Student # _____

Neshaminy School District
Langhorne, Pa 19047

STUDENT REGISTRATION

ESL
First Language Learned
ENGLISH Yes ☐ No ☐
OTHER _____

School _____ Grade Entering _____

Last Name	First Name	Middle	SEX	Birthdate	Registration Date
			☐ M ☐ F		
Street Address		Apartment Name & #		Birthplace	Previous Neshaminy School Attended-Date
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

OFFICE USE ONLY

1st Attendance Date _____ Teacher _____
Section _____ Affidavit _____
Tuition _____ Entry Code _____
Curriculum Code _____ 1305/1306 (Circle One)

Resident _____ Ethnic Code _____
Census Code _____ Roll Call _____
Room Number _____ Home Dist. _____
Proof of Residency Submitted Date: _____

_____ Name – Institution

_____ Address

_____ Placing Agency

_____ Guardian

Distribution: White – Cumulative Folder/Canary – Pupil Services

8/06 NSD#920020

Neshaminy School District

Emergency Information Card

Please PRINT

Students's Name _____ _____ _____
Last First Homeroom

Adress _____ Town _____ Zip _____ Home Phone _____

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 pernonnell 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)	Sex M ◯ F ◯	Date of Birth (Month/Day/Year)	School	Grade
	◯ ◯			
	◯ ◯			
	◯ ◯			
	◯ ◯			

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.

Please complete this section if student has been or is presently suspended or expelled from another school:	
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:

Name of School	State	Dates Attended

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?

_____

☐ ADD ☐ ADHD ☐ Autism
☐ Bowel Concerns ☐ Cancer ☐ Diabetes
☐ Hearing Problems ☐ Heart Disease ☐ In Counseling
☐ Kidney/Bladder Disease ☐ Orthopedic/Bone ☐ Seizure Disorder
☐ Social/Emotional/Behavioral ☐ Vision Problem ☐ Other _____
☐ Takes Medication Daily at: ☐ Home ☐ 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

H514.027

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 or 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

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	CHECK ONE: *ABNORMAL	CHECK ONE: 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 ☐**