Welcome to Kindergarten At Fairfield Elementary!

Students First!

WELCOME to kindergarten

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 are delighted to join together with you to educate your child in the Fairfield Area School District!

Kindergarten eases children into the routines and structure of "real school", helping them feel comfortable in the school environment. We balance academics and developmentally appropriate activities into an atmosphere of play and fun, as we use the best new approaches with hands-on learning.

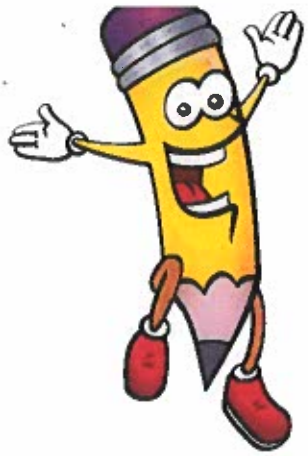
These activities are designed to take advantage of each child's curiosity and enthusiasm for learning. We have reading groups, writing, illustrating stories, solving math problems, and problem solving while using hands-on materials and other means to help your child develop skills in language, fine motor, math, science, social studies and social development. Poetry, music, gym, technology, crafts, guidance and art bring their classroom lessons to life!

Together we can create and maintain the nurturing environment that will lead our students to success! By working together, we will help your child succeed. We look forward to building a relationship with your child and you, as we are sure you know a cohesive team is the BEST way to reach our mutual goal! We are excited that you and your child are a part of the Fairfield Elementary family! WELCOME!

Sincerely,

The Kindergarten Teachers

Drop off your packets & select a screening time on March 23 or 24.



Kindergarten Readiness Skills

I can...

- ❑ Listen and follow directions
- ❑ Work at a task without constant help
- ❑ Show an interest in books
- ❑ Say the ABC song
- ❑ Name some letters
- ❑ Write my name
- ❑ Draw a person with body parts
- ❑ Count to 10 and recognize some numbers
- ❑ Form a group of 10 things or less
- ❑ Clap back a pattern
- ❑ Hold and use pencils, crayons, scissors, paint brushes
- ❑ Use the toilet by myself
- ❑ Dress myself

Fairfield Area School District
Fairfield, Pennsylvania

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 <u>WILL NOT BE REGISTERED</u> 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)

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

☐ 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: ☐ M ☐ F
Street Address (Include apartment number)	Date of Birth	Place of Birth	Birth Cert. /Baptism #
P.O. Box	**Race: Please check only one**		
City / Zip / Phone Number	White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian or Alaskan ☐		
Grade Placement Anticipated _____	**Language spoken in home:** _____		

Child Lives with: Both Parents ☐ Mother ☐ Father ☐ Step-Parent ☐ Grandparents ☐ Guardian ☐ Foster Parent ☐

Did child attend pre-school? Yes ☐ No ☐ 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 / Address	Last Grade Attended	Was the child identified as exceptional? Hearing ☐ Gifted ☐ Speech ☐ Learning Support ☐

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

PARENT OR GUARDIAN INFORMATION - (Please list those guardians living with the student whether step-parent, biological, or foster)

Father's Name (Last, First, MI)	Address (If different from student)	Marital Status ☐ Married ☐ Divorced ☐ Separated

Home Phone	Employer	Employer Phone	Occupation	Birth Date

Mother's Name (Last, First, MI)	Address (If different from student)	Marital Status ☐ Married ☐ Divorced ☐ Separated

Home Phone	Employer	Employer Phone	Occupation	Birth Date

Type of Residence: ☐ House ☐ Apartment ☐ Mobile Home ☐ Owned ☐ Rented	If rented, owner's name

Is the student's parent / guardian an active duty member of a branch of the United States Armed Forces? (Army, Navy, Air Force, Marines and Coast Guard) including full-time Reserve or National Guard duty? Yes ☐ No ☐

Please list any additional children/residents at this address who are not listed above:

(Last, First, Middle)	Employer (if applicable)	Birth Date	School / Employer	Grade	Sex

IF PARENT CANNOT BE REACHED IN CASE OF EMERGENCY OR EARLY CLOSING OF SCHOOL, THE CHILD IS TO GO TO:

Name (Last, First)	Address	Phone Number	Relationship to Student

(TO BE COMPLETED BY OFFICE PERSONNEL)

Start Date		Student ID #	FASD School Attending	School Year	Grade	Effective Date of Transportation	Bus #	Bus Stop

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 717-642-2028.

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

Students First

Fairfield Area School District

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? YES NO
   If NO, what was the first language?_____
2. Does your family speak English at home? YES NO
   If NO, what language is spoken in your home? _____
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. YES NO
   If YES, which language? _____
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 NO
   Si contesta NO, ¿cuál es el primer idioma que aprendió primero?
   _____
2. ¿Su familia habla Inglés en la casa? SI NO
   Si contesta NO, ¿cuál idioma se habla en su casa?
   _____
3. Cuando su hijo(a) estaba aprendiendo Inglés, ¿el/ella oía seguido otro idioma? SI NO
   Si contestó SI ¿cuál idioma? _____
4. Nosotros, los padres/tutores, necesitamos tener información escrita que la escuela envía traducida en otro idioma. SI NO
   Si contesta SI, ¿en cuál idioma? _____
5. Nosotros, los padres/tutores, necesitamos un intérprete en conferencias y juntas. SI NO
   Si contesta SI, ¿en cuál idioma? _____

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 United States Department of Education and Pennsylvania Department of Education; a two-part Ethnicity and Race question are required to be completed.

Part 1: Ethnicity (choose one):

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Part 2: Race (choose one or more):

- ☐ **AMERICAN INDIAN/ALASKAN NATIVE** - A person having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **ASIAN** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **BLACK or AFRICAN AMERICAN (NON-HISPANIC)** - A person having origins in any of the black racial groups of Africa (except those of Hispanic origin).
- ☐ **NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER** - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **WHITE (NON-HISPANIC)** - 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:_____

2023-2024 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.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

Student Cell Phone Number:	Bus # (AM)	Bus # (PM)
☐ 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 Cell:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Home: Work:
City:	State:	Zip:	Language
Employer:			

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Resides With ☐ Yes	Email: Are you a current military family? ☐ Yes ☐ No ☐ Refuse to Answer

Other Parent/Guardian RESIDING AT ABOVE ADDRESS Last:	First:	Middle:	Telephone Cell:
Street Address: (If providing PO Box, must also provide street address). **********SAME AS ABOVE**********		Apt. #	Home: Work:
City: *******	State: *******	Zip: *******	Language
Employer:			

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Email:

Other Parent/Guardian Last:	First:	Middle:	Telephone Cell:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Home: Work:
City:	State:	Zip:	Language
Employer:			

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Should contact receive mailings throughout the school year: ☐ Yes ☐ No Email:

Other Parent/Guardian Last:	First:	Middle:	Telephone Cell:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Home: Work:
City:	State:	Zip:	Language
Employer:			

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Should contact receive mailings throughout the school year: ☐ Yes ☐ 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

Revised July 2019

Complete reverse side.

STUDENT'S NAME: (PRINT) _____ **GRADE** _____

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

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 *(Tylenol)*	_____	_____
Ibuprofen *(Advil)*	_____	_____
Antacid *(Tums)*	_____	_____
Benadryl *(Allergy Symptoms)*	_____	_____

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

Welcome to Kindergarten!

Helpful Tips from the Health Office

To make your child's transition to Kindergarten even easier, use these summer months to work on independence with your child on activities of daily living. Parents are responsible for assisting their child to master these skills before school entrance. If we find a student is having trouble with these skills we will collaborate with parents and teachers to create a plan of action. We may also ask for a consultation with your child's physician to rule out medical problems.

Kindergarten activities of daily living skill expectations:

*Proper hand washing skills using soap and water - lots of suds and 20 seconds or more
*Toilet trained on both bowel and bladder
*Proper hygiene skills when using bathroom
*Can properly use a tissue
*Knows to cover their nose and mouth with elbow when coughing/sneezing
*Knows when to wash hands/use hand sanitizer after touching face, mouth, etc.

Please know that Covid-19 has caused many unknowns for school systems. Once we have a directive from the Pennsylvania Department of Education (PDE), we will share that information on the district website. Until then, please have your child accustomed to wearing a mask.

ANY medication that needs to be given at school needs a doctor order. The school has standing physician orders Tylenol, Ibuprofen, Tums or Benadryl. Medication Permission Forms are available online at the district website listed below. Medication Permission Forms are needed for any over the counter medications, antibiotics, vitamins, medicated eye drops, topical creams, sunscreen, etc.

Extra forms for physical, dental exams and info for vaccine requirements are on our website at: www.fairfieldpaschools.org (Select DEPARTMENTS" > "Health Office" >Forms K-12)

If you have any questions please contact the school nurse or office. We will be happy to help.

Kristi Ebaugh, RN, BSN District School Nurse
Fairfield Area School District
(717) 642-2016
ebaughk@fairfield.k12.pa.us

Health Requirements for Kindergarten

***If your child is not up-to-date on their vaccines or physical exam, please email ebaughk@fairfield.k12.pa.us with the name of your child, the date their exam is scheduled, and the name of the doctor's office ASAP.**

- **Vaccines** - In accordance with the Public School Code of PA, all students must meet vaccination requirements - **4 doses of DTaP*, 4 doses of Polio*, 2 doses of MMR, 3 doses of Hepatitis B, 2 doses of Varicella (or evidence of immunity) PRIOR TO the first day of Kindergarten.** There is not a grace period for Kindergarten vaccines. Failure to submit proof of immunization prior to the first day of school will result in **exclusion** from school. *One dose of Polio and DTaP must be on or after 4th birthday.

- **Physical Exam** - the Public School Code of PA requires all children entering Kindergarten to have a physical exam. Please submit your physical form prior to the first day of Kindergarten. Failure to provide a completed physical exam form will result in **exclusion** from school.

- **Dental Exam** - the Public School Code of PA requires all children entering Kindergarten to have a dental exam. This can be a private or school dental exam. Please submit your dental form prior to the first day of Kindergarten. If you do not have a dentist and would like to have the school dentist provide an exam, please contact the school nurse for details.

**Health forms can be easily submitted by taking a picture and emailing directly to the District Nurse at ebaughk@fairfield.k12.pa.us, turned in to the administration office or (when school is in session) can be given to the nurse.

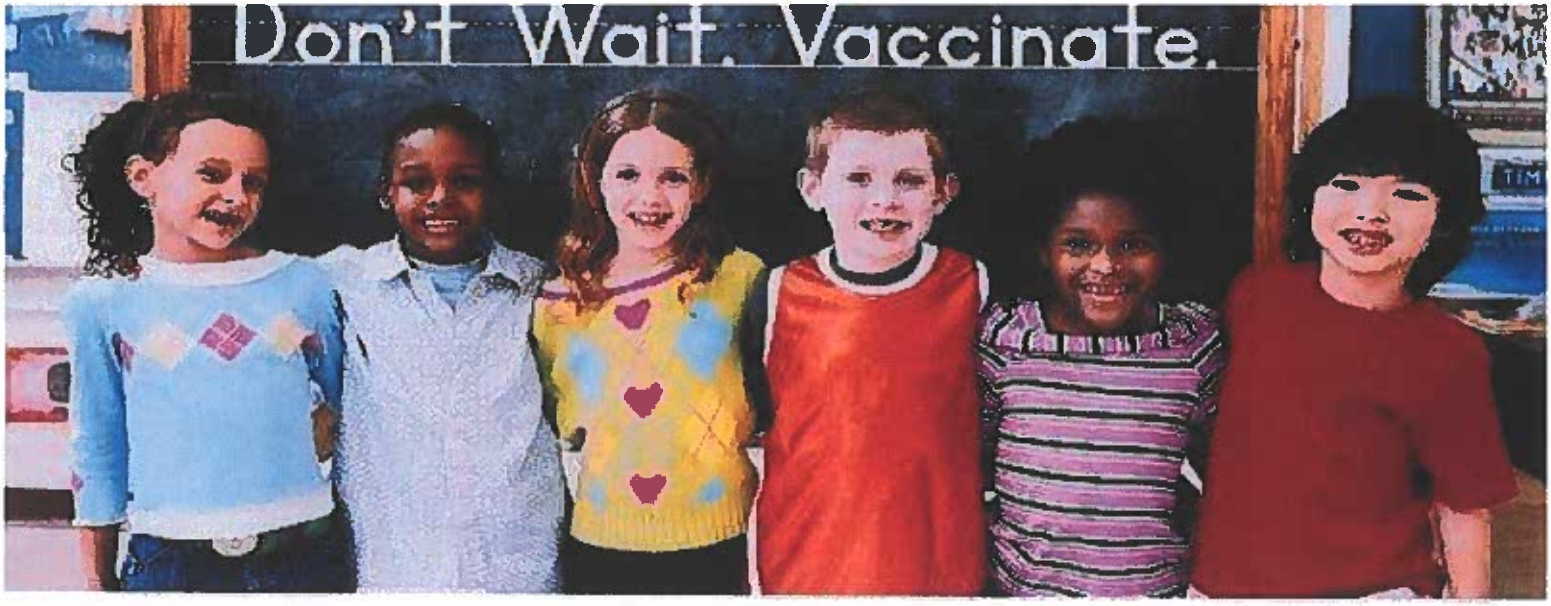
Date of Issue September 2017

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	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 Visual Acuity Test	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Near Visual Acuity Test	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



SCHOOL VACCINATION INFORMATION FOR PARENTS

Immunization 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 BEING EXCLUDED FROM SCHOOL.

A child must have the required doses complete, or medically appropriate doses up to date and a plan in place for remaining doses by the fifth day of school, or they are at risk of exclusion. For a single dose vaccine, the child must have this vaccine before the first day of school or the child may be excluded from attending. Talk to your child's pediatrician about the vaccines your child needs to attend school.

- Four doses of DTaP (one dose on or after the 4th birthday)
- Four doses of polio (fourth dose on or after 4th birthday)*
- Two doses of measles, mumps, rubella (MMR)
- Three doses of hepatitis B
- Two doses of varicella (chickenpox) or evidence of immunity
- Seventh grade - in addition to those above, one dose of Tdap and one dose of MCV4
- 12th grade - in addition to those above, a second dose of MCV4

*A fourth dose is not necessary if the third dose was administered at age 4 or older, and at least 6 months after the previous dose

For more information on the vaccines your child needs to attend school visit:
https://www.health.pa.gov/topics/programs/immunizations/Pages/School.aspx **or talk to your child's pediatrician.**

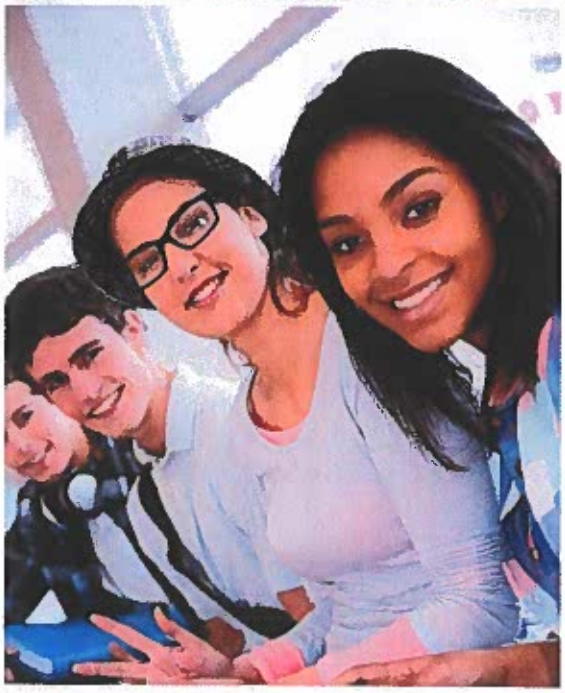
pennsylvania
DEPARTMENT OF HEALTH

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

FAIRFIELD AREA SCHOOL DISTRICT

4840 Fairfield Road, Fairfield, PA 17320 | (717) 642-2016 | Fax (717) 642-2018 | fairfieldpaschools.org

Thomas Haupt
Superintendent
hauptt@fairfield.k12.pa.us

Kristi 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. Medical and dental forms are available in each of the school offices or can be printed from the FASD online page. Necessary information and forms can be found on the district/school website by selecting the **Department** tab and then selecting the **Health Office** tab.

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 school year to complete the required assessments. (Note: The dental exam is a screening only- cleanings/treatments are not performed.)

Please select one option for Physical Exam and one option for Dental Exam:

___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_____

___I give permission for the school doctor to provide the Physical **Exam** of my Kindergartener (date TBD).

___I give permission for the school dentist to provide the Dental **Exam** of my Kindergartener (date TBD).

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 Date of Birth Teacher

_____ _____
Signature of Parent/Guardian Date

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

01/2023 KE

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

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

Student's name _____ Today's date _____

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

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

_____

_____

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

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

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

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

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

Signature of parent / guardian / emancipated student _____ Date _____

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

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: 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 ☐**

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)					

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