

WELCOME TO
KINDERGARTEN
AT
FAIRFIELD ELEMENTARY!



STUDENTS FIRST!



Dear Kindergarten Families,

Welcome to Fairfield Area Elementary School! We are thrilled to have your child join our Kindergarten community this year. This is such an exciting time for both you and your little one, and we are committed to making this journey a positive and enriching experience.

At Fairfield Elementary, we believe in fostering a nurturing and engaging environment where children can grow, explore, and develop their love for learning. Our dedicated teachers and staff are here to support both you and your child every step of the way. We understand that starting school is a big transition, and we will do everything we can to make it a smooth and joyful one for your family.

Throughout the year, we will keep you informed of upcoming events, important dates, and classroom activities. Please feel free to reach out with any questions or concerns you may have—we're here to help!

Once again, welcome to the Fairfield Knight family. We look forward to an exciting year of learning, growth, and fun!

In Partnership,

Colleen Rebert
Elementary Principal

Important Dates:

Meet with the Principal/ Kindergarten Registration Packet Drop off:

Time-by appointment

Dates: March 27 and 28, 2025

Kindergarten Screening (Bring your child)

Time- by appointment

Date: May 30, 2025

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 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)

*****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

FAIRFIELD AREA SCHOOL DISTRICT STUDENT REGISTRATION FORM

Parent Signature _____

Date _____

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						
City	Zip	Phone Number		Race: Please check appropriate boxes.		
				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"/>	Guardian <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		Was the child identified as exceptional?		
Address		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 for Special Education placement or a 504 Plan? _____						
Family Physician				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)		Email:		Marital Status		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
Home Phone	Employer	Employer Phone	Occupation					Birth Date		
Mother's Name (Last, First, MI)		Address (If different from student)		Email:		Marital Status		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
Home Phone	Employer	Employer Phone	Occupation					Birth Date		
Other Guardian (Last, First, MI)		Address (If different from student)		Email:		Marital Status		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
Home Phone	Employer	Employer Phone	Occupation					Birth Date		

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

(Last, First, Middle)	Employer (if applicable)	Birth Date	School (If applicable)	Grade	Gender

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:

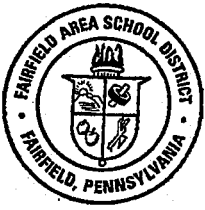
AM Pick-up Location	
PM Drop off Location	

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

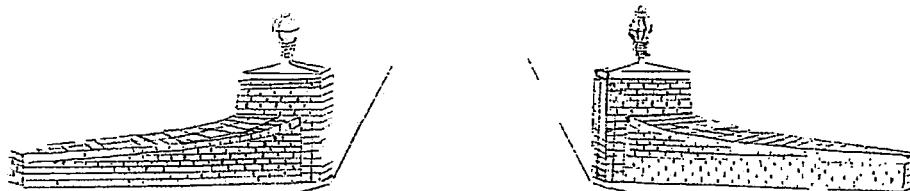
Dear Fairfield Resident:

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

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 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: _____



2025-2026 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: <input type="checkbox"/> M <input type="checkbox"/> F	Grade:
Student Cell Phone Number:			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 Cell:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Home: Work:
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 Cell:
Street Address: (If providing PO Box, must also provide street address).		Apt. #	Home: Work:
*****SAME AS ABOVE*****			
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 Cell:
Street Address: (If providing PO Box, must also provide street address).		Home: Work:
City:	State:	Zip:
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 Cell:
Street Address: (If providing PO Box, must also provide street address).		Home: Work:
City:	State:	Zip:
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

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!

FROM THE SCHOOL NURSES

Kindergarten is a big step for children and their parents/guardians. As exciting as this time may be, it can also be challenging. There can be an initial struggle with the long days, learning new materials, new routines, gaining independence and getting used to time spent away from home. Our health office staff, nurses Kristi and Carrie, have prepared a list of tips to help make this transition an easier one for your family.

What can you do to help your child be prepared for their first day?

- **Establish a healthy bedtime routine** - Encourage a consistent bedtime routine that allows for everyday hygiene (like taking a bath, putting on pajamas, brushing teeth, etc.) and around 10 hours of sleep each night.
- **Encourage healthy eating habits** - Eat a balanced breakfast. Remember to pack a snack and a leak-proof water bottle. Try fruits and vegetables with each meal. When possible, sit together while eating meals so you are able to focus on talking and connecting with your child.
- **Practice independence with meals** - Allow your child to practice eating a packed lunch and let them practice independence with opening bags, containers, juice/milk and more.
- **Potty training** - Kindergarteners should be fully potty trained before starting school. It is expected that children at this age can independently manage their toileting needs. If your child has a medical diagnosis or developmental delay that is preventing your child from being potty trained, please reach out to the school to discuss their specific needs so we can create a supportive plan.
- **Hand washing** - Prevent colds and sickness by teaching your child when and how to wash their hands. Hand washing, with lots of suds for at least 20 seconds, should be done before handling food or eating, after using the bathroom, after blowing their nose or coughing in their hand, after playing outside and after playing with animals. Hand washing is best but hand sanitizer can be used when soap and water isn't available.
- **Be active** - our bodies are made to move! You can support your child by encouraging them to get at least one hour of active play every day, more is better!

Medications at School

Any medication that needs to be given at school must have a Medication Permission Form completed by their doctor before it can be administered at school. This includes any over the counter medication, topical creams, vitamins, etc. The school does have general physician orders for Tylenol, Advil, Tums, and Benadryl - these medications can be given as long as the parent/guardian has completed the online permission form in Skyward or signed the medication form in the registration packet.

Does your child have a serious medical condition?

Serious medical conditions can include life-threatening allergies with anaphylaxis, diabetes, seizures, asthma, heart conditions, cerebral palsy and more.

If your child has a serious medical condition, please email the School Nurse, Kristi Ebaugh, as soon as possible at ebaughk@fairfield.k12.pa.us. Together, with your child's teacher and principal, we can determine if accommodations will be needed for your child in the classroom.

Is your child too sick to go to school?

There will be times that your child is not feeling well enough to participate in school. On those days, you need to notify your child's teacher and the attendance secretary, preferably by email before 9:00 am that day. For a detailed list of reasons that your child may be too sick to go to school please visit our school webpage <https://www.fairfieldpaschools.org/domain/35> and select the link titled "Illness Guidelines - How to Know When Your Child Should Stay Home." If your child becomes sick at school, health office staff will reach out to you to pick up your child. If you are unable to pick up your child in a reasonable timeframe, please have an additional adult who is able to do so. If you have questions or concerns, please contact the health office and we'll be happy to help.

Additional Information

Additional information, such as contact information, vision and hearing screening information, Medication Permission Forms and more, can be found on the school website. Please visit [fairfieldpaschools.org](https://www.fairfieldpaschools.org) > District Services > Health Services to learn more.

If you have additional questions or needs throughout the year, please remember that the school nurse can be an excellent resource for you and your child.

Kristi Ebaugh, BSN, RN, CSN
Fairfield Area School District School Nurse
ebaughk@fairfield.k12.pa.us



FAIRFIELD AREA SCHOOL DISTRICT

Thomas J. Haupt
Superintendent

Kristi D. Ebaugh
District School Nurse

Pennsylvania Health Requirements for Kindergarten

The Pennsylvania School Health Law requires a variety of mandated screenings and immunizations. Please review the information below to ensure you have included all necessary documents with your child's registration. Incomplete health records could delay the start of your child's first day of school. If your child is not up-to-date on their immunizations or physical exam at the time you are submitting their registration packet, 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 as soon as possible.

PA Public School Code Section 1402 requires that students entering kindergarten submit the following:

- ☐ Four year old well child health physical with physical form completed
- ☐ Dental exam with dental form completed between April 2025 - May 2026
- ☐ Vaccines as listed below
 - ☐ 4 doses of DTaP* (diphtheria, tetanus, acellular pertussis)
 - ☐ 4 doses of Polio*
 - ☐ 2 doses of MMR (measles, mumps, rubella)
 - ☐ 3 doses of Hepatitis B
 - ☐ 2 doses of Varicella (chicken pox) or evidence of immunity

**4th dose must be given on or after 4th birthday.*

Please note, all students must meet immunization requirements **PRIOR TO the first day of kindergarten**. There is not a grace period for this kindergarten requirement. If you have not submitted your child's immunizations prior to August 1, 2025, please email the school nurse so we can collaborate on a plan for your student. Failure to submit proof of immunization prior to the first day of school may result in **exclusion** from school.

Health forms can easily be submitted by scanning/emailing them directly to the District Nurse at ebaughk@fairfield.k12.pa.us or turned in to the administration office.

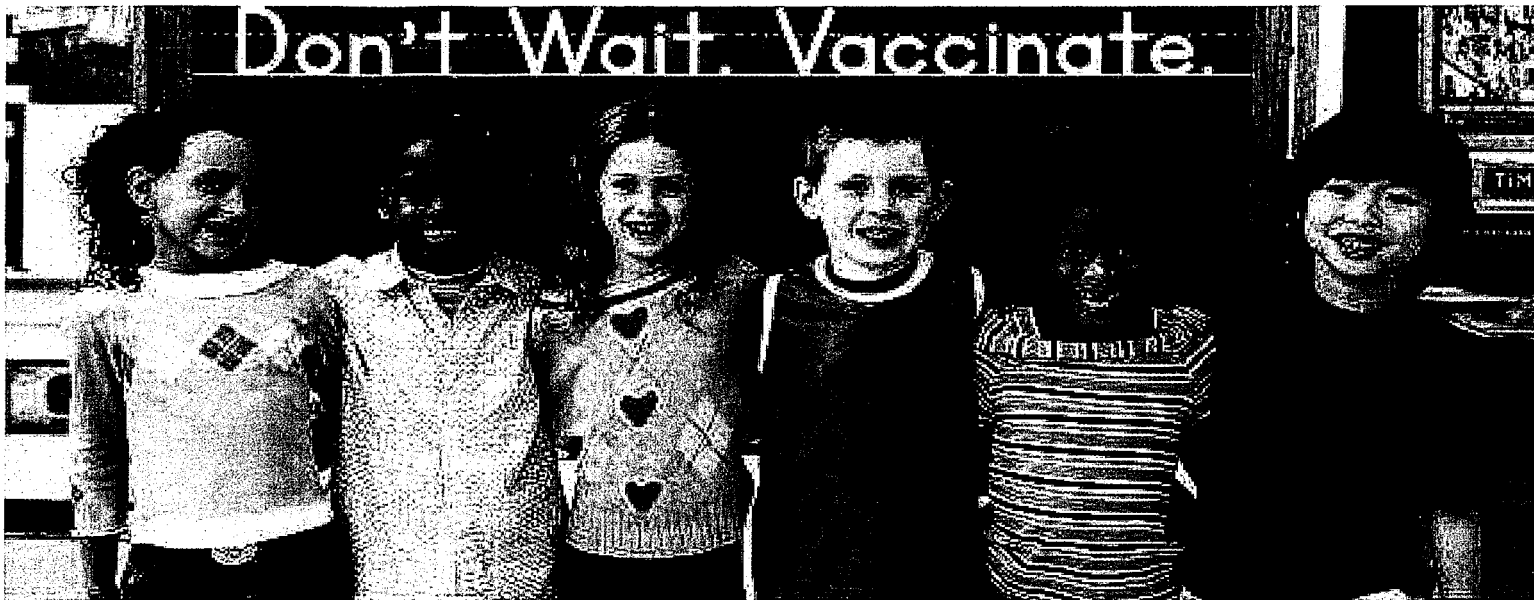
Provision of School Health Services and Mandated School Health Services

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

Don't Wait. Vaccinate.



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.

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



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

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

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

Signature of parent / guardian / emancipated student _____ Date _____

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

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

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

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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)					

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

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

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	29	28	27	26	25	24	23	22	21	20	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