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

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:

City: State: Zip Code:

County: Telephone:

Mailing Address (If Different From Home Address)

City: State: Zip Code:

Date Of Birth: Age:

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
_____ Legal Guardian
_____ Both Parents Alternately
_____ Foster Parents
_____ Mother Only
_____ Other Adult
_____ Father Only

Special Custodial Court Instructions: (If Yes, Please Provide a Copy of Court Order.)
_____ Yes
_____ No

Complete Parent/Guardian Name and Address Information As Applicable

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

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

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.

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

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

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

Child's first name: _____

Child's family name: _____

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

Questions for Parents or Guardians

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

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

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:_____

HOPE for Hyndman Charter School
130 School Drive
Hyndman, PA 15545
www.hopeforhyndman.org

2022-23 EMERGENCY CONTACT FORM

*Please list all students in your home:

Student's Name: _____ (First Name / Last Name) Grade: _____

Student's Name: _____ (First Name / Last Name) Grade: _____

Student's Name: _____ (First Name / Last Name) Grade: _____

Student's Name: _____ (First Name / Last Name) Grade: _____

Student's Name: _____ (First Name / Last Name) Grade: _____

- 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, _____ (Name of Parent/Guardian), authorize HOPE for Hyndman Charter School to 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.*

⑨ A. Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer ⑨ B. Waiting for foster care placement

⑨ C. Sharing the housing of others due to loss of housing, economic hardship or similar reason

⑨ D. Living in a car, park, campground, abandoned building, or other inadequate accommodation

⑨ E. Temporarily living in a motel or hotel due to loss of housing, economic hardship or similar reason

⑨ 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:

- Continue to attend school in the school attended before you became homeless (school of origin).
- Receive transportation to the school of origin
- 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.
- Receive the same special programs and services, if needed, as provided to all other children served in these programs.
- 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.

- 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: →

❑ Benadryl	❑ EpiPen	Other _____	
❑ Asthma	If checked,	❑ uses inhaler	❑ on daily medication
❑ Seizures	If checked, on medication?	❑ Yes	❑ No
❑ Diabetes	If checked, insulin dependent?	❑ Yes	❑ No

❑ Movement limitations: _____
❑ Other (please explain): _____

_____
_____
_____

We recommend that you duplicate this card for your records.

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

Form 4710 Rev. 6/20/11

Emergency Contacts

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 _____ ❑ Male ❑ Female Grade _____
Last Name First Middle

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

_____ Lives with: ❑ Mother ❑ Father ❑ Both Parents ❑ Other _____
Mailing Address, if different from above City State/Zip 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) _____ | ___ | _____ (2) _____ | ___ | _____
Name Grade School 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** _____

Continued ⇨

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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 NAME:

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

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

Print name of examiner _____

Print examiner's office address _____ Phone _____

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

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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

H514.027

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 (Last / First / Middle)	AGE	SEX	GRADE	SECTION/ROOM
		☐ 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