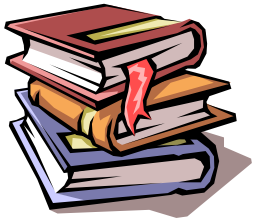
SOUTHERN LEHIGH SCHOOL DISTRICT
5775 MAIN STREET
CENTER VALLEY, PA 18034



KINDERGARTEN REGISTRATION REQUIREMENTS

Children **must** be age 5 before September 1

Completion of the following forms is required for student registration:

- ☐ Registration Form
- ☐ New Entrant Health Form
- ☐ Affirmation of Prior Discipline Record
- ☐ Home Language Survey
- ☐ Transportation Form
- ☐ Private Dentist Report
- ☐ Private Physician Report
- ☐ Kindergarten Questionnaire

The following documentation must accompany registration forms:

- ☐ Birth certificate or other proof of age as per policy
- ☐ Current immunization records
- ☐ Proof of Residency (i.e. utility bill, lease, sales agreement)
- ☐ IEP if applicable
- ☐ Custody agreement if applicable

Questions: call 610-282-3121

SOUTHERN LEHIGH SCHOOL DISTRICT
STUDENT REGISTRATION

For School Personnel Use Only

Date Registered:_____

Start Date:_____

School:_____

Document Copies - For School Personnel Use Only

Birth Certificate ☐ Transfer Card ☐

Proof of Residence ☐ Report Card ☐

Immunization Records ☐

Student Information (Please Print) **Grade:**

Last Name:		Gender:	☐ Female ☐ Male
First Name:		Birthdate:	
Middle Name:		Phone #:	**Unlisted:** ☐
Suffix:		Email:	

Student Physical Address (Please Print)

Address 1:	
Address 2:	
City:	
State:	
Zip + 4:	
Township:	
County:	

Ethnicity

Ethnicity: (Choose One)

☐ Hispanic/Latino ☐ Non Hispanic/Latino

Race: (Choose One)

☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Black/African American

☐ White ☐ American Indian/Alaskan Native

Parent/Guardian Contact Information

Relation to Child:			
Lives With:	☐ Yes ☐ No	Same Address	☐ Yes
Release to:	☐ Yes ☐ No		
Title:			
Last Name:			
First Name:			
Address 1:			
Address 2:			
City:			
State:			
Zip + 4:			
Home Phone #:			
Cell Phone #:			
Work Phone #:			
Email:			
Occupation:			
Employer:			
Receive Mailers:	☐ Yes ☐ No		

Parent/Guardian Contact Information

Relation to Child:			
Lives With:	☐ Yes ☐ No	Same Address	☐ Yes
Release to:	☐ Yes ☐ No		
Title:			
Last Name:			
First Name:			
Address 1:			
Address 2:			
City:			
State:			
Zip + 4:			
Home Phone #:			
Cell Phone #:			
Work Phone #:			
Email:			
Occupation:			
Employer:			
Receive Mailers:	☐ Yes ☐ No		

Parent/Guardian Contact Information			
Relation to Child:			
Lives With:	☐ Yes ☐ No	Same Address:	☐ Yes
Release to:	☐ Yes ☐ No		
Title:			
Last Name:			
First Name:			
Address 1:			
Address 2:			
City:			
State:			
Zip + 4:			
Home Phone #:			
Cell Phone #:			
Work Phone #:			
Email:			
Occupation:			
Employer:			
Receive Mailers:	☐ Yes ☐ No		

Parent/Guardian Contact Information			
Relation to Child:			
Lives With:	☐ Yes ☐ No	Same Address	☐ Yes
Release to:	☐ Yes ☐ No		
Title:			
Last Name:			
First Name:			
Address 1:			
Address 2:			
City:			
State:			
Zip + 4:			
Home Phone #:			
Cell Phone #:			
Work Phone #:			
Email:			
Occupation:			
Employer:			
Receive Mailers:	☐ Yes ☐ No		

Additional Information	
Document for Proof of Residency:	
Southern Lehigh SD Entry Date:	
Date First Entered PA School:	
Date First Entered US School:	
Document for Birthdate Verification:	
Birth State:	
9th Grade Entry Date: **Gr 9-12 Only**	
60 Day Waiver	☐ Yes ☐ No
Homeless:	☐ Yes ☐ No

Prior School Information (Grades K-12only)	
School Name:	
Address:	
City:	
State:	
Phone #:	
Contact:	

Programs			
Special Ed (IEP):	☐ Yes ☐ No	Type:	
Current ELL Student:		☐ Yes ☐ No	

Please list all students living in the same household as the registering student: (Last Name, First Name, Grade)

1. 4.
2. 5.
3. 6.

Additional Comments:

Parent/Guardian Signature Date

SOUTHERN LEHIGH SCHOOL DISTRICT

New Entrant Health Form

INFORMATION FOR EMERGENCY CARD

Student's Name_____Birthdate _____

Address _____Home Phone Number _____

Child Lives With: Both Parents ☐ Father ☐ Mother ☐ Guardian (Relationship) _____

Name and ages of Siblings _____

_____

Parent/Guardian Last Name _____

Mother's First Name _____Mother's Work Number _____Cell_____

Father's First Name _____Father's Work Number _____ Cell_____

Emergency Contact Person _____ Phone Number _____

Emergency Contact Person _____ Phone Number _____

Family Doctor _____Hospital Preference _____

Family Dentist _____

Special Health Needs: _____

_____

IMMUNIZATION INFORMATION **(Please give complete dates)**

(If you are giving us a paper with you child's immunizations, you do <u>not</u> need to fill out)

Diptheria/Tetanus (DPT)	_____	_____	_____	_____	_____
Polio/Oral (OPV/IPV)	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____		
MMR	_____	_____			
Varicella Vaccine	_____	_____			
Meningitis	_____				
HIB	_____	_____	_____	_____	

Other Immunization _____

(OVER)

Does your Child have or had any of the following? Give dates and details.

	YES	***NO***	***IF YES, PLEASE EXPLAIN***
Asthma	☐	☐	
Uses inhaler	☐	☐	
Allergies:	☐	☐	
Medications	☐	☐	
Foods	☐	☐	
Insect stings	☐	☐	
Other	☐	☐	
Diabetes	☐	☐	
Convulsions/Seizures	☐	☐	
ADD / ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Blood Disorder	☐	☐	
Cardiovascular Disorder	☐	☐	
Gastrointestinal Disorder	☐	☐	
Musculoskeletal Disorder	☐	☐	
Neurological Disorder	☐	☐	
Renal Disorder	☐	☐	
Respiratory Disorder	☐	☐	
Cancer	☐	☐	
Hearing Problems	☐	☐	
Vision problems	☐	☐	
Speech Problems	☐	☐	
Emotional Problems	☐	☐	
Other - Please Specify	☐	☐	

Is your child currently under medical treatment? ☐(YES) ☐(NO)
If yes, please explain _____
Does your child currently take any medications? ☐(YES) ☐(NO)
If yes, please list _____
Does your child require special consideration in classroom? ☐(YES) ☐(NO)
If yes, please explain _____
Does your child require special consideration in phys. ed.? ☐(YES) ☐(NO)
If yes, please explain _____
List any information which you feel should be known to the school nurse _____
_____

Parent/Guardian Signature_____

SOUTHERN LEHIGH SCHOOL DISTRICT

AFFIRMATION OF PRIOR DISCIPLINE RECORD

Section 1304 –A of Act 26 of the Pennsylvania School Code states the following:

(A) 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 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. The Registration shall be maintained as part of the students disciplinary record.

(B) Any willful false statement made under this section shall be a misdemeanor of the third degree.

DIRECTIONS: Check the applicable paragraph, provide all appropriate information, and sign this document.

☐ The undersigned affirms that _____ has **NOT** been suspended or expelled from any public or private school in Pennsylvania 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 against persons and/or property committed on school premises, at any school sponsored activities or on any public or private conveyance providing transportation to or from a school or school sponsored activity.

☐ The undersigned affirms that _____ has been suspended or expelled from any public or private school in Pennsylvania 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 against persons and/or property committed on school premises, at any school sponsored activities or on any public or private conveyance providing transportation to or from a school or school sponsored activity.

If you checked paragraph two, explain the circumstances in detail. Include the school name, dates of suspension or expulsion, and a description of the incident giving rise to the suspension or expulsion.

_____ _____

Parent's or Guardian's Signature Date

_____ _____

Student's Signature (Grade 6-12 only) Date

HOME LANGUAGE SURVEY*

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

School District: **Date:**
School:

Student's Name: **Grade:**

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

2. **Does the student speak a language(s) other than English?**
   (Do not include languages learned in school.)

   ☐ **Yes** ☐ **No**

   If yes, specify the language(s): _____

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

4. **Has the student attended any United States school in any 3 years during his/her lifetime?**

   ☐ **Yes** ☐ **No**

   If yes, complete the following:

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

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

Parent/Guardian signature:

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

TRANSPORTATION

SOUTHERN LEHIGH SCHOOL DISTRICT

5775 Main Street
CENTER VALLEY, PENNSYLVANIA 18034

PHONE: (610) 282-5589
RideWithUs@slsd.org

Student Name: _____ Birthdate: _____

Gender: _____ F _____ M Grade:_____

Home Address: _____

City: _____ Zip _____

Home Phone No.: _____ Cell Number _____

Work Phone No.: _____ E-mail Address _____

Parent Name: _____

Will student be attending Day Care? _____ Yes _____ No

When: _____ Morning _____ Mid-day _____ Afternoon

Location of Day Care: _____

Elementary School Age Sibling(s) (Grades Kindergarten-3rd only)

Name: _____ School: _____ Grade: _____

Name: _____ School: _____ Grade: _____

Name: _____ School: _____ Grade: _____

Comments: _____

Revised 4/10/15

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

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

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

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

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

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

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

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

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

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

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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

REQUIRED FOR KINDERGARTEN STUDENTS ONLY

KINDERGARTEN QUESTIONNAIRE

1. Name the child goes by _____

2. Has your child had any preschool experience? Please do not list day care

Yes: _____ ☐ _____ No: _____ ☐ _____

If yes: How many years? _____

Number of hours per day _____

Number of days per week _____

3. Can your child remember

his/her birthday? _____

his/her age? _____

short messages? _____

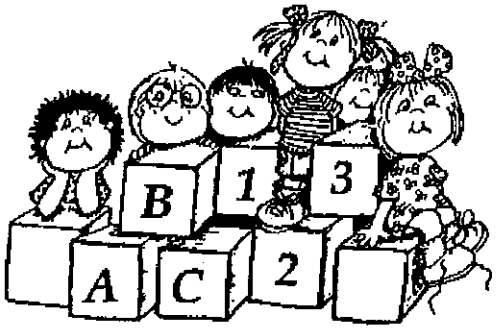
his/her address? _____

4. Is your child able to read a short story independently? Yes _____ ☐ _____ No _____ ☐ _____

5. My child's favorite activities are:

_____

_____



Check each area as it applies to your child and comment below. Does he/she:

	Frequently	*Seldom*	*Never*
1. Play cooperatively with other children	☐	☐	☐
2. Prefer to play alone	☐	☐	☐
3. Join group activities	☐	☐	☐
4. Understand taking turns	☐	☐	☐
5. Willingly share his/her possessions with other children	☐	☐	☐
6. Appear overly aggressive or hostile while playing with other children	☐	☐	☐
7. Have difficulty finding interesting things to do by himself without needing constant direction or prodding	☐	☐	☐
8. Cling to parent in new situations	☐	☐	☐
9. Appear fearful of new situations and strangers	☐	☐	☐
10. Daydream	☐	☐	☐
11. Bite his/her nails	☐	☐	☐
12. Suck his/her thumb	☐	☐	☐
13. Cry easily	☐	☐	☐
14. Have tantrums	☐	☐	☐
15. Become easily distracted	☐	☐	☐
16. Follow several directions after being told once	☐	☐	☐
17. Persist at tasks until completion	☐	☐	☐
18. Pay attention to the reading of a short (10 minutes) story	☐	☐	☐
19. Appear extremely quiet, shy, or non talkative	☐	☐	☐

Additional information about your child that you feel would be helpful:

_____

_____

_____

_____