East Penn School District

Registration and Admission Procedures

Welcome to East Penn School District. You are registering your child in a district that is a leader in curriculum, instruction, assessment, and staff development. East Penn is a suburban school district located in Lehigh County, with administrative offices in Emmaus.

In order to be enrolled in kindergarten, your child **must** be five years old on or before September 1, **without exception**.

IMPORTANT:
In order to establish and verify your residence within the East Penn School District, several documents need to be completed and approved. All procedures are in accordance with Sections 1301 and 1302 of the Pennsylvania School Code and Regulations 11.11 and 11.19 of the Pennsylvania State Board of Education.

The East Penn School District requires proof of age, proof of guardianship, proof of immunizations, and two proofs of residency prior to the student's admission to our schools. Please complete a registration packet for each child you are enrolling.

Prior to registration, please read the following items found at www.eastpennsd.org:

- **Student Handbook, follow link to your home building**
- **Acceptable Use Policy and Internet Access Brief**
- **Online Educational Resources, found at www.eastpennsd.org/edservices**

Proof of Residency Requirements

- Property Deed, Agreement of Sale **OR** Lease Agreement

AND one of the following:

- Moving Permit
- Current Utility Bill
- Current Tax Bill/Receipt
- Current Bank Statement/Pay Stub
- Vehicle Registration Card
- Health Insurance Card/Insurance Statement

For a certified copy of your Deed go to:

Lehigh County Government Center
Recorder of Deeds
455 West Hamilton St.
1st Floor, File Review Area
Allentown, PA 18101
610.782.3162
Monday thru Friday 8:00 a.m. to 4:00 p.m.
Cost is 25 cents per page plus $1.50 for certification (payable in cash or check only).

Call Recorder of Deeds Office for information and cost for receiving a mailed certified copy.

East Penn Household Registration Checklist

Checklist for _____
(Student Name) (Grade) (School)

(Checklist to be completed by EPSD)

Verification of Student Birth:

_____ **Original Birth Certificate or Passport**
(may not apply to homeless, ESL, migrant)

_____ **Valid Photo ID (parent/guardian)**

_____ **1st Proof of Residency** – must be either

🗁 Agreement of Sale, Deed OR Rental Lease Agreement

AND

_____ **2nd Proof of Residency** – one of the items below

🗁 Moving Permit
🗁 Current Utility Bill
🗁 Current Tax Bill/Receipt
🗁 Current Bank Statement/Pay Stub
🗁 Vehicle Registration Card
🗁 Health Insurance Card

_____ **Multiple Occupancy** ☐ Yes ☐ No If Yes, application obtained? _____

_____ **Immunization Records** ☐ Yes ☐ No

_____ **Educational Records Request**

_____ **Act 26 Documentation**

_____ **Related Resident Forms**

🗁 Education of Children Residing with an Adult other than Natural Parent - 1302
OR
🗁 Entrance Certificate for Child Placed in Home of Resident (foster) – 1305

_____ **Technology Forms:** Permission Form, On-Line Consent Form & AUP

EP ID # _____ PA SECURE ID # _____

East Penn School District

STUDENT INFORMATION (Please print)

* First Name	
* Middle Name	
* Last Name	* Generation Code (i.e. Jr., Sr., III)
* Address	
* Gender	
* Grade	
* Date of Birth	* City, State, Country of Birth:

*Race/Ethnicity

Part 1: Ethnicity (choose **one**)

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Part 2: Race (choose **all** that apply)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

* PA School Entry Date:

* Name of former school:

Address of former school:

* Is this student a Migrant? ☐ Yes ☐ No

* Does this student currently have a 504 Plan? ☐ Yes ☐ No

* Does this student currently have an IEP? ☐ Yes ☐ No

* Does this student currently have a GIEP? ☐ Yes ☐ No

Home Language Survey:

1. * What is/was the student's first language? _____
2. Does this student speak a language(s) other than English? (do not include languages learned in school) ☐ Yes ☐ No
   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 3 years during his/her lifetime? ☐ Yes ☐ No

   If yes, complete the following: (list all years attended U.S. schools)

Name of School	State	Dates Attended

5. * Initial U.S. entry date (Date entered U.S. or first enrolled in U.S. school) _____

Please note any special conditions you wish to call to the attention of the Professional Staff (including any parent deceased):

_____

_____

_____ _____

Parent/Guardian Signature Date

(Office Use Only)

EP ID#: (auto assigned by eSchoolPLUS) * Homeroom:

* EP School Attending: If different, EP attendance-area school:

Registration Date: * Entry Date: * Entry Code:

Eligible for Transportation? **Yes / No** * If yes, Bus #: * Bus Stop:

* Enter into eSchoolPLUS

East Penn Household Registration Form

Student Name: _____
First Name Middle Name Last Name

*Home Phone: _____ ☐ Listed ☐ Unlisted

* CUSTODIAL PARENT/ GUARDIAN (Resides)	
First Name	PO Box / Apt. #
Middle Name	Number/ Street
Last Name	City
Work Phone	State
Cell Phone	Zip Code
E-mail	Housing Development
Relationship	County

****Are you an active duty member of a branch of the armed forces (Army, Navy, Air Force, Marine Corps, Coast Guard) including full time National Guard duty? _____Yes _____No**

* CUSTODIAL PARENT/ GUARDIAN	
First Name	PO Box / Apt. #
Middle Name	Number/ Street
Last Name	City
Work Phone	State
Cell Phone	Zip Code
Home Phone	Housing Development
E-mail	County
Relationship	

****Are you an active duty member of a branch of the armed forces (Army, Navy, Air Force, Marine Corps, Coast Guard) including full time National Guard duty? _____Yes _____No**

* NON-CUSTODIAL PARENT / STEP-PARENT	
First Name	PO Box / Apt. #
Middle Name	Number/ Street
Last Name	City
Work Phone	State
Cell Phone	Zip Code
Home Phone	Housing Development
E-mail	County
Relationship	Permission to Access Student Info: ___Yes ____No

- **If guardian is other than mother or father, additional documents will be required.**
- **Limitation of contact/correspondence to non-custodial parent must be supported with legal document (Lehigh County court order).**

(Office Use Only): _____On File _____Requested _____Not on File

* Enter into eSchoolPLUS

EP ID # _____
(Office Use Only)

East Penn School District

Student Name: _____

First Name Middle Name Last Name

Other Children Residing in Household

First Name	
Middle Name	
Last Name	
Gender	
Date of Birth	
Relationship	
First Name	
Middle Name	
Last Name	
Gender	
Date of Birth	
Relationship	
First Name	
Middle Name	
Last Name	
Gender	
Date of Birth	
Relationship	
First Name	
Middle Name	
Last Name	
Gender	
Date of Birth	
Relationship	
First Name	
Middle Name	
Last Name	
Gender	
Date of Birth	
Relationship	

EP ID # _____

(Office Use Only)

East Penn School District
CERTIFICATE OF MULTIPLE OCCUPANCY

(More than one family per household)

The homeowner/lessee must provide **TWO** current proofs of residency, as listed below, showing the East Penn School District address.

The multiple occupant must provide **TWO** forms of identification showing the East Penn School District address within 30 days of registration.

Examples of these proofs are:

Homeowner/Lessee

- Property Deed, Agreement of Sale **OR** Lease Agreement **AND** one of the following
  - Current Utility Bill
  - Tax Bill/Receipt
  - Current Bank Statement
  - Vehicle Registration Card
  - Health Insurance Card/Insurance Statement

Multiple Occupant

- Moving Permit
- Current Bank Statement
- Current Billing Statements
- Health Insurance Card/Insurance Statement
- Vehicle Registration for change of address

This form is to be filled out by the East Penn Property Owner/ Lessee

I certify that I am the legal owner or lessee of the property listed below, which is located in the East Penn School District. With this certificate, I am providing two current proofs of residence showing my East Penn School District address. I further swear that the parent(s)/guardian and child(ren) listed below are living on a permanent full-time basis at that address. I assume responsibility for notifying East Penn School District should the described circumstances change.

I am submitting this certificate and making the factual representations contained herein, for the purpose of enrolling the child into the East Penn School District. I understand that the School District is relying upon the facts stated in this certificate and the information I provide in support of this certificate. I understand that the facts as stated are subject to investigation at any time. Should it be determined that any statement made in this certificate is not true, either now or in the future, East Penn School District has the right to remove the student(s) from the East Penn Schools. Furthermore, I am aware that I shall then be liable to reimburse the School District at the tuition rate for the time the child(ren) was/were enrolled.

Name of Child(ren)

NOTE: Proofs of residency, as stated above, must be provided with this certificate showing the East Penn School District address.
East Penn School District reserves the right to reverify Multiple Occupancy.

_____ _____
Signature of Property Owner/Lessee Name of Parent(s)

_____ _____
Address of East Penn Property Relationship of Property Owner to New Resident

_____ _____
Telephone Number Date

On this day, the _____of _____, _____, before me, the undersigned Notary Public, personally appeared _____, known to me (or satisfactorily proved) to be the person(s) whose name(s) is/are subscribed to me within instrument, and acknowledged that they executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

_____
NOTARY PUBLIC SIGNATURE NOTARY SEAL

East Penn School District

Act 26 Documentation

Student Name: _____
First Name Middle Name Last Name

1.a. Is the student currently or has the student ever been suspended or expelled from school for an act or offense involving weapons, alcohol, drugs or the willful infliction of injury to another person or for any act of violence committed on school property?

☐ Yes ☐ No

1.b. If Yes, what is the name of the school district? _____

1.c. Dates of expulsion or suspension: _____

2.a. Is the student currently on probation?

☐ Yes ☐ No

2.b. If Yes, list County and State Probation Department: _____

_____

_____

_____ _____
Parent/Guardian Signature Date

Any willful false statement made under this section shall be a Misdemeanor of the Third Degree.

EP ID # _____
(Office Use Only)

East Penn School District

Office of Student Registrar
Phone: 484.519.3210

Educational Records Request

We/I hereby authorize:

Previous School Name: _____

Address: _____

_____

Phone: _____ Fax: _____

To release information from the records of:

Student: _____ Birthdate: _____

For the purpose of _____

Please release all data that applies to the student including:

Scholastic/Education Record	Team Action Plan (IST, SAP, etc.)	Medical History
Academic Evaluations	SAP Initiated D & A Evaluation	Psychiatric Evaluation
Developmental History/Social	Psychological Evaluation/ ER/ GWR	Immunization Records
Discharge Summary/Aftercare Plan	Notice of Recommended Ed. Placement (NOREP)	Individualized Education Program (IEP)
Section 504 Service Agreement	Notice of Recommended Assignment (NORA)	Gifted IEP (GIEP)
Other: _____		

Please forward information to:

School Name: _____

Address: _____

_____

Phone: _____ Fax: _____

IF THE STUDENT HAS AN INDIVIDUALIZED EDUCATION PROGRAM (IEP),

GIFTED (GIEP) or SECTION 504 SERVICE AGREEMENT, please forward to:

East Penn School District, Administrative Building
Student Services Office
Attention: Director of Special Education
800 Pine Street, Emmaus, PA 18049
Phone: 610.966.8354
Fax: 610.965.1628

We/I have been told that in order to protect the limited confidentiality of records our/my agreement to obtain or release information is necessary and that this consent is limited for the purposes and to the person listed above and will be effective for one (1) year after the date of our/my signature(s), unless specified below. We/I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

This consent shall be in effect from: _____ to _____.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

East Penn School District

Emergency Contact/Health Information
School Year: 2019/2020

Name of student:

_____
Last First MI

Grade: _____

Birth Date: _____

Emergency Contact(s) – If parents/guardians cannot be reached:

	1st Contact	2nd Contact	3rd Contact
First Name:	_____	_____	_____
Middle Name:	_____	_____	_____
Last Name:	_____	_____	_____
Relationship:	_____	_____	_____
Home Phone:	_____	_____	_____
Cell Phone:	_____	_____	_____
Work Phone:	_____	_____	_____

_____ _____
Parent Signature Date

EAST PENN SCHOOL DISTRICT, 800 Pine Street, Emmaus, PA 18049 610-966-8300

SCHOOL HEALTH QUESTIONNAIRE

To Parent(s)/Guardian(s):
The information requested on this form will be of assistance to the certified school nurse in evaluating the health status of your child and assisting him/her to receive maximum benefits from this educational opportunity. **Please complete all sections.**

Student's Name: _____ Birthdate: _____ Gender ___M ___ F

Student's Address: _____

Parent(s) Name(s): _____ Phone(s): _____

_____ Phone(s): _____

Preferred hospital is: _____

Signature of Parent Completing the Form: _____

ATTACH COPY OF IMMUNIZATION RECORD

Student's Primary Care Physician: _____Phone: _____
Date of last visit: _____

Is the student currently being seen by a specialist for a health concern? _____ Yes _____ No
If yes, provide name of specialist, phone number and reason he/she sees this doctor.
_____
_____
_____

Student's Dentist: _____ Phone: _____
Date of last visit: _____

1. Has your child ever had a hearing test? _____ Yes _____ No
   If Yes, when? _____ Name of Examiner: _____
   Results: _____

2. Has your child ever had an eye examination by an eye doctor? _____ Yes _____ No
   If Yes, when? _____ Name of Examiner: _____
   Were glasses prescribed? _____ Yes _____ No
   Constant wear? _____ Yes _____ No

3. List <u>all current medications</u> including those prescribed by a health care provider or those purchased over the counter.

Medication Name	***Dosage***	***How Often Taken***	***Reason medication is taken***

School Health Questionnaire

4. List any hospitalizations and/or surgeries

Date	***Description* - why *hospitalized* / type of surgery**

5. Tuberculosis Skin Test: _____ Never had one
_____ Negative Test – Year _____ _____ Positive Test – Year _____

6. Were there any complications during pregnancy and/or labor / delivery? _____ No _____Yes
If Yes, explain _____

7. Has the student had any serious accidents resulting in visit to Emergency Room or hospitalization?
____ No _____ Yes If Yes, explain_____
_____

8. Has the student experienced any recent traumatic events? (divorce, family crisis, death of close friend/relative)

If Yes, explain _____

9. List Allergies

Allergy	***Treatment (if any)***

10. Has the student been prescribed an Epi-Pen? _____ Yes _____No If yes, please contact school nurse.

For what reason was it prescribed? _____

Health History

Check any of the following illnesses/conditions your child has experienced or been treated for. Indicate approximate date.

	Check		*Check*		*Check*
Anxiety		Diphtheria		Mumps	
Arthritis		Ear Infections		Nosebleeds	
Asthma		Eczema		Pneumonia	
Autism Spectrum Disorder		Headaches/Migraines		Polio	
Bladder Infection		Heart Murmur		Rheumatic Fever	
Blood Disorder		Heart Problems		Rubella (German Measles)	
Blood Pressure-High or low		Hepatitis		Scarlet Fever	
Broken Bones		High Fever		Seizures	
Bronchitis		Hives		Stomach aches	
Cancer		Kidney disease		Thyroid Disease	
Celiac disease		Malaria		Tonsillitis	
Chickenpox		Measles		Tuberculosis	
Concussion		Meningitis		Typhoid	
Diabetes		Mental Health Issues		Whooping Cough	
Depression		Mononucleosis		Other	

Additional Comments:

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.

pennsylvania
DEPARTMENT OF HEALTH

EAST PENN SCHOOL DISTRICT,
District Administration, 800 Pine Street, Emmaus, PA 18049
610 - 966-8300

2019/2020 School Year

Dear Parent(s)/Guardian(s):

The Pennsylvania School Health Act requires a physical examination of every student entering school for the first time, in sixth grade and eleventh grade. A student entering the district from out of state or from another district will be required to submit an exam to meet this requirement.

You may choose to have the examination done by the school doctor at no cost to you, or by your family health care provider at your own expense. Your family health care provider has a better knowledge of your child's past physical history and is in the best position to recommend necessary immunizations, tests or treatments.

If you choose to take your child to your family health care provider, any exam dated on or after **JULY 1, 2018** is acceptable. The attached *Private Physical Examination Report* must be completed by the health care provider and returned to the school by **SEPTEMBER 30, 2019**.

If you choose to have the examination done by the school physician, you will be notified of the specific date and time by the school nurse. Please be aware that you will be required to bring your child to a central location in the district on a Saturday morning for this examination. Examination for female genitalia will **not** be conducted as part of the school exam.

If the physical examination is not completed and proof submitted to the appropriate school nurse, OR you do not give written permission for your child to see the school physician, your child may be excluded from school.

Please fill out the lower portion of the form at this time showing your choice, and return the form to the school nurse.

Sincerely,

Thomas P. Mirabella, Ed.D.
Director of Student Services

****

(Return to school nurse **immediately**)

CHILD'S NAME: _____

SCHOOL: _____ GRADE: _____

____ **I CHOOSE TO HAVE MY CHILD'S PHYSICAL EXAMINATION DONE BY MY FAMILY PHYSICIAN.**
Please sign below and return slip to school nurse.

Date of exam by Family Health Care Provider: _____

____ **I CHOOSE TO HAVE MY CHILD'S PHYSICAL EXAMINATION DONE BY THE SCHOOL PHYSICIAN AND GIVE MY PERMISSION BY SIGNING BELOW.**
Please sign below and return slip to school nurse.

_____ _____
Parent(s)/Guardian(s) Signature *Date*

SS Revised 12/2018

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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	*ABNORMAL	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 ☐**

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)

pennsylvania
DEPARTMENT OF HEALTH

Oficina de Sistemas de salud comunitarios
División de salud escolar

Examen físico
PRIVADO O ESCOLAR
DEL ALUMNO EN EDAD ESCOLAR

PADRE/MADRE/TUTOR/ALUMNO:
Complete la primera página de este formulario antes del examen del alumno. Lleve el formulario completo a la cita.

Nombre del alumno _____ Fecha de hoy _____

Fecha de nacimiento _____ Edad al momento del examen _____ Sexo: ☐ Masculino ☐ Femenino

Medicamentos y alergias: enumere todos los medicamentos con receta, medicamentos sin receta y suplementos (a base de hierbas/nutricionales) que el alumno toma actualmente:

¿Tiene el alumno alguna alergia? ☐ No ☐ Sí (Si la respuesta es sí, enumere las alergias y reacciones específicas).

☐ Medicamentos ☐ Polen ☐ Alimentos ☐ Picaduras de insectos

Complete la siguiente sección con una marca en las columnas SÍ o NO; encierre en un círculo aquellas preguntas cuya respuesta desconoce.

INFORMACIÓN GENERAL DE SALUD: ***El alumno:***	**SÍ**	**NO**
1. ¿Tiene alguna afección médica permanente? Si es así, nómbrela: ☐ Asma ☐ Anemia ☐ Diabetes ☐ Infección Otra _____		
2. ¿Alguna vez ha pasado más de una noche internado?		
3. ¿Alguna vez ha tenido una cirugía?		
4. ¿Alguna vez ha tenido convulsiones?		
5. ¿Ha tenido antecedentes de haber nacido sin un riñón, un ojo, un testículo (si es hombre), el bazo o algún otro órgano, o no tiene alguno de estos órganos en la actualidad?		
6. ¿Alguna vez se ha sentido mal mientras hacía ejercicio expuesto al calor?		
7. ¿Ha tenido calambres musculares frecuentes mientras hacía ejercicio?		
CABEZA/CUELLO/COLUMNA VERTEBRAL: ***El alumno:***	**SÍ**	**NO**
8. ¿Ha tenido dolores de cabeza al hacer ejercicio?		
9. ¿Alguna vez ha sufrido una lesión o contusión en la cabeza?		
10. ¿Alguna vez ha tenido un golpe en la cabeza que le haya causado confusión, dolores de cabeza prolongados o problemas de memoria?		
11. ¿Alguna vez ha sentido entumecimiento, hormigueo o debilidad en sus brazos o piernas luego de haberse golpeado o caído?		
12. ¿Alguna vez no ha podido mover los brazos o piernas luego de haberse golpeado o caído?		
13. ¿Ha notado o se le ha informado que tiene la columna vertebral curvada o con escoliosis?		
14. ¿Ha tenido algún problema con sus ojos (visión) o antecedentes de lesión en un ojo?		
15. ¿Usa anteojos o lentes de contacto recetados?		
CORAZÓN/PULMONES: ***El alumno:***	**SÍ**	**NO**
16. ¿Alguna vez ha utilizado un inhalador o ha tomado medicamentos para el asma?		
17. ¿Alguna vez ha tenido un diagnóstico médico de problemas de corazón? Si es así, marque lo que corresponda: ☐ Soplo cardíaco o infección cardíaca ☐ Hipertensión arterial ☐ Enfermedad de Kawasaki ☐ Colesterol alto ☐ Otro_____		
18. ¿Ha recibido el pedido de un médico de realizarse un examen cardíaco? (Por ejemplo, ECG, electrocardiograma).		
19. ¿Ha tenido tos, jadeo, dificultad al respirar, falta de aliento o se ha sentido mareado DURANTE o DESPUÉS de hacer ejercicio?		
20. ¿Ha sentido malestar, dolor, sensación de ahogo u opresión en el pecho durante el ejercicio?		
21. ¿Ha sentido que el corazón se acelera o saltea latidos durante el ejercicio?		
HUESOS/ARTICULACIONES: ***El alumno:***	**SÍ**	**NO**
22. ¿Ha tenido una quebradura o fractura, fractura por fatiga o una articulación dislocada?		
23. ¿Ha tenido lesiones en un músculo, ligamento o tendón?		
24. ¿Ha tenido una lesión que requirió aparatos ortopédicos, yeso, muletas o aparatos ortésicos?		
25. ¿Ha necesitado una radiografía, una resonancia magnética, una tomografía computarizada, una inyección o fisioterapia luego de una lesión?		
26. ¿Ha sentido dolor, inflamación, calor o enrojecimiento en articulaciones?		
PIEL: ***El alumno:***	**SÍ**	**NO**
27. ¿Ha tenido sarpullidos, úlceras por presión u otros problemas cutáneos?		
28. ¿Ha tenido herpes o alguna infección cutánea por SARM?		

APARATO GENITOURINARIO: ***El alumno:***	**SÍ**	**NO**
29. ¿Ha tenido dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?		
30. ¿Ha tenido antecedentes de infecciones en el tracto urinario o de orinarse en la cama?		
31. SOLO PARA MUJERES: ¿Ha tenido el periodo menstrual? ☐ Sí ☐ No Si la respuesta es sí: ¿A qué edad fue su primer período menstrual? _____ ¿Cuántos períodos ha tenido en los últimos 12 meses? _____ Fecha del último período: _____		
DENTAL:	**SÍ**	**NO**
32. ¿Ha tenido algún dolor o problema en las encías o dientes?		
33. Nombre del dentista del alumno: _____ Última visita al dentista: ☐ menos de 1 año ☐ entre 1 y 2 años ☐ más de 2 años		
CONDUCTA SOCIAL/APRENDIZAJE: ***El alumno:***	**SÍ**	**NO**
34. ¿Ha recibido un diagnóstico de discapacidad del aprendizaje, discapacidad intelectual o del desarrollo, retraso cognitivo, TDA/TDAH, etc.?		
35. ¿Ha sido víctima de intimidación o ha experimentado comportamientos relacionados con la intimidación?		
36. ¿Ha experimentado sufrimiento, trauma u otros acontecimientos de vida importantes?		
37. ¿Ha mostrado cambios importantes en su comportamiento, sus relaciones sociales, sus calificaciones, sus hábitos de alimentación o de sueño, o se ha mostrado introvertido con familiares o amigos?		
38. ¿Ha estado preocupado, triste, disgustado o enojado la mayor parte del tiempo?		
39. ¿Ha mostrado pérdida general de energía, motivación o entusiasmo?		
40. ¿Ha tenido inquietudes sobre el peso; ha tratado de aumentar o bajar de peso, o ha recibido una recomendación de subir o bajar de peso?		
41. ¿Ha consumido (o consume actualmente) tabaco, alcohol o drogas?		
SALUD FAMILIAR:	**SÍ**	**NO**
42. ¿Existen antecedentes familiares de las siguientes enfermedades? Si es así, marque lo que corresponda: ☐ Anemia/trastornos sanguíneos ☐ Enfermedades/síndromes hereditarios ☐ Asma/problemas pulmonares ☐ Problemas de riñón ☐ Problemas de salud conductual ☐ Convulsiones ☐ Diabetes ☐ Rasgo drepanocítico o anemia drepanocítica Otra _____		
43. ¿Existen antecedentes familiares de alguno de los siguientes problemas cardíacos? Si es así, marque lo que corresponda: ☐ Síndrome de Brugada ☐ Síndrome de QT ☐ Miocardiopatía ☐ Síndrome de Marfan ☐ Hipertensión arterial ☐ Taquicardia ventricular ☐ Colesterol alto ☐ Otro_____		
44. ¿Algún familiar ha sufrido desmayos o convulsiones sin explicación, o ahogamiento inminente?		
45. ¿Algún familiar/pariente ha muerto de problemas cardíacos antes de los 50 años de edad o ha sufrido una muerte súbita inesperada/sin explicación antes de los 50 años de edad (incluido ahogamiento, accidentes automovilísticos sin explicación, síndrome de muerte súbita infantil)?		
PREGUNTAS O INQUIETUDES	**SÍ**	**NO**
46. ¿Existen preguntas o inquietudes que el alumno, padre, madre o tutor quisieran analizar con el proveedor de atención médica? (Si la respuesta es sí, escríbalas en la página 4 de este formulario).		

Por el presente, certifico que, según mi leal saber y entender, toda la información es verdadera y completa. Doy mi consentimiento para el intercambio de información médica entre el personal de enfermería de la escuela y los proveedores de atención médica.

Firma del Padre/Madre/Tutor/Alumno emancipado _____ Fecha_____

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 _____

Print name of examiner _____

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

Signature of examiner _____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

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
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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
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Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
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	6	7	8	9	10
	11	12	13	14	15
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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)					

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

EAST PENN SCHOOL DISTRICT,
Administration, 800 Pine Street, Emmaus, PA 18049
610 - 966-8300

2019/2020 School Year

Dear Parent(s)/Guardian(s):

The Pennsylvania School Health Act requires a dental examination of every student entering school for the first time, in third grade and seventh grade. A student entering the district from out of state or from another district will be required to submit an exam to meet this requirement.

You may choose to have the examination done by the school dentist at no cost to you, or by your family dentist at your own expense. Your family dentist has a better knowledge of your child's past dental history than the school dentist and is in the best position to clean teeth, apply preventive treatments, and plan corrective procedures.

If you choose to take your child to your family dentist, any exam dated on or after **JULY 1, 2018** is acceptable. The attached *Family Dentist Report* must be completed by the family dentist and returned to school by **SEPTEMBER 30, 2019**.

If you choose to have the examination done by the school dentist, you will be notified in advance of the visit in the event that you wish to be present. The school dental exam consists of a visual assessment of the teeth and gums by a licensed and practicing dentist. You will be notified by the school nurse of any condition requiring the attention of your family dentist.

If the dental examination is not completed and proof submitted to the appropriate school nurse, OR you do not give written permission for your child to see the school dentist, your child may be excluded from school.

Please fill out the lower portion of the form at this time showing your choice, and return the form to the school nurse.

Sincerely,

Thomas P. Mirabella, Ed.D.
Director of Student Services

****

(Return to school nurse **immediately**)

CHILD'S NAME: _____

SCHOOL: _____ GRADE: _____

_____ **I CHOOSE TO HAVE MY CHILD'S DENTAL EXAMINATION DONE BY MY FAMILY DENTIST.**
Please sign below and return slip to school nurse.

Date of Exam with Family Dentist: _____

_____ **I CHOOSE TO HAVE MY CHILD'S DENTAL EXAMINATION DONE BY THE SCHOOL DENTIST AND GIVE MY PERMISSION BY SIGNING BELOW.**
Please sign below and return slip to school nurse.

_____ _____
Parent(s)/Guardian(s) Signature *Date*

SS – Revised 12/2018

East Penn
School District

Administrative Offices
800 Pine Street
Emmaus, PA 18049
610-966-8300

Dear Parent/Guardian:

Thank you for registering your child to attend the East Penn School District schools. In agreeing to accept your child, the East Penn School District has accepted, as true, all statements made in your registration forms. In particular, the school district has relied on your representation that you are residents of the East Penn School District. If that representation is inaccurate, or if you no longer reside in the school district, you will not only be charged the full tuition rate for a non-resident student, but the school district will also remove your child from the attendance rolls and refer you to the police for criminal prosecution for theft of services. Depending upon the amount of time it is determined you illegally have sent your child, you may be subject to significant penalties including the possibility of a substantial fine and imprisonment.

Sincerely,

Mr. Douglas E. Povilaitis
Assistant Superintendent

Name of Student	Parent Signature	Date

EAST PENN SCHOOL DISTRICT

ACCEPTABLE USE POLICY AND INTERNET ACCESS ACKNOWLEDGEMENT FORM

I have read the East Penn School District Acceptable Use of Technology Resources, Electronic Communications and Information Systems Policy Brief and I will comply with its terms. The Acceptable Use of Technology Resources, Electronic Communications and Information Systems Policy #815 is available in the main office of each school and online. Go to https://www.eastpennsd.org. Scroll to the bottom of the homepage and select the Acceptable Use Policy link.

I understand that district technology resources are provided for the purpose of exploring educational topics, conducting research and classroom activities, and communicating with others in support of educational goals and the business of the district.

I understand that the district has the right to review any material stored on any system that the district provides and to edit or remove any material. I acknowledge that my access to such material is a privilege, not a right. I acknowledge that it is impossible for the district to restrict access to all controversial and inappropriate materials, and I will not hold the district responsible for the materials acquired on the network.

I understand that violation of this policy may have consequences ranging from revocation of access privileges to district disciplinary actions, and that violations may be reported to local, state, and/or federal legal authorities when applicable.

Name of Student (please print): _____ Student ID: _____

Student's Signature: _____

School: _____ Grade: _____ Date: ____/____ /_____

Name of Teacher: _____ (elementary only)

If above signatory is a minor, a parent or guardian signature is required. By signing below, I (as a parent or guardian) have read the above-mentioned policy and agree that my child and I will comply with its terms. I hereby give permission for my child to access the Internet as an academic resource.

Name (please print): _____

Signature of parent/guardian: _____ Date: ____/____ /_____

Phone: _____

Forms will be kept on file in the main office.

EAST PENN SCHOOL DISTRICT

ADMINISTRATIVE OFFICES
800 PINE STREET
EMMAUS, PA 18049
610-966-8300

Dear School Administrator(s):

We have read and understand the School Handbook, Discipline Code (secondary schools only) and acknowledge that we may call the school for further information and clarification.

☐ I **have reviewed** the Student Handbook. At the secondary level, this includes the Discipline Code.

☐ I **do not give** permission for my child to be in the school yearbook during the 2019-2020 school year.

Please choose one of the below:

☐ I **give** permission for my child to be video recorded/photographed in small or individual group setting to be used to publicize and promote school activities in local newspapers, on-line sources of news media outlets, district published newsletters/brochures, the school district website or our Social Media outlets Twitter and YouTube during the 2019-2020 school year.

☐ I **do not give** permission for my child to be video recorded/photographed in small or individual group setting to be used to publicize and promote school activities in local newspapers, on-line sources of news media outlets, district published newsletters/brochures, the school/district website or our Social Media Outlets during the 2019-2020 school year.

Date _____

_____ _____
Parent/Guardian's Name (Please Print) Parent/Guardian's Signature

_____ _____
Student's Name (Please Print) Student's Signature (secondary level only)

Student's Grade _____

Student's Homeroom _____

Student's Teacher _____
(Elementary only)

Permission forms will be kept on file in the main office.

EPSD – Revised 02/2019

EAST PENN SCHOOL DISTRICT

ADMINISTRATIVE OFFICES
800 PINE STREET
EMMAUS, PA 18049
610-966-8300

Parental / Guardian Consent for Online Educational Resources

The East Penn School District understands the importance of student online safety and maintains a process for vetting online resources used by our students. In order to comply with vendor requirements and other legal requirements consent is required.

The School District has compiled a list of vetted online educational resources. Parents or guardians of students must consent before students will be permitted to access these approved online resources. The list of approved resources is updated regularly. Parents and guardians should check back often to stay up to date on additions to these online educational resources.

Approved websites and apps address: https://www.eastpennsd.org/edservices

My signature below constitutes consent to access the School district approved online educational resources referenced on the website listed above.

Student Name (Print) _____

Student ID Number _____

School _____ Grade _____

Homeroom Teacher Name _____

Parent / Guardian Name (Print) _____

Parent / Guardian Signature _____ Date _____

If you have questions or concerns, regarding application or websites, please contact your student's teacher.