Moniteau School District

1810 West Sunbury Road, West Sunbury, PA 16061
Phone: 724-637-2117 Fax: 724-637-3862

KINDERGARTEN REGISTRATION

(District Use) Student ID No.______________ Student Start Date: __________________

Student Information:

Name: ____
(Last) (First) (Middle)

Date of Birth: ____/____/_________ Grade________ Gender__________________

Address: ____

City: ____________________________________ State: _________ Zip Code: ______________

County: _____________ Twp.: ____________________ Telephone: ________________________

Place of Birth: ______________________
(City and State)

Student Lives With: Both Parents_____ Father/Stepmother_____ Mother/Stepfather_____
Mother Only_____ Father Only______ Legal Guardian_____ Foster Parents_____ (Please Provide Documentation)

Special Custodial Court Instructions:
No_____ Yes_____ (If Yes, Please Provide a Copy of Court Order)

Father/Step Father Name: ____
Address: ____
City: _____________________ State: ____________________ Zip Code: ____________________
Home Phone: _______________ Cell Phone:_______________Work Phone:__________________
Email Address: ____

Mother/Step Mother Name:______________________________Maiden Name________________
Address: ____
City: _____________________ State:_____________________Zip Code:____________________
Home Phone: ______________ Cell Phone:________________Work Phone:__________________
Email Address____

<u>If The Student Is Not Living With Parents, Please Complete This Section and Provide Paperwork</u>

Guardian **or** Foster Parent's Name____
Address: ____
City: _____________________ State:_____________________Zip Code:____________________
Home Phone: ______________ Cell Phone:________________ Work Phone:_________________
Email Address: ____

Emergency Contact: Only if a parent/guardian cannot be reached

Name_____________________________________ Phone_____________________________

Name_____________________________________ Phone_____________________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Former School Information:

Name of Former School____

Address of Former School____

Special Services: ***Does your child currently receive any Special Services?*** **No______ Yes______** ***please mark***

Has IEP____ Has GIEP_____ Speech & Language_____
Chapter 15/504_____ Other______________________________

Ethnicity/Race: **The district is required to collect ethnicity/race data in order to satisfy US Department of Education audit requirements**

Ethnicity (Choose one)
______Hispanic / Latino
______Not Hispanic / Latino

Race (Choose all that apply)
______American Indian or Alaskan Native
______Asian
______Black or African American
______Native Hawaiian or Pacific Islander
______White

☐ **ALL newly registering students regardless of race, nationality, or language origin MUST complete the Home Language Survey.** Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Home Language Survey:

1. Is a language other than English spoken in the child's home? No ______ Yes____ (language)____________
2. Does your child communicate in a language other than English? No______ Yes____ (language)____________
3. What is the language that your child first learned to speak? ____

Parent/Guardian Signature: ____ Date:_______________

Is the student's parent/guardian an active duty member of a branch of the United States Armed Forces? Yes_____ No_____

Do you have internet access? Yes_____ No_____

Moniteau School District

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Phone: 724-637-2117   Fax: 724-637-3862

Child Care Questionnaire

Child's Name____

What was your child's educational experience prior to kindergarten?

_____Head Start

_____Pennsylvania Pre-K Counts

_____Family Child Care

_____Home-Based Care

_____Relative / Neighbor Care

_____Licensed Private Academic Nursery Program

_____Locally Funded Pre-K Program

_____School-Based Pre-Kindergarten Program

_____Child Care Center

_____None

_____Don't know / Can't answer

Please provide name of the center / program your child attended:

____

SCHOOL DISTRICT
STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,

The McKinney-Vento Act, as amended by the No Child Left Behind Act of 2001, defines homelessness and outlines the rights of homeless students. Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name: ______________________ **Birth Date:** ________________

   Person completing form: ________________Relationship to child: ____________

2. In what type of setting is the student living now?

Check one box below –

SECTION A	SECTION B
☐ In an emergency or transitional shelter ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations ☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings ☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings CONTINUE to Question 2 if you checked any box in SECTION A	☐ None of the choices in Section A apply. STOP If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.

3. Contact number for person completing the form: ______________________

   Address where student is now living: ______________________

   ____

4. The student lives with:

   Check all that apply

   ☐ Parent(s) or legal guardian
   ☐ Relative, friend(s), or other adult(s)
   ☐ Alone
   ☐ Other: ______________________

5. School student attended last : ______________________________

   Address of school: ______________________________

   ____

   Telephone number of school: ______________________________

   Contact person at school (if known): ______________________________

6. Does the student have an IEP or a Chapter 15/504 agreement?

   ☐ NO

   ☐ YES. Please explain: ______________________________

The staff person who is helping you register will contact the homelessness coordinator to review the information provided. If homelessness is verified, addition information will be needed to complete enrollment. The Homelessness Coordinator will contact you by the end of the next school day (or sooner) to share the determination regarding homeless status, to gather additional information and to discuss the plans for placement.

Signature of Parent/Legal Guardian:

____

Date:

____

NOTE TO STAFF: All forms with a checked box in <u>Section A</u> are to be faxed *immediately* to the Homeless Liaison to eliminate any delay.

CONSENT FORM Pre-School
Vision Screening
Please Fill Out In Full

Child's Name ______________________________ Age _______ Sex: M___ F___

Address ____

City/State/Zip ____________________________ County ______________

Parent/Guardian Name (Print): ______________________________________

Phone Home (_____)________________________ Phone Cell (_____)____________________

Email Address: ____

Screening Location: ____

As the undersigned parent/guardian, I hereby grant permission to The Blind Association of Butler and Armstrong to screen the vision of the above-named child.

I understand that this procedure is a limited vision screening, designed only to detect certain symptoms of potential vision problems in children. It is not an eye examination and is not intended to take the place of a professional eye exam. **If a professional examination is recommended,** I give my consent to permit The Blind Association of Butler and Armstrong to obtain information, from the examining eye specialist, regarding my child's eye examination and recommended treatment, and to furnish such information, as needed, to the appropriate school/ agency. I also understand that follow-up is required and that I may be contacted by the agency for further information.
Parent/Guardian Signature:______________________________ Date: ___________

Has your child had a professional eye Examination? YES (   )   NO ( )

CHECK ALL THOSE THAT APPLY:
___Wears glasses ___Shuts or covers one eye ___Squints at objects
___Complains about eyes ___Tilts or thrusts head forward ___Holds objects close to eyes
___Blinks more than usual ___Rubs eyes excessively
___Either eye turns in, out, up or down (which one?) __________________________
Family history of eye problems (specify): ______________________________________ Other observations (describe): ______________________________________

Thank you, The Blind Association of Butler and Armstrong, 724-287-4059

For Office Use Only

Referred: Yes ___ ID # _____ No ___ C B H A NA O (circle one)

Moniteau School District

Transportation Department

TRANSPORTATION CHANGE NOTIFICATION

REASON FOR CHANGE-

SCHOOL -Dassa McKinney Elementary

Please complete the section below

Student Name	
Parent / Guardian	
Address	**Phone Number**
Grade	

Bus Company to complete the section below

Bus Number	
Bus Stop Location	
Pick Up Time	**Drop Off Time**
Start Date	

TRANSPORTATION DEPARTMENT USE ONLY

Date Bus Company Notified: 2/2/2024 3:31 PM	Parent Notified By: ☐ Phone ☐ Letter ☐ Email

Student Health History Form

Child's Name:____

First Middle Last

MEDICAL HISTORY

Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No

☐ Yes (If yes, explain) ____

Is your child taking any **prescription medicines**?

☐No. My child does not take any prescription medicines.

☐Yes - Please list the child's medicines ____________________________________

What **over-the-counter medicines does** your child take regularly?

☐ Vitamins

☐ Herbal medicine (please list) ____

☐ Other (please list) ____

☐ None, my child does not take any over-the-counter medicines regularly.

Does your child have any **allergic reaction** from any of the following? (Check all that apply)

☐ Outside or Indoor allergies (for example: grass, pollen, cats …)

☐ Food Allergies (for example: peanuts, milk, wheat …)

☐ Medicine or shots (immunization)

☐ No, my child has no known allergies

Has your child had any of the following **diseases**?

Measles	☐Yes	☐No	☐Don't Know
Mumps	☐Yes	☐No	☐Don't Know
Chicken Pox	☐Yes	☐No	☐Don't Know
Whooping Cough	☐Yes	☐No	☐Don't Know
Rubella	☐Yes	☐No	☐Don't Know
Rheumatic Fever	☐Yes	☐No	☐Don't Know
Scarlet Fever	☐Yes	☐No	☐Don't Know
Pneumonia	☐Yes	☐No	☐Don't Know

Please check any of the following **medical problems** that your child has **ever** had.

Ear infections	☐ Yes ☐ No
Nose problems (sinus infections, nose bleeds)	☐ Yes ☐ No
Eye problems (blurry vision, need to wear glasses)	☐ Yes ☐ No
Hearing problems	☐ Yes ☐ No
Mouth or throat problems (Strep throat, swallowing problems)	☐ Yes ☐ No
Diarrhea (having frequent and runny bowel movements)	☐ Yes ☐ No
Constipation (problems having a bowel movement)	☐ Yes ☐ No
Throwing up (vomiting)	☐ Yes ☐ No
Problems **peeing** (bed wetting, pain when peeing)	☐ Yes ☐ No
Back problems (crooked back, back pain)	☐ Yes ☐ No
Growing pains (bone or body pains due to growing)	☐ Yes ☐ No
Muscle and bone problems (weak muscles, pain in joints)	☐ Yes ☐ No
Skin problems (acne, flaking skin, rashes, hives)	☐ Yes ☐ No
Seizures (shaking fits)	☐ Yes ☐ No
ADD/ADHD (problems paying attention, sitting still)	☐ Yes ☐ No
Sleeping problems (falling or staying asleep)	☐ Yes ☐ No
Breathing problems (cough, asthma)	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Warts	☐ Yes ☐ No
Jaundice (yellow skin)	☐ Yes ☐ No

Can the child use the toilet without help? YES____________ NO________________

ABOUT MOM WHEN PREGNANT

The following questions are about the mother of the child during pregnancy and birth.

What was the general **health of the mother** during pregnancy?

☐ Excellent ☐ Good ☐ F air ☐ Poor ☐ Unknown

Did the mother take any medications (other than iron or vitamins) **during the pregnancy**?

☐ Yes

☐ No

Did the mother have any of the following **conditions or problems during pregnancy**?

☐ Preeclampsia (high blood pressure)

☐ Emotional stress

☐ Injury or serious illness

☐ Diabetes

☐ Other

☐ none of the above

Was the birth:

☐ On the due date

☐ Before the due date -by how much____

☐ After the due date -by how much____

What was the baby's birth weight?____

ABOUT THE CHILD AS A BABY

In the first **6 months after birth**, did the child have:

☐ Jaundice (yellow skin)

☐ Colic (upset stomach, crying)

☐ Breathing problems

☐ Other ___________________________

☐ None of the above

At what age did the child begin to **crawl**? ____

At what age did the child begin to **sit up**? ____

At what age did the child begin to **walk**? ____

At what age did the child begin to **say two or three words** together?___________________

Please list what your child typically **eats and drinks in a day** for:

Breakfast-
Lunch-
Dinner-
Snacks-

Do you have additional concerns about the child that you would like to share? (Shy, sad, temper tantrums, disobedience, property destruction, stuttering, thumbsucking, bowel concerns, wetting during the day, feeding, nightmares, fighting with other children, restless, easily upset, day dreams, stubborn, etc.)

FAMILY

Check all the people that the **live in the household with the child**:

☐ Mother

☐ Father

☐ Brothers (how many?)______

☐ Sisters (how many?) ______

☐ Other family members (list)

☐ Friends or other people (list)

What medical problems do people in the child's family have?

Mother	☐ **Depression**	☐ **Anxiety**	☐ **Learning difficulty**
	☐ **Diabetes**	☐ **High Blood Pressure**	☐ **Asthma /Wheezing**
	☐ **Cancer**	☐ **Heart problems**	☐ **Allergies/Eczema**
	☐ **Seizures**	☐ **Hearing loss**	☐ **Blood disorder**
	☐ **Other**________________________________		

Father	☐ **Depression**	☐ **Anxiety**	☐ **Learning difficulty**
	☐ **Diabetes**	☐ **High Blood Pressure**	☐ **Asthma /Wheezing**
	☐ **Cancer**	☐ **Heart problems**	☐ **Allergies/Eczema**
	☐ **Seizures**	☐ **Hearing loss**	☐ **Blood disorder**
	☐ **Other**________________________________		

Siblings	☐	**Depression**	☐	**Anxiety**	☐	**Learning difficulty**
	☐	**Diabetes**	☐	**High Blood Pressure**	☐	**Asthma /Wheezing**
	☐	**Cancer**	☐	**Heart problems**	☐	**Allergies/Eczema**
	☐	**Seizures**	☐	**Hearing loss**	☐	**Blood disorder**
	☐	**Other**____				

Have any members of the immediate family died? ☐ Yes ☐ No

If so, who?_________________________________

Dassa McKinney Elementary School
Moniteau School District 391 Hooker Road, West Sunbury, PA 16061
724-637-2321 FAX: 724-637-3877

Authorization for Prescription Medication

During School Hours

I am requesting my child receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program.

Child's name: ____

Homeroom:____

Name of medication:____

Purpose of medication:____

Time to be administered:_______________________________________

Dosage with any special instructions:_____________________________

Possible side effects:____

Procedure to follow if reaction should occur: ______________________

____

Termination date for administering the medication: __________________

I hereby authorize the medication listed above to be administered to my child by the school nurse or other school employee. I do hereby release, discharge and hold harmless the Moniteau School District, it's agent and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

__________________________ ______________

Signature of Parent/ Guardian Date

Dassa McKinney Elementary School

Moniteau School District *391 Hooker Road, West Sunbury, PA 16061*
724-637-2321 FAX: 724-637-3877

Dear Parent or Guardian,

The following information explains the physical examination requirements established by the Pennsylvania Department of Health. These regulations apply to all school aged children.

The Department of Health mandates that a complete physical examination be given to all children upon original entry into school (kindergarten or first grade), along with grades six and eleven. A complete dental examination is also required upon entrance to school and in grades three and seven.

As in previous years, the law and Health Department policy provides for the use of family physicians and dentists in performing these required examinations, should it be the wish of the parents. Forms for having the examinations completed by the family physician or dentist during the summer are attached. If these forms are not returned before the exam is scheduled in school, your child will be examined by the school physician or nurse practitioner and the school dentist. Any private physical or dental examination that is given within six months of the start of school will be accepted.

Your prompt attention to this letter and the attached examination forms are appreciated. If you have any questions concerning these examinations, please contact the school nurse.

Sincerely,

Mr. Kevin M. Boariu
Principal

Ms. Leslie Fallen, RN, BSN, CSN
School Nurse

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 Last First Middle	AGE	SEX ☐ M ☐ F	GRADE	SECTION/ROOM

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

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__________

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

 STUDENT NAME:

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: