



kindergarten Readiness Skills

- ❖ Willingness to play and share
- ❖ Can work at a task without constant help
- ❖ Shows an interest in books
- ❖ Knows the ABC song
- ❖ Can name some of the letters of the alphabet
(Children entering kindergarten knew an average of 15 capital letters, 11 lowercase)
- ❖ Can write his/her name (1st letter capital, the rest lower case)
- ❖ Can draw a person with body parts (head, legs, feet, trunk, face...)
- ❖ Name body parts
- ❖ Knows basic colors (red, blue, black, brown, purple, orange, yellow, green, white)
- ❖ Knows basic shapes (circle, square, rectangle, triangle, oval, rhombus, heart, star)
- ❖ Can count to 20.
- ❖ Can form a group of 10 objects or less
(Ex. Show me 5 cars... Show me 9 Cheerios)
- ❖ Listens and follows directions
- ❖ Clap back a pattern
- ❖ Can recall what they've seen
(Ex. Details in a picture, what they ate for a meal)
- ❖ Can manipulate materials such as pencils, crayons, scissors, paint brushes
- ❖ Can take care of self-help skills and toilet needs
(Ex, open lunch/snack items independently)
- ❖ Can dress self
(zip, button, snap, tie)





Certainly one of the most exciting days in your child's life is the first day of kindergarten- the beginning of what we hope will be a rewarding formal education. We welcome you and look forward to educating your child in the Fairfield Area School District.

Our full-day kindergarten program eases children into the routines and structure of "real school," helping them feel comfortable in the school environment. The program strives to balance the best of traditional kindergarten, an atmosphere of play and nurturing, with the best new approaches to hands-on learning.

Daily activities are designed to take advantage of each child's natural curiosity and enthusiasm for learning. Activities such as shared reading of books, drawing, writing in journals, and solving math problems using hands-on materials are meant to help children develop skills in language, math and science. Poetry, music, crafts, dramatics, and field trips help bring their classroom lessons to life.

Fairfield kindergarten children also enjoy additional classes of art, music, physical education, library, technology, and guidance.

Together we can create and maintain the nurturing environment that will lead to student success. By working together, we will help your child succeed. We look forward to this partnership with you as your child enters kindergarten at Fairfield Elementary.

Sincerely, The Kindergarten Teachers
 Mrs. Linda McMullen
 Mrs. Laura Spalding
 Mrs. Terri Westfall



**We look forward to seeing you on
 Friday, April 5th !**



Coming To Kindergarten Should be Easy And Fun For Your Child! We Think This is Just What you May Be Looking For!

We want to offer a great opportunity to your incoming kindergartner to make the transition from home or preschool as easy as possible! To help in this endeavor we are planning some really fun activities and would like to have your child participate!

*****Thursday, April 25: Hand in Hand (Which includes LUNCH in the Cafeteria!) – 9:30-11:20am** (If your child is coming he/she is **expected** to buy lunch – \$2.65. For chicken nuggets, milk, etc. Check www.fairfieldpaschools.org for the complete menu for the day)

*****Wednesday, May 15: Teddy Bear Picnic – 9:30-10:30am**

These activities require parents to drop off their Incoming Kindergartener and pick up PROMPTLY on time, please.

You MUST R.S.V.P. if your child is coming so teachers can have enough supplies available. Please call the school 642-2016 and leave your response with Mrs. Luty, the school secretary.

*****R.S.V.P. one week prior to each activity (April 18th and May 8th)**

Please understand that we cannot accommodate parents for these activities as we have limited space in the classroom and cafeteria. Also, this is a time when your child needs to understand that school is a place where they will be independent of you and we believe it is important they understand that at the beginning...and we feel these FUN activities are a good place to start!

If you feel your child would not do well being without you, then keeping them home would be the other option. As much as we would love to have all the Incoming Kindergartners for this event, we teachers will be very busy with our own kindergarten class plus the Preschool children, so we are counting on you to know your child's limitations and expectations as far as independence is concerned! Thank you!!!

**We are thrilled to begin this educational journey with
your family and your child!**

Fairfield Area School District

Fairfield, Pennsylvania

*****Children of any grade level, K-12, must show proof of immunization before they can attend school in this Commonwealth of PA.***

REGISTRATION CHECKLIST - KINDERGARTEN

This checklist is provided to assist you in the registration process. Please present the following items requested at the time of your registration.

YOUR CHILD WILL NOT BE REGISTERED UNTIL ALL INFORMATION REQUESTED IS RECEIVED BY THE DISTRICT.

- Completed Registration Form
- Completed Transportation Form
- Certified Copy of Birth Certificate
- Proof of Residency- copy of mortgage or lease agreements, utility bills (PS Code 1302 statement)
- Separation / Divorce Form
Custody, Guardianship, Court Placement or Foster Care documentation
- Home Language Survey Form
- Student Identification Form
- Residence Questionnaire
- Emergency/Medical Information Form
- **Record of Immunizations (shot record book, etc.)**
- Required Screening/PA State Mandated School Health Services Form
- Physical Form completed by physician (grades K, 6 & 11)
- Dental Form completed by dentist (grades K, 3 & 7)



Check if previously registered in Fairfield Area School District

Parent Signature _____

Date _____

FAIRFIELD AREA SCHOOL DISTRICT STUDENT REGISTRATION FORM

STUDENT INFORMATION

Student Legal Name (Last) _____ (First) _____ (Middle) _____ (Name used if other than legal name)		GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address (Include apartment number) _____		Date of Birth _____	Place of Birth _____
P.O. Box _____		Race: Please check only one	
City _____	Zip _____	Phone Number _____	White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/>
Grade Placement Anticipated _____		Language spoken in home: _____	
Child Lives with:	Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Grandparents <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/>		
Did child attend pre-school? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what pre-school _____			
If the child was placed in your custody by an agency, give name, contact, address, and phone number of agency. _____			
Are there custody papers pertaining to this student? If yes, please furnish a copy of the custody papers to the registrar.			
Last School Attended _____		Last Grade Attended _____	
Address _____		Was the child identified as exceptional? Hearing <input type="checkbox"/> Gifted <input type="checkbox"/> Speech <input type="checkbox"/> Learning Support <input type="checkbox"/>	
Does your child currently have an Individual Education Plan, Special Education placement or a 504 Plan? _____		If YES, in what State? _____	
Family Physician _____	Address _____	Physician Phone Number _____	

Fairfield Area School District

4840 Fairfield Road, Fairfield, PA 17320

717-642-8228

TRANSPORTATION

Name of Child:

Will the student use district transportation?

Yes No

Will the student need transportation from home address?

Yes No

If, No please list alternative site address:

AM Pick-up Location	
PM Drop off Location	

If you require transportation to an alternate site please list the following:

Babysitter/ Day Care Information:

Name	Address	Phone #

If you have any questions, please call the transportation department at 642-2028.

Students First



FAIRFIELD AREA SCHOOL DISTRICT

4840 Fairfield Road, Fairfield, PA 17320 (717) 642-8228 Fax (717) 642-2036

Dear Fairfield Resident:

According to Pennsylvania School Code 1302, a child can attend a school in the school district where his/her parent(s) / guardian(s) reside. In addition, when a resident of the school district keeps a child in his/her home, supporting the child gratis as if the child were his/her own, the child may also attend the district's schools. However, before the child can attend the district's schools, the resident must provide documentation to show dependency or guardianship or a sworn statement that:

**He/she is a resident of the district,
He/she is supporting the child gratis,
He/she assumes all personal obligations for the child relative to school requirements, and
He/she intends to keep and support the child continuously and not just through the school term.**

A form to verify dependency or guardianship must be completed by the resident and can be obtained in the Central Office where central registration is conducted. Upon completion, the resident is to return the form to the Superintendent. The resident will receive written notification to confirm his/her compliance with the School Code and the child's enrollment in the Fairfield Area School District. Written notice will also be sent should the documentation fail to adequately substantiate guardianship in which case the child will not be enrolled in the school district.

If you have any questions, please feel free to contact Ann Brown in the Superintendent's Office at Fairfield Area School District (717) 642-2003.





FAIRFIELD AREA SCHOOL DISTRICT

4840 Fairfield Road, Fairfield, PA 17320 (717) 642-8228 Fax (717) 642-2036

SEPARATION / DIVORCE

It is the intent of the **Fairfield Area School District** to remain neutral toward families split by divorce or separation. We do not want to take sides with one parent against the other where there may be possible conflict over children attending school in this district. If you have a court decree that establishes you as legal guardian, please provide a copy of such a document for attachment to the child's permanent record. We will refer to this as a legal base for working with the custodial parent.

In the absence of such a document, you must be aware that we cannot deny either parent access to his/her child. We cannot withhold information or refuse to communicate with the other parent.

If the status of your court decree changes you as legal guardian, we would need to be advised of the change. Please provide a copy of the revised document as soon as the change/changes occur.

I have read the above:

Parent Signature

Date

Name of Child

Name of School

Name of Child

Name of School

Name of Child

Name of School



FAIRFIELD AREA SCHOOL DISTRICT HOME LANGUAGE SURVEY

The Fairfield Area School District is committed to ensuring that all students, regardless of their ethnic origin, or home language, receive equal opportunity to access a high quality education and that parents/guardians receive understandable information from school. To assist the District in accomplishing these goals, please complete this HOME LANGUAGE SURVEY.

Child's name: _____

First Name

Middle Name

Last Name

- | | | |
|---|-----|----|
| 1. Was English the first language your child learned to speak?
If NO, what was the first language? _____ | YES | NO |
| 2. Does your family speak English at home?
If NO, what language is spoken in your home? _____ | YES | NO |
| 3. When your child was learning to speak English, did he/she often hear another language?
If YES, what was the other language? _____ | YES | NO |
| 4. We, the parents/guardians, need to have the written information that is sent home from school translated into another language.
If YES, which language? _____ | YES | NO |
| 5. We, the parents/guardians, need to have an interpreter at conferences and meetings.
If YES, which language? _____ | YES | NO |

=====

El distrito Escolar de Fairfield Area se obliga a que todos los estudiantes, sin importar su origen étnico, o su idioma, reciban igual oportunidad de tener una educación de alta calidad y que los padres/tutores reciban información entendible de la escuela. Para ayudar al Distrito a cumplir estas metas, por favor llene esta forma, CUESTIONARIO SOBRE EL IDIOMA MATERNO y devuelva el cuestionario con su hijo(a) tan pronto como le sea posible. Gracias.

- | | | |
|---|----|----|
| 1. ¿Fue Inglés el primer idioma que su hijo(a) aprendió?
Si contesta NO, ¿cuál es el primer idioma que aprendió primero?
_____ | SI | NO |
| 2. ¿Su familia habla Inglés en la casa?
Si contesta NO, ¿cuál idioma se habla en su casa?
_____ | SI | NO |
| 3. Cuando su hijo(a) estaba aprendiendo Inglés, ¿el/ella oía seguido otro idioma?
Si contestó SI ¿cuál idioma? _____ | SI | NO |
| 4. Nosotros, los padres/tutores, necesitamos tener información escrita que la escuela envía traducida en otro idioma.
Si contesta SI, ¿en cuál idioma? _____ | SI | NO |
| 5. Nosotros, los padres/tutores, necesitamos un intérprete en conferencias y juntas.
Si contesta SI, ¿en cuál idioma? _____ | SI | NO |



**FAIRFIELD AREA SCHOOL DISTRICT
HOME LANGUAGE SURVEY**

(continue)

Other students in your family.
Otros estudiantes en su familia

School/Grade
Escuela/Año escolar

Name of Parent/Guardian _____
(Nombre del Padre/Tutor)

Signature/Firma _____ Date/Fecha _____

FAIRFIELD AREA SCHOOL DISTRICT STUDENT IDENTIFICATION

In order to complete records required by the Department of Education; please choose only one of the following racial/ethnic categories.

- AMERICAN INDIAN/ALASKAN NATIVE** - A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.

- ASIAN/PACIFIC ISLANDER** - A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or Pacific Islands. This includes people from China, Japan, Korea, the Philippine Islands, Samoa, India and Vietnam.

- BLACK (NON-HISPANIC)** - A person having origins in any of the black racial groups of Africa (except those of Hispanic origin).

- HISPANIC** - A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

- WHITE** - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East (except those of Hispanic origin).

Student Name: _____

Grade: _____ Building: _____

Parent/Guardian Signature: _____

Fairfield Area School District STUDENT/FAMILY RESIDENCE QUESTIONNAIRE

Your child may be eligible for additional educational services through Title 1 Part A, Title 1 Part C-Migrant and/or Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

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

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

- Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer
- Waiting for foster care placement
- Sharing the housing of others due to loss of housing, economic hardship, or similar reason
- Living in a car, park, campground, abandoned building or other inadequate accommodations
- Temporarily living in a motel or hotel due to loss of housing, economic hardship or similar reason
- Living alone as a minor student 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 the remainder of this form but still need to submit it to school personnel.

2. If you checked any box above, please list all children currently living with you. **ONLY ONE FORM NEEDED PER FAMILY.**

First	M.I.	Last	M/F	Birth Date	Grade	School Name

Signature above certifies that the information provided is accurate.

Your children have the right to:

- Continue to attend school in the school attended before you became displaced (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 to enroll
- 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 ensures the educational rights above for the students who are experiencing homelessness. The McKinney Vento School Liaison for Fairfield Area School District is the Elementary Principal and can be reached at 717-642-2016. If you wish to have a copy of this document, please ask the staff person helping you today.

Printed name of staff member assisting with this process: _____



EMERGENCY CARE INFORMATION

In the case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian or a designated emergency contact.
2019-2020

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Grade:
			Bus # (AM)	Bus # (PM)	
<input type="checkbox"/> Student has medical alert information on file.					

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the resident parent/guardian. The resident parent/guardian is the natural or adoptive parent or legal guardian with whom the student resides for a full calendar year.

Enrolling Parent/Guardian Last:	First:	Middle:	Telephone Home:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Work:
			Cell:
City:	State:	Zip:	Language
Employer:			
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		Resides With <input type="checkbox"/> Yes	Email: Are you a current military family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refuse to Answer

Other Parent/Guardian Residing at Above Address

Last:	First:	Middle:	Telephone Home:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Work:
			Cell:
City:	State:	Zip:	Language
Employer:			
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		Email:	

Other Parent/Guardian Last:

First:	Middle:	Telephone Home:
Street Address: (If providing PO Box, must also provide street address).		Work:
		Cell:
City:	State:	Language
Employer:		
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		Should contact receive mailings throughout the school year: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Email:

Other Parent/Guardian Last:

First:	Middle:	Telephone Home:
Street Address: (If providing PO Box, must also provide street address).		Work:
		Cell:
City:	State:	Language
Employer:		
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other _____		Should contact receive mailings throughout the school year: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Email:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. By listing these individuals you are granting permission to pick your student up from school during the school day.

Name of Person	Relationship	Language	Telephone

MEDICAL HISTORY (Your child's medical condition will be shared with necessary school personnel unless otherwise indicated). Please check any medical condition that pertains to your child and provide an explanation.

Condition	Yes	Comments	Condition	Yes	Comments
ADD/ADHD			Cardiovascular		
Allergy:			Diabetes		
Bee Sting			Gastrointestinal		
Drug		Comment Required:	Hearing Disorder/Deafness		
Food		Comment Required:	Migraines		
Latex			Orthopedic Disorder		
Peanut			Seizure Disorder		
Seasonal			Vision Disorder		
Tree Nut			Other		
Asthma			Other		

Additional Information:

Physician's Name	Telephone
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MEDICATIONS TAKEN AT HOME:

Please list the name and reason for any medication, *prescribed or over-the-counter*, that your child is receiving on a regular basis.

Name	Reason	Dose	Times

OVER-THE-COUNTER-MEDICATIONS AVAILABLE AT SCHOOL/CAMP per School Physician Order: Please note that any medication/s NOT on this list will require a physician's order to be given at school/camp.

My child may **NOT** be given any medications while at school: _____

My child may be given (please initial medications you authorize):

Medication	Initial	Dose
Acetaminophen (<i>Tylenol</i>)	_____	_____
Ibuprofen (<i>Advil</i>)	_____	_____
Antacid (<i>Tums</i>)	_____	_____
Benadryl (<i>Allergy Symptoms</i>)	_____	_____

If you do not indicate a dose, it will be administered according to the student's age/weight.

Parent/Guardians release the Fairfield Area School District, its officers, agents, and employees from all claims and liabilities of any kind arising out of the dispensing of medication to the student pursuant to the authorization granted herein.

In the event of an emergency which would require medical care and treatment to be administered to the student, I/we hereby authorize any physician, hospital, or other health care provider to give emergency medical care and treatment to this student.

The undersigned have read this Medical Authorization Consent Form and declare and affirm that I/we agree to the consents herein stated.

Parent/Guardian – Please Print	Signature	Date
Parent/Guardian – Please Print	Signature	Date
Student's Signature (only if student is 18 or older)		Date



FAIRFIELD AREA SCHOOL DISTRICT

4840 Fairfield Road, Fairfield, PA 17320 (717) 642-8228 Fax (717) 642-2064

Michael P. Adamek
Superintendent
adamekm@fairfield.k12.pa.us

Kristi D. Ebaugh, BSN, RN
District School Nurse
ebaughk@fairfield.k12.pa.us

Required Screenings/PA State Mandated School Health Services

The Pennsylvania School Health Law requires a variety of mandated screenings and immunizations. Necessary information and forms can be found on the district/school website by selecting the **Services** tab and then selecting the **School Health Office** tab. Medical and dental forms are available in each of the school offices or can be printed out.

What does this mean for my Kindergarten student?

Kindergarten students are required to have physical and dental examinations completed. As soon as possible, please have the providers complete these forms based on the most recent (5 year old exam) and return them to the school along with an updated immunization record. Please note the required immunizations for entrance.

- If your Kindergartener is in need of a physical or dental exam, our school doctor and dentist will visit during the 2019/2020 school year to complete the required assessments. (Note: The dental exam is a screening only- cleanings/treatments are not performed.)

Please select:

I will have/have had a private Physical Exam done for my Kindergartener, and will return the completed paperwork.

Date of appointment _____ Practice/Physician name _____

I will have/have had a private Dental Exam done for my Kindergartener, and will return the completed paperwork.

Date of appointment _____ Practice/Dentist name _____

OR

I give permission for the school doctor to examine my Kindergartener (date TBD).

I give permission for the school dentist to examine my Kindergartener (date TBD).

I would like to accompany my child during the school physical and/or dental exam. (You will be notified prior to the date).

As a reminder, **FAILURE TO HAVE A DOCUMENTED PHYSICAL EXAM/DENTAL EXAM FOR YOUR CHILD MAY RESULT IN THE CHILD'S EXCLUSION FROM SCHOOL.**

PLEASE RETURN THIS FORM with the registration packet.

Student Name

Teacher

Signature of Parent/Guardian

Date

*****Parent Signature required for School Physical and Dental Exam!!!*****

01/2019 GJ

Provision of School Health Services and Mandated School Health Services

School entities are to provide the following health services for students who attend or who should attend an elementary, grade or high school, either public or private, and children who are attending a kindergarten which is an integral part of a local school district. These requirements also apply to students who are home schooled.

Mandated School Health Services														
SERVICE	K	1	2	3	4	5	6	7	8	9	10	11	12	Notes
School Nurse Services	X	X	X	X	X	X	X	X	X	X	X	X	X	
Maintenance of Health Record	X	X	X	X	X	X	X	X	X	X	X	X	X	
Immunization Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	
Medical Examination	*	*				X						X		*Required on original entry- K or 1st grade
Dental Examination	*	*	X				X							*Required on original entry- K or 1st grade
Growth Screen	X	X	X	X	X	X	X	X	X	X	X	X	X	
Hearing Screen	X	X	X	X			X					X		
Scoliosis Screen							X							6th grade physical may be used in lieu of 6th grade screen
Tuberculin Test	*	*								X				*Required on original entry- K or 1st grade. Unless approved to discontinue
Vision Screen-Far	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Near	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Convex Lens Test (Plus Lens)	X													1st grade students meeting criteria & new students (any grade) not previously screened
Vision Screen-Color Vision Test	*	*												*1st or 2nd grade & new students (any grade) not previously screened
Vision Screen-Stereo/Depth Perception Test	*	*												*1st or 2nd grade & new students (any grade) not previously screened

Don't Wait. Vaccinate.



SCHOOL VACCINATION INFORMATION FOR PARENTS

The Department of Health is changing school immunization regulations beginning in August 2017. The regulations are intended to ensure that children attending school in the commonwealth are adequately protected against potential outbreaks of vaccine preventable diseases.



A CHILD MUST HAVE REQUIRED VACCINES OR RISK EXCLUSION FROM SCHOOL.

A child must have the required medically-appropriate vaccines or a plan to complete those vaccines or risk exclusion from school. A child may still obtain medical, religious or philosophical exemption from meeting the immunization requirements. Talk to your child's pediatrician about the vaccines your child needs to attend school.



NEW VACCINATION REQUIREMENTS:

- combination form for diphtheria and tetanus;
- pertussis vaccination;
- combination form for measles, mumps and rubella; and
- meningococcal conjugate vaccine for entry into 12th grade, or in an ungraded school, in the school year the child turns 18.

For more information on the vaccines your child needs to attend school, visit dontwaitvaccinate.pa.gov or talk to your child's pediatrician.

dontwaitvaccinate.pa.gov

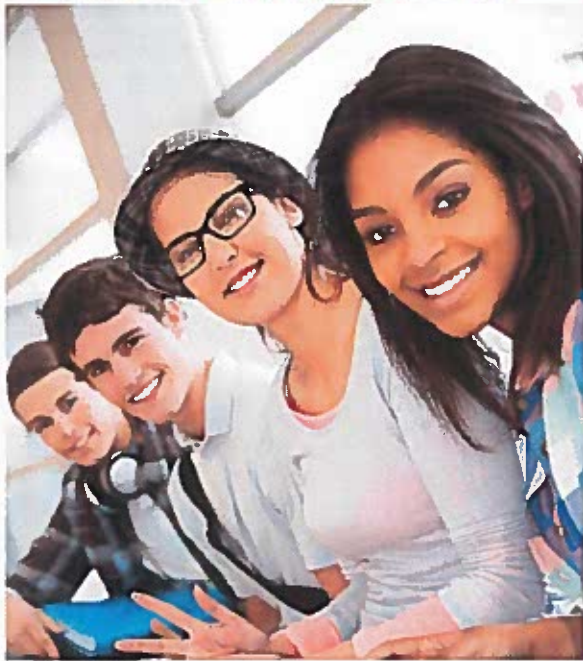


SCHOOL VACCINATION REQUIREMENTS FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:



- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
 - 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
 - 2 doses of measles, mumps, rubella***
 - 3 doses of hepatitis B
 - 2 doses of varicella (chickenpox) or evidence of immunity
- *Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*



ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.



pennsylvania
DEPARTMENT OF HEALTH

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last _____ First _____ Middle _____		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /		Varicella Disease or Lab Evidence Date: _____	
Other _____					

- MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____ Date _____

Result of Diagnostic Studies: _____ Date _____

Preventive Anti-Tuberculosis - Chemotherapy ordered. No Yes _____ Date _____

Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

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 <input type="checkbox"/> M <input type="checkbox"/> F	GRADE	SECTION/ROOM
_____ <small style="display: flex; justify-content: space-between; font-size: 8px;"> Last First Middle </small>				

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				UPPER
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	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