

## Midd-West School District

Dear Parents:

The following pages of information must be printed and completed by appropriate parties to register your child for kindergarten. If you are unable to print the documents, please stop by the office of the elementary school where they will attend and pick up a registration packet. Please drop off your completed paperwork or mail it to your neighborhood school by March 30th, 2026. If you have any questions, please call the office at (570) 837-0046.

**•Official birth certificate of student.**

**•Immunization records** (you can get a copy of your child's immunization records from your child's physician). Every child in grades K 12 must be immunized, unless exempt for medical reasons, religious beliefs or philosophical/ strong moral or ethical conviction.

**•Proof of Residence** in Midd-West Area School District (one of the following):

- Lease (renter)
- Current utility bill
- Current check stub for wages, public assistance, social security or other source of income indicating the address within the District
- Current credit card bill
- Current property tax bill
- Current identification card (state issued)
- Current vehicle registration
- Pennsylvania driver's license indicating the address within the District

**Page 3-6 -Student Registration Form (2 copies) Both must be completed.**

Be sure to spell the child's name as it appears on his/her birth certificate. Bring Proof of residency.

**Page 7 - Home Language Survey**

**Page 8 -Speech and Language Survey**

Complete the top section of these forms. They will be used during kindergarten registration.

**Page 9 -Student Health History**

Complete this information as accurately as possible.

**Page 10-11 Health Services Information Form**

**Page 12 Hearing and Vision Screen Survey**

**Page 13 -Physical Choice**

**Page 14-18 -Private Physician's Report of Physical Examination of Pupil of School Age**

To be completed by your Physician

**Page 19- Dental Choice**

**Page 20 -Private Dentist Report of Dental Examination of a Pupil of School Age**

To be completed by your Dentist

*Other information enclosed in this packet is not required but informational. If you have any questions concerning this information, please contact the school Nurse.*

**Jayla Hoover, RN, BSN, CSN**

Middleburg Elementary 570-837-0046, ext. 4400  
West Snyder Elementary 570-837-0046, ext. 5400

# 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.

# MIDD-WEST SCHOOL DISTRICT

## NEW STUDENT REGISTRATION FORM

Registration Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: MES WSES MWMS MWHS or HS EOD

Student Name: \_\_\_\_\_  
Last Name First Name Middle Name

Gender: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_  
Month Day Year City/State Unlisted?  Y  N

Home Address	
House Number _____	Apartment Number _____
Street Name _____	
P. O. Box _____	Borough/Township _____
City _____	Zip Code _____

Ethnicity – Please check (✓) one: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander
---

Did the child ever attend school in this District? Y N Which school? \_\_\_\_\_ Grades? \_\_\_\_\_

Who has legal custody of student?  
 Both Parents  Mother  Father  Child Care Agency  
 Guardian  Other: \_\_\_\_\_

Was the child in any of the following programs at their previous school? <input type="checkbox"/> ESL <input type="checkbox"/> Gifted <input type="checkbox"/> Title I <input type="checkbox"/> Speech <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Alternative Education <input type="checkbox"/> Special Education (IEP) (NOREP Attached)
--

Marital Status of adults with whom child resides:  
 Married  Single  Common Law  Separated  Divorced  
 Widow

Is the student's parent/guardian an ACTIVE service member of a branch of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, Space Force, and Coast Guard) including full-time National Guard? \_\_\_\_\_

Father	Mother	Step Parent/Guardian
Name _____	Name _____	Name _____
Address _____ (if different than child)	Address _____ (if different than child)	Address _____ (if different than child)
Place of Employment _____	Place of Employment _____	Place of Employment _____
Home Phone (if different than child) _____	Home Phone (if different than child) _____	Home Phone (if different than child) _____
Work Phone _____ Ext. _____	Work Phone _____ Ext. _____	Work Phone _____ Ext. _____
Cell Phone _____	Cell Phone _____	Cell Phone _____
Pager _____	Pager _____	Pager _____
Email _____	Email _____	Email _____
Student Lives with? <input type="checkbox"/> Yes <input type="checkbox"/> No Release OK." <input type="checkbox"/> Yes <input type="checkbox"/> No Receive Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent Internet Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Student Lives with? <input type="checkbox"/> Yes <input type="checkbox"/> No Release OK." <input type="checkbox"/> Yes <input type="checkbox"/> No Receive Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent Internet Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Student Lives with? <input type="checkbox"/> Yes <input type="checkbox"/> No Release OK." <input type="checkbox"/> Yes <input type="checkbox"/> No Receive Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent Internet Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No

NAME OF ALL CHILDREN AT CHILD'S ADDRESS	RELATIONSHIP TO CHILD	AGE/SCHOOL/GRADE

TRANSPORTATION

Is student a  Bus Rider  Walker Does the student require a wheelchair?  Yes  No

Address of AM Stop : \_\_\_\_\_

Address of PM Stop: \_\_\_\_\_

PIMS INFORMATION

Date First Enrolled in PA School \_\_\_\_\_

Grade 9 Entry Date \_\_\_\_\_

Student is a Single Parent  Yes  No

Foreign Exchange Student  Yes  No

Migrant Student  Yes  No

PIMS Assessment Participation:

Please check (✓) all that apply

CDT  Keystones  PASA  PSSA

None

Other Assessment \_\_\_\_\_

INTERNET ACCESS/PHOTO RELEASE

The Mid-West School District has my permission (as parent or legal guardian) to use student's picture in:

The school yearbook  Yes  No

The school newspaper or newsletter  Yes  No

In other school publications, handbooks, calendars, etc.  Yes  No

The school website  Yes  No

As parent/legal guardian, I grant permission for the student to use and have access to the Internet (World Wide Web) for educational purposes and to adhere to the Mid-West School District Policy Guide 815, Acceptable Use and Internet Safety.

Yes  No

Name of Former School

SIGNATURE OF PARENT/GUARDIAN

DATE

-----OFFICE USE ONLY-----

START DATE:

VERIFICATION OF BIRTH

Student name as it appears on birth certification

\_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Documentation \_\_\_\_\_

Signature of School Personnel \_\_\_\_\_ Date \_\_\_\_\_

FORMER SCHOOL INFORMATION

Name of School

Address of School

School Telephone Number \_\_\_\_\_ Date of Withdrawal \_\_\_\_\_

Verification of Act 26  Yes  No

VERIFICATION OF RESIDENCY

Resident  Non-Resident

Proof of Residency \_\_\_\_\_

If not applicable, District of residency \_\_\_\_\_

SIS Entry Date \_\_\_\_\_ By \_\_\_\_\_

MWSD Network/Internet Access Account Created

FOSTER PLACEMENT 1305

Name of Agency

Address of Agency

Caseworker

Building \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_ Locker # \_\_\_\_\_ Teacher \_\_\_\_\_

Bus # \_\_\_\_\_ Bus Stop \_\_\_\_\_ Entry Code \_\_\_\_\_ Student Number \_\_\_\_\_

INSTRUCTIONS: PLACE ORIGINAL OF THIS FORM IN STUDENT'S PERMANENT RECORD FOLDER. MAKE COPIES AND SEND TO:

- Principal/Main Office  Guidance Office/Counselor  Transportation  Cafeteria/Food Service  School Nurse  Special Education  Attendance Secretary

Signature of Principal

Date

# MIDD-WEST SCHOOL DISTRICT

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Student Name: \_\_\_\_\_  
Last Name First Name Middle Name

Gender: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_  
Month Day Year City/State Unlisted?  Y  N

Home Address	
House Number _____	Apartment Number _____
Street Name _____	
P. O. Box _____	Borough/Township _____
City _____	Zip Code _____

Ethnicity – Please check (✓) one: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander
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Marital Status of adults with whom child resides:  
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Is the student's parent/guardian an ACTIVE service member of a branch of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, Space Force, and Coast Guard) including full-time National Guard? \_\_\_\_\_

Father	Mother	Step Parent/Guardian
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Home Phone (if different than child) _____	Home Phone (if different than child) _____	Home Phone (if different than child) _____
Work Phone _____ Ext. _____	Work Phone _____ Ext. _____	Work Phone _____ Ext. _____
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Is student a  Bus Rider  Walker Does the student require a wheelchair?  Yes  No

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Address of PM Stop: \_\_\_\_\_

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Please check (✓) all that apply

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Yes  No

Name of Former School \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

-----OFFICE USE ONLY-----

START DATE: \_\_\_\_\_

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Student name as it appears on birth certification \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Documentation \_\_\_\_\_

Signature of School Personnel \_\_\_\_\_ Date \_\_\_\_\_

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\_\_\_\_\_  
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Address of School

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Proof of Residency \_\_\_\_\_

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Name of Agency

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Address of Agency

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Caseworker

SIS Entry Date \_\_\_\_\_ By \_\_\_\_\_

MWSD Network/Internet Access Account Created

Building \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_ Locker # \_\_\_\_\_ Teacher \_\_\_\_\_

Bus # \_\_\_\_\_ Bus Stop \_\_\_\_\_ Entry Code \_\_\_\_\_ Student Number \_\_\_\_\_

INSTRUCTIONS: PLACE ORIGINAL OF THIS FORM IN STUDENT'S PERMANENT RECORD FOLDER. MAKE COPIES AND SEND TO:

- Principal/Main Office  Guidance Office/Counselor  Transportation  Cafeteria/Food Service  School Nurse  Special Education  Attendance Secretary

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

MIDD-WEST 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 identification.

Building: \_\_\_\_\_ Date \_\_\_\_\_

Name of Child \_\_\_\_\_ Grade \_\_\_\_\_

1. What is/was the student's first language? \_\_\_\_\_

2. 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 in your home?  
\_\_\_\_\_

4. Has the student attended any United States school in any three (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):  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\*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 the school district/charter school/full-day AVTS in the future.

MIDD-WEST SCHOOL DISTRICT  
SPEECH AND LANGUAGE SURVEY  
for Kindergarten Registration

Building: \_\_\_\_\_ Date \_\_\_\_\_

Name of Child: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

The following questions are designed to give an impression of your child's speech and language skills. Your answers to the following questions will assist in the process of screening your child on the day of kindergarten registration.

1. How old was your child when he/she began to say first words? \_\_\_\_\_ and Simple sentences and phrases? \_\_\_\_\_
2. Are there any sounds your child cannot say? Yes No  
If so, which sound(s)? \_\_\_\_\_
3. Is your child \_\_\_talkative \_\_\_\_\_average \_\_\_\_\_very quiet?
4. Does your child like talking? Yes No  
Does he/she like talking at home? Yes No  
Does he/she like to talk in public? Yes No
5. Does your child use words to ask for help and to get your attention? Yes No
6. Does your child follow simple directions like "go get your coat?" Yes No
7. Does your child follow everyday routines without step-by-step instructions, like "get ready for bed?" Yes No
8. Does your child answer "wh" questions like who, what, when, where? Yes No
9. Has your child had any previous speech and/or language therapy? Yes No  
If so, who provided this service?

SCHOOL USE ONLY

The results of the kindergarten registration speech and language screening for your child indicate that he/she:

- seems to be developing speech and language skills normally and will not require further evaluation.
- seems to be delayed in his/her speech and language skills and should have further evaluation and/or speech therapy.

Recommendations: \_\_\_\_\_

\_\_\_\_\_

## STUDENT HEALTH HISTORY

Name \_\_\_\_\_

### THE NATURE AND PURPOSE OF THIS HEALTH RECORD

I understand that the information I give to the School Nurse is important for the school staff to understand and help the health and education of my child.

I understand that the information will be kept confidential by the School Health Staff and will be shared with other professionals in the school and in other institutions only when the School Nurse and/ or the School Physician believe that it is in the best interests of my child's health and education.

Copies of this health record will be sent to other agencies who request it only with my written consent.

\_\_\_\_\_  
Signature of Parent/Guardian

### PERMISSION FOR EXAMINATIONS AND TESTS

- I give permission for my child to receive health screenings as provided by the School Health Services of the Mid-West School District in accordance with Pennsylvania School Law.
  
- I understand that I will be informed of any abnormal results of examinations and tests given to my child.

I give permission for the following:

- health history
- screening tests for
- growth
- body mass index
- vision
- color vision
- hearing
- development

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



PLEASE LIST THE FOLLOWING IMMUNIZATIONS AND BRING PROOF OF LISTED IMMUNIZATIONS WITH YOU! {Please include Month/Day/Year}

DIPHTHERIA/TETANUS/PERTUSSIS:	#1	#2	#3	#4	#5
ORAL/INJECTABLE POLIO:	#1	#2	#3	#4	
HEPATITIS B:	#1	#2	#3	#4	
MMR:	#1	#2		#4	
CHICKEN POX VACCINE:	#1	#2			
CHICKEN POX DISEASE:	DATE:				
LAST TB. TEST:	#1				
HIB:	#1	#2	#3	#4	
HEPATITIS A:	#1	#2			

MEDICAL EXEMPTION [The physical condition of child is such that immunization would endanger life or health.]

RELIGIOUS EXEMPTION [Includes a strong moral or ethical conviction similar to a religious belief]

MIDD-WEST SCHOOL DISTRICT  
VISION AND HEARING SCREENING SURVEY  
for  
Kindergarten Registration

Building: MES  WSES

Date \_\_\_\_\_

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

The following questions are designed to give an impression of your child's vision and hearing. Your answers to the following questions will assist in the process of screening your child on the day of kindergarten registration.

1. Do you think there is anything the matter with your child's eyes? \_\_\_\_\_ Yes No
2. Is there a family history of crossed eyes or lazy eye? Yes No
3. Has your child had eye surgery? Yes No
- If yes, give the date and type of surgery: \_\_\_\_\_

- 
4. Does your child blink, squint, or rub his/her eyes? Yes No
5. Does your child wear glasses? Yes No
6. Do you know or suspect that your child has a hearing loss? Yes No
7. Does your child wear a hearing aid? Yes No
8. Does any member of the family have a hearing loss? Yes No
- If yes, what is his/her relationship to your child? \_\_\_\_\_ :
9. Does your child have frequent ear infections? Yes No
10. Has your child ever had ear tubes? Yes No

SCHOOL USE ONLY

*Vision Results:*

Acuity Far: RE  Pass  Fail

LE  Pass  Fail

4K

Acuity Near: RE  Pass  Fail

LE  Pass  Fail

4K

Referred  Rescreen

*Hearing Results:*

Right:

250 500 1K 2K

Left:

250 500 1K 2K

Pass  Referred

F. **MEDICAL HISTORY** {Circle NO/YES and fill in blanks for all YES answers}

- |   |    |     |
|---|----|-----|
| 1. Is your child presently receiving medical treatment?                                     | NO | YES |
| With Whom? _____  |    |     |
| 2. Is your child presently taking any medications?  | NO | YES |
| a. Reason for medication? _____   |    |     |
| b. Name and dosage of medication? _____   |    |     |
| c. How often is medication taken? _____   |    |     |
| d. Will the medication be continued during school hours?                                    | NO | YES |
| 3. Has your child ever had an allergy or reaction to any medication? Specify: _____         | NO | YES |
| 4. Has your child ever had a reaction to insect bites or animal dander? Specify: _____      | NO | YES |
| 5. Does your child need a special diet or have any food problems? Specify: _____            | NO | YES |
| 6. Has your child ever had a serious accident or injury? Specify: _____                     | NO | YES |
| 7. Has your child ever had any type of surgery? Specify: _____                              | NO | YES |
| 8. Does your child have any orthopedic [bone] problems? Specify: _____                      | NO | YES |
| 9. Has your child had more than six colds or throat infections, with a fever, a year?       | NO | YES |
| 10. Has your child had any trouble with ears or hearing?                                    | NO | YES |
| 11. Has your child had any trouble with eyes or vision?                                     | NO | YES |
| 12. Does your child complain of headaches?  | NO | YES |
| 13. Has a doctor ever said your child has a heart murmur?                                   | NO | YES |
| 14. Does your child complain of frequent abdominal pain?                                    | NO | YES |
| 15. Has your child ever had eczema or any skin problems?                                    | NO | YES |
| 16. Does your child ever complain of pain in the arms or legs?                              | NO | YES |
| 17. Has your child ever had swelling of any joints or limping?                              | NO | YES |
| 18. Is your child toilet trained?   | NO | YES |
| 19. Does your child have any emotional problems or excessive fears?                         | NO | YES |
| 20. Does your child have any speech problems? Specify: _____                                | NO | YES |
| 21. Are you covered by Medical Assistance [Welfare]?  | NO | YES |
| 22. Is your child presently enrolled in any Intermediate Unit Program?                      | NO | YES |
| Name of Program: _____  |    |     |
| 23. Is there any other information we should know about your child's health? Specify: _____ | NO | YES |
| 24. Name of Family Physician: _____   |    |     |
| Telephone: _____  |    |     |
| 25. Name of Family Dentist: _____ Telephone: _____  |    |     |

IT IS MANDATORY that pupils who show symptoms of communicable disease be excluded from classes until readmission is acceptable to school authorities. ALSO: No pupil will be excused from P.E. without a Written permit from a physician. Your cooperation will be greatly appreciated. Thank you!

# MIDD-WEST SCHOOL DISTRICT

## PHYSICAL EXAMINATION CHOICE

### Grades K/1

Dear Parents:

As required by the Pennsylvania School Code, all students in Grades K/1, must receive a physical examination. We encourage students to have this completed by their own private physician because that physician knows your child's health best. You may choose to have the examination completed by your own physician or a school examination can be chosen. **The Mid-West School District Policy Guide 209, Health Examinations, states that these examinations are required and if a private examination is chosen, the physical examination form must be returned to the school, or the student may not be permitted to start school in August 2027.**



*Please mark your choice for this examination and return the form as soon as possible:*

1. \_\_\_\_\_ I prefer to have the physical examination completed by the School Physician.  
(For male students, a testicular exam may be performed.)
2. \_\_\_\_\_ I prefer to have the physical examination completed by a private physician. I understand that if I choose to have the physical examination completed by my own physician, the form must be returned to the school, or my child may not be permitted to start the next school year.

---

Name of Student

---

Signature of Parent

---

Date

*Jayla Hoover, R.N., BSN, CSN*  
School Nurse  
837-0046, Ext 4400 {ME}  
837-0046, Ext. 5400 {WSES}

*Jenelle VanHorn, R.N.*  
School Nurse  
837-0046, Ext. 2400 {MWHS}  
837-0046, Ext. 3400{MWMS}



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 <b>DURING</b> or <b>AFTER</b> 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. <b>FEMALES ONLY:</b> 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 <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>
Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20____
Print name of examiner _____
Print examiner's office address _____ Phone _____
Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>

**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
<b>Other Vaccines: (Type and Date)</b>					



MIDD-WEST SCHOOL DISTRICT

DENTAL EXAMINATION CHOICE

Grades K/1, 3

Dear Parents:

As required by the Pennsylvania School Code, all students in Grades K/ 1, 3 and 7 must receive a dental examination. We encourage students to have this completed by their own private dentist because that dentist knows your child's dental health best. You may choose to have the examination completed by your own dentist or a school examination can be chosen. The Midd-West School District Policy Guide 209, Health Examinations, states that these examinations are required and if a private examination is chosen, the dental examination form must be returned to the school.

These forms are given out at this time of year so students may have the examination completed over the summer.

*Please mark your choice for this examination and return the form as soon as possible:*

1. \_\_\_ I prefer to have the dental examination completed by the School Dentist.
2. \_\_\_ I prefer to have the dental examination completed by a private dentist. I understand that if I choose to have the dental examination completed by my own dentist, the form must be returned to school.
3. \_\_\_ I prefer to have the dental examination completed by the mobile dentist.

The mobile dentist will be at school in winter 2027.

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Name of Student

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Signature of Parent

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Date

*Jayla Hoover, RN, BSN, CSN*  
School Nurse  
837-0046, Ext. 4400 {ME}  
837-0046, Ext. 5400 {WSES}

*Jenelle VanHorn, R.N.*  
School Nurse  
837-0046, Ext. 2400 {MWHS}  
837-0551, Ext. 3400 {MWMS}

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT**  
**OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_

<u>NAME OF STUDENT</u>	<u>DATE OF BIRTH</u>	<u>GRADE</u>	<u>SECTION/ROOM</u>
_____ Last                      First                      Middle	_____	_____	_____
<u>ADDRESS</u>			

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

**REPORT OF EXAMINATION/SCREENING**

		<u>TOOTH CHART</u>																
		<u>RIGHT</u>								<u>LEFT</u>								
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>	<u>11</u>	<u>12</u>	<u>13</u>	<u>14</u>	<u>15</u>	<u>16</u>	
<u>UPPER</u>					<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>	<u>J</u>				<u>Upper</u>
<u>LOWER</u>		<u>32</u>	<u>31</u>	<u>30</u>	<u>29</u>	<u>28</u>	<u>27</u>	<u>26</u>	<u>25</u>	<u>24</u>	<u>23</u>	<u>22</u>	<u>21</u>	<u>20</u>	<u>19</u>	<u>18</u>	<u>17</u>	<u>Lower</u>
<u>EXAM</u>	<u>UPPER</u>																	<u>Upper</u>
	<u>LOWER</u>																	<u>Lower</u>

Untreated Decay:                      No              Yes

Treated Decay:                      No              Yes

Sealants on Permanent Molars              No              Yes

Treatment Urgency:                      None              Early              Urgent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dental Provider                      Print Name of Dental Provider

\_\_\_\_\_  
Address of Dental Provider