

Student # _____

Neshaminy School District
Langhorne, Pa 19047

ESL
First Language Learned
ENGLISH Yes No
OTHER _____

STUDENT REGISTRATION

School _____			Grade Entering _____		
Last Name	First Name	Middle	SEX	Birthdate	Registration Date
Street Address		Apartment Name & #		<input type="checkbox"/> M <input type="checkbox"/> F	Birthplace
City	Zip Code	Phone #	Birth Certificate Verification		Immunization

Name of Parent/Guardian:				Child Lives With	Relationship	Citizenship	Education	Occupation
#1	Last	First	Middle					
#2	Last	First	Middle					
#3	Last	First	Middle					

Email #1		#2	#3
Employer of Parent/Guardian:			
	Employer Name	Employer Address	Employer Phone
#1			
#2			
#3			

Marital Status of Parent/Guardian: Please check as appropriate						
	Single	Married	Separated	Divorced	Widowed	Remarried
#1						
#2						
#3						

Brother/Sisters at Home	Birthdate	Brother/Sisters at Home	Birthdate
Name of Previous School		Address of Previous School	
Principal /Counselor of Previous School		Dates Last Attended _____ Grade Last Attended _____	

Was this child in special education program? Yes No Type of Program _____
 Does your child have permission to use the Internet? Yes No
 Does your child have permission to be photographed or video taped for school purposes? Yes No
 Do you have a custody agreement on file? Yes No

Parent/Legal Guardian Signature _____	Print Name of Parent/Legal Guardian _____
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OFFICE USE ONLY

1st Attendance Date _____ Teacher _____ Resident _____ Ethnic Code _____
 Section _____ Affidavit _____ Census Code _____ Roll Call _____
 Tuition _____ Entry Code _____ Room Number _____ Home Dist. _____
 Curriculum Code _____ 1305/1306 (Circle One) Proof of Residency Submitted Date: _____

Name - Institution Address

Placing Agency Guardian

Neshaminy School District

Emergency Information Card

Please PRINT

Students's Name _____

Address _____ Last _____ Town _____ First _____ Zip _____ Home Phone _____ Homeroom _____

Mother's Name _____ Work Phone _____ Cell _____

Father's Name _____ Work Phone _____ Cell _____

If student lives with someone other than a parent:

Name _____ Relationship _____ Cell _____

List two people to assume temporary care of your child if you cannot be reached. These individuals will be permitted to sign your child out of school only in cases initiated by a school nurse or administrator.

1. Name _____ Relationship _____ Cell _____

2. Name _____ Relationship _____ Cell _____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, one of the people designated above is to be contacted. If it is not possible to reach either of them, I authorize school peronnell to take steps to insure my childs health and safety.

Signature of Parent/Guardian _____ Date _____

Family Physician _____ Phone _____

Dentist _____ Phone _____

NESHAMINY SCHOOL DISTRICT

Office Use: **Provided with Student Registration**

CENSUS ENUMERATION FORM

Parcel # _____

(Please Print)

Date: _____

Current Address: _____

Boro/Twp: _____

Former Address: _____

Boro/Twp: _____

Do you: Own your home Rent (name of landlord _____)

How long have you been a resident at your current address? _____

PLEASE LIST ALL RESIDENTS OVER 18 YEARS OF AGE

Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
Occupation	Employer	Employer Address

PLEASE LIST ALL CHILDREN UNDER 18 LIVING AT YOUR ADDRESS (FROM OLDEST TO YOUNGEST)

Name (Last, First, Middle)	M Sex F	Date of Birth (Month/Day/Year)	School	Grade
	<input type="radio"/> <input type="radio"/>			
	<input type="radio"/> <input type="radio"/>			
	<input type="radio"/> <input type="radio"/>			
	<input type="radio"/> <input type="radio"/>			

Please state intention of pre-school children to attend **public, private or parochial school**

THIS INFORMATION IS REQUIRED FROM ALL RESIDENTS OF NESHAMINY SCHOOL DISTRICT

**NESHAMINY SCHOOL DISTRICT
ACT 26 REGISTRATION STATEMENT**

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or the willful infliction of injury to another person or for any act of violence committed on school property."

To be completed by the Parent or Guardian:

Student: _____ DOB: _____

I hereby swear or affirm that my child (was (was not previously suspended or expelled, or (is (is not presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act of offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

<i>Please complete this section if student has been or is presently suspended or expelled from another school:</i>	
Name of school from which student was suspended or expelled:	
Dates of suspension or expulsion: (Please provide additional schools and dates of suspension/expulsion)	
Reason for suspension/expulsion: (optional)	

Signature of Parent or Guardian

Date

Any willful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.
24 P.S. §13-1317-2

**NESHAMINY SCHOOL DISTRICT
HOME LANGUAGE SURVEY***

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

(Please Print)

School District: NESHAMINY SCHOOL DISTRICT Date: _____

School: _____ Grade: _____

Student's Name: _____

Parent/Guardian Name: _____

Phone number with area code: (____) _____

Country of Birth: _____

1. Initial US entry date: ____/____/____ Immigrant: Yes No

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

Does the student speak a language(s) other than English? Yes No (Do not include languages learned in school)

If yes, specify the language(s): _____

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

4. Number of years in US schools: _____

a. Has the student attended any United States school in any 3 years during his/her lifetime? Yes No

If yes, complete the following:

<u>Name of School</u>	<u>State</u>	<u>Dates Attended</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Parent/Guardian Signature: _____

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

OFFICE USE: Student ID# _____
English Proficiency Level: _____ Program Start Date: _____
If one of the answers is a language other than English or the country of origin is other than the United States, send a copy of this form to the District ELL Coordinator and the school's ELL teacher. Place the original in the child's cumulative folder. This form remains in the folder throughout the child's school career.



Neshaminy School District

2001 Old Lincoln Highway • Langhorne, Pennsylvania 19047-3295

Dear Parent/Guardian,

The Pennsylvania School Code requires school entities to maintain a School Health Record on each student under its jurisdiction. Each student's record contains identification data, notable medical history, the student's immunization record, results of health screening exams performed in the school setting, reports of exams by physicians and dentists, and notes on health issues related to the student's school attendance and academic success.

Maintenance of the School Health Record is the responsibility of the certified school nurse. The certified school nurse is extended the authority to perform mandated health screenings. The following screenings are performed by the school nurses in Neshaminy at the grade level designated by the state:

- **Growth screen including calculation of the BMI percentile**
- **Vision screen including far vision acuity, near vision acuity, stereo depth perception, color discrimination and convex lens acuity**
- **Auditory screen**
- **Scoliosis screen**

The Pennsylvania School Code also requires periodic screening exams by a dentist and a physician. The state encourages these exams to be performed by the family health care providers who can best evaluate changes to the child's health status. Neshaminy School District will provide a screening physical and/or dental exam for any student who is unable to obtain an exam from their family health care provider. Parents will be notified at least one week prior to the date of the school based dental and physical exams. Parents will be notified of any abnormal findings from any screening exams performed at school.

_____ I acknowledge the receipt of the above information regarding the School Health Program in the Neshaminy School District and I agree that my child may receive screening exams from the certified school nurses on an annual basis as required by the School health Code.

Student's Name

Date of Birth

Signature of Parent/Guardian

Date

This document will remain in effect for as long as my child is enrolled in the Neshaminy School District.



Neshaminy School District

2001 Old Lincoln Highway • Langhorne, Pennsylvania 19047-3295

Student Health History

Previous School Attended: _____ Current Grade: _____

Address of Previous School: _____

Student's Name (Last, First): _____ M ___ F ___ Birthdate: _____

Address: _____ Phone: _____

Father's Name: _____ Mother's Name: _____

Person with whom student lives / relationship: _____

Conditions

___ Allergy to: _____ Treatment: _____

___ Asthma Symptoms: _____

What does your child do to manage his/her own condition?

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Bowel Concerns | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> In Counseling |
| <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Orthopedic/Bone | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Social/Emotional/Behavioral | <input type="checkbox"/> Vision Problem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Takes Medication Daily at: | <input type="checkbox"/> Home | <input type="checkbox"/> School |

Medication is: _____ for: _____

Provide any other information that you think we should know about your child.

Names and ages of other children in the family: _____

Parent/Guardian

Date

Attach a Copy of Student's Immunization Record

Neshaminy District Offices - 215-809-6000

Neshaminy High 215-809-6100 • Maple Point Middle 215-809-6230 • Poquessing Middle 215-809-6210 • Carl Sandburg Middle 215-809-6220
Pearl Buck Elem. 215-809-6300 • Samuel Everitt Elem. 215-809-6320 • Oliver Heckman Elem. 215-809-6330 • Herbert Hoover Elem. 215-809-6340 • Lower Southampton Elem. 215-809-6350
Waller Miller Elem. 215-809-6360 • Joseph Ferderbar Elem. 215-809-6370 • Albert Schweitzer Elem. 215-809-6380

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 or Township	County	State	Zip
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REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	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				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
				T	S	R	Q	P	O	N	M	L	K				
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



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