North Hills School District

PRIDE • TRADITION • EXCELLENCE

Home and Health Packet

This packet should be completed, printed and submitted during all new student registration appointments. Please use checklist below to ensure all forms have been completed.

- ☐ **Foster Care Questionnaire**
  - Completed by parent/guardian

- ☐ **Home Language Survey**
  - Completed by parent/guardian

- ☐ **English as a Second Language Student Background Questionnaire**
  - Completed by parent/guardian

- ☐ **Private or school medical/dental exam permission form**
  - Completed by parent/guardian

- ☐ **Physical Examination**
  - Page 1 completed by parent/guardian
  - Pages 2-4 completed by physician
  - **Be sure to include copy of student's immunization record**

- ☐ **Lead Testing Record**
  - Top portion completed by parent/guardian
  - Bottom portion completed by physician

- ☐ **Private Dental Exam**
  - Completed by dentist

NORTH HILLS SCHOOL DISTRICT
REGISTRATION FOR
NONRESIDENT STUDENTS IN PRIVATE HOMES
"FOSTER CARE"

Must be Completed for All Students

School: _____ **Date:** _____

Student Name: _____ **Date of Birth:** _____ **Grade:** ____

Is this student in foster care? Yes No

If yes, complete the following information:

Name of Foster Parent/s with whom student is placed: _____

Address: _____ **Phone:** _____

_____

Name of Placing Agency: (Required): _____

Address: _____ **Phone:** _____

_____ **Date of Placement:** _____

Name of Natural Parents: _____

Address: _____

_____

Name of school district in which the natural parent resides:

_____

Name of school building student would have attended:

_____

Address: _____

_____

Required:

A. Information on foster placement received on agency letterhead Yes No
B. Stipend identified in letter Yes No
C. Foster parent stated intent to adopt Yes No
D. If yes to C, is there any court documentation which identifies pre-adoptive status Yes No
E. If no to D, inform foster parents that once pre-adoptive status is obtained through court documentation that they must notify the school district so that we may adjust our records accordingly and file appropriate documents with student's attendance file.

HOME LANGUAGE SURVEY

Must be completed for All Students

Building: _____ Date: _____

Student Name: _____
(Last) (First)

Date of Birth: _____ Gender: M F Grade Level: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____

The Civil Rights Act of 1964, Title VI-Language Minority Compliance Procedures, requires that school districts/charter schools identify limited English proficient (LEP) students. Pennsylvania Department of Education has selected the Home Language Survey as the method for the identification.

What was the student's first language? _____

Does the student speak a language other than English? Yes No

If yes, please indicate language: do not include languages learned in school:

_____

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

Has the student attended any United States school in any three (3) years during his/her lifetime: Yes/No

If yes, please complete the following:

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

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

Parent/Guardian Signature: _____ Date: _____

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

Please file original with student's records.
Forward a copy to your District ESL Administrator.

School District: _____
School: _____ Grade: ___

English as a Second Language
Student Background Questionnaire

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

Male / Female (circle one) Birthday: _____ (month) (day) (year) Age: _____ Telephone: _____

Address: _____

Father's Name _____ Father's Native Country _____

Mother's Name _____ Mother's Native Country _____

Names and ages of brothers and sisters: _____

_____

Names and relationships of others living in the home: _____

_____

Was your child born outside the U.S? ☐ No ☐ Yes If yes, list the country: _____

Child's First Spoken Language: _____

When did this student come to the United States? _____

What language is used with parents? _____ With siblings? _____
With friends? _____

If your child is cared for by another person, what language is most often used? _____

Is an interpreter needed for home/school communication? ☐ No ☐ Yes

My child…	Very well	Only a little	Not at all
Reads English			
Writes English			
Reads first language			
Writes first language			

Student's Name: _____

SCHOOL HISTORY

Please give the following information. Fill in name of each school one time. Indicate any breaks in schooling. Give any information that would help us understand your student's background better.

Age	Grade	Name of School; Location	Language(s) Used
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18+			

Last grade completed: _____ When? _____

Has your child studied English? ☐ No ☐ Yes How long? _____

Has your child ever received ESL instruction? ☐ No ☐ Yes Where? _____

Additional information you want us to know:

Student's special interests: _____

In school, student does well in: _____

Special medical problems the school should know about:

_____

Does your child have learning difficulties? _____

Other: _____

_____

Form filled out by: _____

(Signature) (Date)

Student grade placement (if determined): _____

North Hills School District

PRIDE • TRADITION • EXCELLENCE

Dear Parent or Guardian,

Pennsylvania School Health Law requires that all students have a medical examination upon **entrance to school** and in **6th** and **11th** grades. A dental examination is also required upon **entrance to school** and in **3rd** and **7th** grades.

The best interests of your child are served by having a continuous relationship with a family physician and dentist. Please have your child's physician and dentist complete the enclosed examination forms and **return to the school nurse**.

Medical and dental examinations will be accepted from previous year to current year.

If you prefer, the school physician/dentist will do the examination. If you select this option below, the school nurse will notify you of the date of the examination.

Please contact the school nurse with any questions.

- **Physical and dental forms are due by October 1**
- **Any outstanding immunizations MUST be completed and documentation received BY the first day of the student's attendance**

Please complete and return to school as soon as possible

NAME OF CHILD_____
(Last) (First) (Middle)

SCHOOL_____GRADE_____

1. _____ My child will be examined by his/her _____ physician/ _____ dentist.

Name of physician_____ Name of dentist_____

2. _____ I request that the school _____ physician/ _____ dentist examine my child.

_____ _____
Date Parent/Guardian Signature

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

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

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

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

Print name of examiner _____

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

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

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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

Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, health department staff)

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

 Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/_____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/_____/____
(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/_____/____
(Physician)

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