above is accurate.

Print Parent/Guardian Name	Signature	Date
(Area Code) Phone number	Street Address	City State Zip

Your children have the right to:

- 1. Continue to attend school in the school attended before you became homeless (school of origin). 2. Receive transportation to the school of origin
- 3. Enroll in school without giving a permanent address and attend classes while the school arranges for a school transfer, immunization records or other documents required for enrollment.
- 4. Receive the same special programs and services, if needed, as provided to all other children served in these programs.
- 5. Have enrollment disputes quickly addressed.

The McKinney Vento Homeless Education Assistance Act and the MMSD Board of Education Policy #4406 ensure the educational rights above for students who are homeless. If you wish to have a copy of this document, please ask the staff person helping you today to make one.

1. HHCS staff assisting with this process:

Name

Signature

Date

HOPE for Hyndman Charter School

Incoming Kindergarten Health Requirements

- *4 doses of tetanus, diphtheria and pertussis- 1 dose on or after the 4th birthday
- *4 doses of polio- 4th dose on or after the 4th birthday and at least 6 months after previous dose given
- *2 doses of measles, mumps and rubella
- *3 doses of hepatitis B
- * 2 doses of varicella(chickenpox) or evidence of immunity

Students entering the following grades must have a physical exam:

- *Kindergarten
- *6th grade
- *11th grade

Students entering the following grades must have a dental exam:

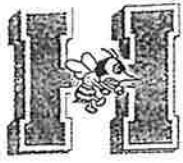
- *Kindergarten
- *3rd grades
- *7th grade

Students entering 7th grade must have the following vaccinations:

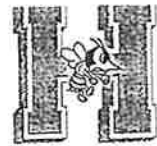
- *Tdap
- *MCV(meningococcal vaccine)- first dose given at 11-15 years of age, a second dose is required at age 16 or entry into 12th grade
- *If the dose was given at 16 years of age or older, only one dose is required.

Students entering 12th grade must have the following vaccination:

- *MCV(meningococcal vaccine)- 2nd dose must be given at age 16 or entry into 12th grade, unless initial vaccination was given at age 16 or older, then only one dose is required.



HOPE for Hyndman Charter School



130 School Drive

Hyndman, PA 15545

www.hopeforhyndmancs.org

Phone 814-842-3918/ Fax 814-842-6246

I give permission for my child, _____ to receive services via the health room at school from the Certified School Nurse or their designee. I understand that the guidelines, rules, and regulations of the health room will be followed at all times. I also understand that the criteria of the health room must be met in order for my child to receive care including first aid or medication administration.

I give permission for my child to receive the following over the counter medications at school:

- Benadryl yes _____ no _____
- Tylenol yes _____ no _____
- Ibuprofen yes _____ no _____
- Antacids yes _____ no _____
- Chloraseptic yes _____ no _____
- Orajel yes _____ no _____
- Cough Drop yes _____ no _____

First Aid:

- Antibiotic ointment yes _____ no _____
- Hydrocortisone cream yes _____ no _____
- Calamine lotion yes _____ no _____
- Burn Cream/Spray yes _____ no _____

May give all medications listed above: yes _____ no _____

Special instructions to be considered:

Signature of Parent or Guardian: _____ Date: _____

STUDENT EMERGENCY CONTACT CARD

Medical Information

STUDENT

Last _____ First _____ Middle _____

MEDICAL/HEALTH INFORMATION-

Medication: Does your child take medication? No Yes

Medication	Dosage	Hour(s) given

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. Also a "Medication/treatment Authorization" form, must be completed and signed by the physician and the parent and must be on file.

Physician/Health Care Provider _____ Phone No. _____

Health Plan/Group Name _____ Policy No. _____

Dentist _____ Phone No. _____

Vision and/or Hearing Information:

Wears glasses/contacts: YES/NO Wears hearing aid(s) YES/NO

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

- Severe Allergies Food/Environmental Stinging Insects/Bees Medicines/Drugs
- Other _____

Please explain: _____

- Requiring: →
- Asthma Benadryl Epipen Other _____
 - Seizures If checked, on medication? Yes No on daily medication
 - Diabetes If checked, insulin dependent? Yes No
 - Movement limitations: _____
 - Other (please explain): _____

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) of _____, do hereby give authorization and consent to the school to obtain emergency medical care and necessary emergency transportation to a healthcare facility

Parent Signature _____ Date _____

RELEASE OF MEDICAL INFORMATION

I hereby understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with school officials and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.

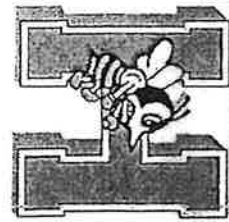
Parent Signature _____ Date _____

EMERGENCY DISMISSAL

In the event of a severe storm or other unscheduled emergency dismissal your child is instructed to:

- Walk Home
- Ride Public Transportation
- Ride School Bus as usual
- Ride Home with parent only
- Ride Home with friend identified on authorized contact list

Parent Signature _____ Date _____



In case of an emergency, it is imperative that the school be able to reach the student's Parent (as defined below). Please fill in the information carefully and accurately. Please use ink and print clearly.

STUDENT

Last Name _____ First _____ Middle _____ Male Female Grade _____

Home Address _____ City _____ State/Zip _____ Home Phone _____ Birthdate _____

Mailing Address, if different from above _____ City _____ State/Zip _____ Lives with: Mother Father Both Parents Other _____ Address change? No Yes If Yes, please contact the School Office.

REGISTERING PARENT

Last Name _____ First _____ Email _____ Employer _____

Home Address _____ City _____ State/Zip _____ Home Phone _____ Work Phone _____ Cell Phone _____

OTHER PARENT

Last Name _____ First _____ Email _____ Employer _____

Home Address, _____ City _____ State/Zip _____ Home Phone _____ Work Phone _____ Cell Phone _____

Other children at home: (1) _____ Name _____ Grade _____ School _____ (2) _____ Name _____ Grade _____ School _____

Has a court prohibited the parent from having contact with the student? No Yes If Yes, contact the School Office. **AUTHORIZED Release/Contact**

Please list the names of persons to whom we may release your child or who we may contact if we cannot reach you. **NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW.** In selecting someone to whom you authorize the release of your child, consider: Is this person prepared to handle any special medical needs required by your child?

I/we hereby authorize contact with, release of emergency related information, or release of the student to the following persons in the event of illness, injury, evacuation or other emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work or Cell Phone

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes.

Parent's Signature _____ Date _____ Relationship _____



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.

Bureau of Community Health Systems
Division of School Health

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"/> High blood pressure <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <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. _____ Date _____

Signature of parent / guardian / emancipated student _____
 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 NAME: _____

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

STUDENT NAME:

A large rectangular area with horizontal lines, intended for writing additional comments. The lines are evenly spaced and cover the majority of the page below the header and student name fields.

