### **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	e	Gender							
Address:										
City:		State:	Zip Code:							
County: Tw	/p.:	Tele	ephone:							
Place of Birth:										
(City and State)										
	_	1 (0 1								
Student Lives With: Both I										
Mother Only Father Oncumentation)	oniy Le	gai Guardian	_ Foster Parents	_ (Please Provide						
Documentation)										
Special Custodial Court Ins	tructions:									
No Yes		Provide a Copy of	Court Order)							
	_	13	,							
Father/Step Father Name:										
Address:										
City:	State:		_ Zip Code:							
Home Phone:										
Email Address:										
Mother/Step Mether Name			Maidan Nama							
Mother/Step Mother Name:										
Address:	State		7in Code:							
Home Phone:										
Email Address										
If The Student Is Not Living	With Parents, Ple	ease Complete Th	is Section and Provide I	<u>Paperwork</u>						
		-		_						
Guardian <b>or</b> Foster Parent's N										
Address:										
City:										
Home Phone:										
Email Address:										
<b>Emergency Contact:</b> Only if	a parent/guardian ca	annot be reached								
Name		Phone								
Name		Phone								

## 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:** 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\_\_\_\_

No\_\_\_\_

**Former School Information:** 

Do you have internet access? Yes\_\_\_\_



### **Moniteau School District**

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# 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.

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 setting ☐ 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 is SECTION A	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:					

<ol><li>School studen</li></ol>	t attended last :
Address of	f school:
Telephone	e number of school:
Contact pe	erson at school (if known):
□NO	ent have an IEP or a Chapter 15/504 agreement?  Please explain:
the information process complete enrollm school day (or soo	who is helping you register will contact the homelessness coordinator to review rovided. If homelessness is verified, addition information will be needed to tent. The Homelessness Coordinator will contact you by the end of the next oner) to share the determination regarding homeless status, to gather additional o discuss the plans for placement.
Signature of Pa	rent/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 ()
Émail Address:	
Screening Location:	
As the undersigned parent/guardian, I hereby gran Armstrong to screen the vision of the above-named cl	nt permission to The Blind Association of Butler and hild.
potential vision problems in children. It is not an eye professional eye exam. <b>If a professional examina</b> The Blind Association of Butler and Armstrong to regarding my child's eye examination and recomme	screening, designed only to detect certain symptoms of a examination and is not intended to take the place of a ation is recommended, I give my consent to permit obtain information, from the examining eye specialist, ended treatment, and to furnish such information, as understand that follow-up is required and that I may be Date:
Has your child had a professional eye Examination? Yi	
CHECK ALL THOSE THAT APPLY: Wears glassesShuts or covers oneComplains about eyesTilts or thrusts headBlinks more than usualRubs eyes excessiveEither eye turns in, out, up or down (which one?) Family history of eye problems (specify): observations (describe):	e eyeSquints at objects If forwardHolds objects close to eyes Ely Other
Thank you, The Blind Association of Butler and Arm	nstrong, 724-287-4059
For Office	ce Use Only
Peferred: Vec ID # No	C B H A NA O (circle one)

# Moniteau School District

**Transportation Department** 



TRANSPORTATION C	TRANSPORTATION CHANGE NOTIFICATION						
REASON FOR CHANGE-							
SCHOOL -Dassa McKinney Elementary							
		I					
Please complete the section below							
Student Name							
Parent / Guardian							
Address		Phone Number					
Grade							
Bus Company to complete the section by Bus Number	below						
Bus Stop Location							
Pick Up Time	Drop Off Time						
Start Date							
TRANSPORTATION	DEPARTMENT USE ONLY						
Date Bus Company Notified: Parent Notified By: Pho	one 🗌 Letter 🗌 Email						



### **Student Health History Form**

Child's Name:				
Fi	rst	Middle	Last	
MEDICAL HISTORY				
Has your child ever bee  ☐ No ☐ Yes (If yes, explain)	•	•	,	
ies (ii yes, explain)				_
Is your child taking any ☐No. My child does not ☐Yes - Please list the c	take any prescript	ion medicines.		
				-
What <b>over-the-counte</b> ☐ Vitamins	r medicines does	your child take regu	larly?	
☐ Herbal medicine (ple	ease list)			
☐ Other (please list)				
☐ None, my child does	not take any over-	the-counter medicin	es regularly.	
☐ Outside or Indoor all	ergies (for example	e: grass, pollen, cats	llowing? (Check all that apply)	
☐ Food Allergies (for e		ilik, wileat)		
<ul><li>☐ Medicine or shots (in</li><li>☐ No, my child has no</li></ul>	•			
ino, my child has no	Known allergies			
Has your child had any	of the following dis	eases?	T	
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 <b>peeing</b> (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
	•
an the child use the toilet without help? YES	NO

### 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 □ Fair □ 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) □ Diabetes ☐ Emotional stress ☐ Other ☐ Injury or serious illness none of the above Was the birth: □ On the due date ☐ Before 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?\_\_\_\_\_

ABOUT MOM WHEN PREGNANT

Please list what yo	ur child	typically eats a	ınd drin	nks in a day for:		
Breakfast- Lunch- Dinner- Snacks-						
tantrums, disobedi	ence, pr	operty destruct	tion, stu	nild that you would like to ttering, thumbsucking, bov ren, restless, easily upset,	vel con	cerns, wetting during the
FAMILY						
Check all the peop ☐ Mother	ole that	the live in the l	househ	old with the child:		
□ Father						
☐ Brothers (how r	many?)_					
☐ Sisters (how ma	any?)_					
☐ Other family me	embers	(list)				
☐ Friends or othe	r people	e (list)				
What medical pro	blems (	do people in th	ne child	I'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	•			

			1			
Siblings		Depression		Anxiety		Learning difficulty
		Diabetes		High Blood Pressure		Asthma /Wheezing
		Cancer		Heart problems		Allergies/Eczema
		Seizures		Hearing loss		Blood disorder
		Other				
				<b>10</b>		
Have any members of the immediate family died? ☐ Yes ☐						
If so, who?				<u></u>		



# Dassa McKinney Elementary School

Montteen: School District 30 l'Hooker Road West Sunbury, 174 16061 7244637-2321 FAX: 7244637-3877

### **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:	<del></del>
Time to be administered:	
Dosage with any special instructions:	
Possible side effects:	
Procedure to follow if reaction should occur: _	
Termination date for administering the medical	
I hereby authorize the medication listed above	e to be administered to my child by the school nurse or
other school employee. I do hereby release, d	ischarge and hold harmless the Moniteau School
District, it's agent and employees, from any ar	nd 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

Eeslie Faller

School Nurse

### COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

# PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL								DATE20						20			
NAME OF CHILD									A	GE	SEX GRADE			S	SECTION/ROOM		
Last		First Middle						ddle			□ M	F					
ADDRESS									***		- 1 · 2 · 2 · 2 · 2 · 2						
No. and Street	City or Post Office Borough/T								Town	ship		Co	ounty			State	Zip
REPORT OF EXA	MIN	ATI	ON														
							ТС	OTF	· CH	ART							
				RIC	THE							LE	FT				
UPPER	1	2	3	4 ^	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	Treat	inent	?									Ye	s [	)	1	10 [	
Treatment Complet	ed											Ye	es 🗀	]	1	40 [	
Date of E		-					_		1867 -		Prin	t Nan	ne of	Denta	l Exa	miner	
	Addre	ss				···											



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 <u>before</u> student's exam. Take completed form to appointment.

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  I Any repoing medical conditions? If so, please identify: □ Asthma □ Lahameta □ Dilection □ Unfection ○ Other □ Sever stay demonstration of the student of	Today's date										
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											
□ Modicines   □ Pollens   □ Food   □ Stingling 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	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.)										
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  GENERAL HEALTH: Has the student  YES NO  GENERAL HEALTH: Has the student  A reposing medical conditions? If so, please identify;  Ashme J Anemia   Olabetes   Infection   Oliver  3. Ever had a healty   Olabetes   Infection   Oliver  3. Ever had a setzum?  3. Ever had a setzum?  3. Ever had a setzum?  5. Had a history of being born without or is missing a kidney, an eye, a testicle (makes), splean, or any other organ?  5. Ever had a setzum?  7. Had frequent musde cremps when everetisho?  8. Had a history of being born without or is missing a kidney, an eye, a testicle (makes), splean, or any other organ?  9. Ever had a head fully or concussion?  9. Ever had a head fully or concussion?  9. Ever had a head fully or concussion?  10. Ever had a history or concussion?  10. Ever had a history or concussion?  11. Ever had manuals to move airms or legs after being his or falling?  12. Ever been made to blow to the head that caused confusion, prolonged headache, or memory problems?  13. Had a history of the student  14. Ever had manuals to move airms or legs after being his or falling?  15. Ever been durable to move airms or legs after being his or falling?  16. Ever bead or been told hardshe has a curved spine or acclosis?  17. Had ireny problem with histher eyes (vision) or had a history of an open light hood pressure   Markshe has a curved spine or acclosis?  18. Had an organ history of the student  18. Ever had a history or or the sand history or or order significant life overal?  19. Ever had the doctor bay hards has a curved spine or acclosis?  19. Had a cough, where, difficulty breathing, shortness of breath or fell lightheaded guesse or contact lenses?  19. Had a cough, where, of life had a history or or order significant life overal?  20. Had an inhalter or taken ashman medicine?  21. Had disconnice, pain, highlyness or chest pressure du											
GENERAL HEALTH: Has the student  VES NO  1. Any engoing medical conditions? If so, please identify:											
GENERAL HEALTH: Has the student  VES NO  1. Any engoing medical conditions? If so, please identify:											
Other Citier Citier 2. Ever stayed more than one night in the hospital? 3. Ever had surgery? 5. Ever had surgery? 5. Had a history of being born without or is missing a kidney, an eye, a testicle (makes), spleen, or any other organ? 5. Ever bead surgery? 6. Ever bead by the secretary of being born without or is missing a kidney, an eye, a testicle (makes), spleen, or any other organ? 7. Had frequent muscle cremps when exercising? 7. Had frequent muscle cremps when exercising? 8. Ever had a head hylay or concussion? 9. Ever had head had concussed the search of the search has a curved splin or sections? 9. Noticed or been told he/hah has a curved splin or sections? 9. Had an history of uninary text infections or bedwesting? 9. Ever had the dead hylay of the search had been had been the search of the sear	YE\$	NO									
2. Ever stayed more than one night in the hospital? 3. Ever had surgery? 5. Hed a history of being born without or is missing a kidney, an eye, a testide (maske), apleny, or any other organ? 6. Ever bacome ill while exercising in the heat? 7. Hed frequent musde cremps when exercising? 8. Hed headeches with exercising? 9. Ever had a head fright or concession? 10. Ever had a head fright or concession? 11. Ever had members, linging or weakness in his/her arms or legs after being ht or failing? 12. Ever become his with his/her eyes (vision) or had a history of an eye highly selected to the head that caused confusion, prolonged headeche, or memory problems? 13. Noticed or been told he/she has a curved spine or accilosis? 14. Had any problem with his/her eyes (vision) or had a history of an eye highly: 15. Ever head make the model or eyes after being ht or failing? 16. Ever head the doctor say hor/she has a head problem? If so, check at that apply: 16. Ever head the doctor say hor/she has a head problem? If so, check at that apply: 17. Ever hed the doctor say hor/she has a head problem? If so, check at that apply: 18. Ever head the doctor say hor/she has a head problem? If so, check at that apply: 19. Hear murmur or heart infection 19. Hear murmur or heart infection 19. Hear murmur or heart infection 19. Hear or constitution or Affile exercise? 20. Had a broken or fractured bore, sizes instaute, or dislocated joint? 21. Hear his/her heart race or skip beats during exercise? 22. Had a broken or fractured bore, sizes instaute, or dislocated joint? 23. Had an injury to a muscle, igament, or tendon? 24. Had an injury to a muscle, igament, or tendon? 25. Head a broken or fractured bore, sizes instaute, or dislocated joint? 26. Had a loints that become paintut, swollan, feel warm, or look red? 26. Had a loints that become											
3. Ever had surgery? 4. Ever had a salzura? 5. Had a history of being born without or is missing a kidney, an eye, a teststide (makes), spiene, or any other organ? 6. Ever become ill white exercising in the heat? 7. Had frequent musde cramps when exercising? 7. Had frequent musde cramps when exercising? 8. Had neadaches with exercise? 9. Ever had a head fighry or concussion? 9. Ever had a hit or filow to the head that caused confusion, prolonged headache, or memory problems? 9. Ever had or hit or filow to the head that caused confusion, prolonged headache, or memory problems? 9. Ever had or memory problems? 11. Ever had numbness, lingling, or weakness in his/her arms or legs after being that or falling? 12. Ever been unable to move arms or legs after being that or falling? 13. Notice or been total brishe has a curved apprixe or sectionsis? 14. Had any problem with his/her eyes (vistor) or had a history of an eye injury? 15. Ever had not had for falling? 16. Ever had not had concerned to the fall had a fall	l Yes	□ No									
4. Ever had a selzure? 5. Had a history of being born without or is missing a kidney, an eye, a testicis (males), spiken, or any other organ? 6. Ever become ill while exercising in the heat? 7. Hed frequent musde cramps when exercishg? 8. Had headaches with exercise? 9. Ever had a head highly or concussion? 8. Had headaches with exercise? 9. Ever had a head highly or concussion? 8. Ever had a head highly or concussion? 8. Ever had a hid or blow to the head that caused confusion, prolonged headache, or memory problems? 11. Ever had numbness, finging, or weakness in hisher 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 healshe has a curved spine or scollosis? 14. Had arry problem with his/her eyes (vislon) or had a history of an eye injury? 15. Been told healshe has a curved spine or scollosis? 16. Ever head in inhaler or teken ashtme medicine? 17. Ever hed the doctor say helshe has a heard problem? 18. Ever head in inhaler or teken ashtme medicine? 19. Ever head in hidder or teken ashtme medicine? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say helshe has a heard problem? 19. Ever head the doctor say hels											
testide (males), spleen, or any other organ?  7. Had frequent musde carens when exercising?  8. Had headeches with exercise?  8. Had headeches with exercise?  9. Ever had a had nity or concussion?  9. Ever had a had nity or concussion?  9. Ever had a hist or blow to the heat that caused confusion, prolonged headeche, or memory problems?  10. Ever had a hit or blow to the head that caused confusion, prolonged headeche, or memory problems?  11. Ever had mumbness, finging, or weakness in his/her arms or legs after being hit or failing?  12. Ever bear unable to move arms or legs after being hit or failing?  13. Sean huilded as sperificant changes in behavior, social relationships, grades, eating or seleping habts, withdrawn from hamily or friends?  14. Had any problem with his/her eyes (vision) or had a history of an eye injury?  15. Been prescribed glasses or contact tenses?  16. Ever had the doctor say he/she has a curved spine or scollosis?  17. Ever had the doctor say he/she has a heart problem?  18. Ever had in inhaler or taken asthma medicine?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart problem?  19. Ever had the doctor say he/she has a heart test? (For example, ECO/EKG, echocardiogram)?  19. Had a cough, wheeze, difficulty breathing, shortness of breath or feel that apply.  19. Ever had the doctor say he/she has a heart test? (For example, ECO/EKG, echocardiogram)?  20. Had a cough, wheeze	-										
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9. Ever had a head fulty or concussion? 10. Ever had a hild or blow to the head that caused confusion, prolonged headache, or memory problems? 11. Ever had uniform the had that caused confusion, prolonged headache, or memory problems? 12. Ever had mumbness, fingling, or weakness in his/her arms or legs after being hit or falling? 13. Exhibited significant changes in behavior, social relationships, grades, eating or siesping habits; withdrawn from lamily or friends? 13. Noticed or been total he/she has a curved spine or socilosis? 14. Had any problem with his/her eyes (vision) or had a history of an eye injury? 15. Been prescribed glasses or contact tenses? 16. Ever had the doctor say he/she has a heart problem? If so, check all that apply: 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: 18. Ever used an inhaler or taken asthma medicine? 19. High blood pressure   Kawasaki disease   Martin Ma	YES	NO									
developmental disability, cognitive delay, ADD/ADHD, etc.?  1. Ever had numbness, fingling, or weakness in his/her arms or legs after being hit or flow to the resident hit or flow to the resident hit or flow to the resident hit or flow to the significant of the significant hanges in behavior, social relationships, grades, eating or sieeping habits, withdrawn from family or frends?  13. Noticed or been told he/she has a curved spine or scollosis?  14. Had any problem with his/her eyes (vision) or had a history of an oye injury?  15. Been prescribed glasses or contact lenses?  16. Ever used an inhalar or laken astimas medicine?  17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:  18. Ever used an inhalar or laken astimas medicine?  19. Ever wad an inhalar or laken astimas medicine?  19. Ever had the doctor say he/she has a heart problem? If so, check all that apply:  19. Heart murmur or heart infection  19. High cholesterol  10. Other:  19. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?  20. Had a cough, wheeze, difficulty breathing, shortness or breath or felt lighthaded doutins or AFER exercise?  21. Felt his/her heart race or skip beats during exercise?  22. Had a in injury to a muscle, Sgament, or tendon?  23. Had an injury to a muscle, Sgament, or tendon?  24. Had an injury that required a brace, cast, crutches, or orthotice?  25. Naeaded an x-ray, MRI, CT scan, injection, or physical therapy following an injury?  26. Had joints that become painful, swellan, feel warm, or look red?  27. Exhibited significant changes in behavior, social relationships, grades, eating or sieeping habits, withdrawn from family or frends?  28. Had an injury to a muscle, Sgament, or chest pressure during exercise?  29. Had an injury to a muscle, Sgament, or tendon?  29. Had an injury to a muscle, Sgament, or tendon?  29. Had an injury to a muscle, Sgament, or tendon?  29. Had an injury to a muscle, Sgament, or tendon?  29. Had an injury to a muscle, Sgament,	TES	NU									
headache, or memory problems?  11. Ever had numbness, fingling, 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 socilosis?  14. Had any problem with his/her eyes (vision) or had a history of an eye injury?  15. Been prescribed glasses or contact lenses?  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:  18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?  19. Had a longh, wheeze, difficulty breathing, shortness of breath or felt lightheaded burning or AFTER exercise?  20. Had a broken or fractured bone, siress fracture, or dislocated joint?  21. Had an injury to a muscle, Igameni, or tendon?  22. Had an injury to a muscle, Igameni, or tendon?  23. Seem lumined or exprenenced major grief, frauma, or tonk resignificant life event?  37. Exhibited significant changes in behavior, social relationships, grades, ealing or sleeping habits; withdrawn from family or frends?  38. Been worried, ead, upset, or engry much of the time?  39. Shown a general loss of energy, motivation, interest or enthuslasm.  40. Had concerns about weight, been trying to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a fective and interest of concerns about weight, been trying to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a recommandation to gain or lose weight or tecelved a fective and the second or currently uses) tobacco, alcohol, or drugs?  41. Used (or currently uses) tobacco, alcohol, or drugs?  42. Is there a family history of the following? If so, check all that apply:  43. Is there a family history of only of the following heart-related probl											
11. Ever had numbness, fingling, or weakness in Nis/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 socilosis?  14. Had arry problem with his/her eyes (vision) or had a history of an eye injury?  15. Been prescribed glasses or contact tenses?  16. Ever used an inhalter or taken astimas medicine?  17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:  18. Been told by the doctor to have a heart feetion  19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded busine or AFER exercise?  19. Had discomfort, pain, lightness or chest pressure during exercise?  20. Had an injury to a muscle, ligament, or tendon?  21. Had an injury to a muscle, ligament, or tendon?  22. Had a broken or fractured bone, siress fracture, or dislocated joint?  23. Newfall was disprificant changed anily or feleding hit or falling?  24. Had an injury to a muscle, ligament, or tendon?  25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?  26. Had all plots that become painful, swolken, feel warm, or look red?  27. Exhibited significant changes a fishility or felephing habits; withdrawn from family or friends?  36. Experienced an inchance, add, upset, or engary much of the time?  37. Exhibited significant changes all pablets; withdrawn from family or friends?  38. Been worried, sad, upset, or engary much of the time?  39. Shown a general loss of energy, motivation, inderest or enthuslasming rades, eading or sleeping habits; withdrawn from family or friends?  39. Shown a general loss of energy, motivation, inderest or enthuslasming and unsured to sade and unsured to save shout weight; been trying to gain or lose weight or received a recommendation to gain or lose weight or received a recommendation to gain or lose weight or received a recommendation to gain or lose weight or received a recommendation to gain or lose weight or rece	1	1									
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 socilosis?  14 Had any problem with his/her eyes (vision) or had a history of an oye injury?  15 Been prescribed glasses or contact lenses?  16 Ever used an inhaler or taken astima medicine?  17 Ever had the doctor say he/she has a heart problem? If so, check all that apply:  18 Ever used an inhaler or taken astima medicine?  19 Had a locustin with 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 burints or AFTER exercise?  21 Had discomfort, pain, tightness or chest pressure during exercise?  22 Had a ni Injury to a muscle, ligament, or tendon?  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, swellen, feel warm, or look red?											
38. Bean worried, sad, upset, or angry much of the time? 39. Shown a general loss of energy, motivation, interest or enthusiasm eye injury? 40. Had any problem with his/her eyes (vision) or had a history of an eye injury? 41. Used 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? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 41. Used (or currently uses) tobacco, alcohol, or drugs? 42. Is there a family history of the following? If so, check all that apply:											
## Had any problem with his/her eyes (vision) or had a history of an eye injury?  ## Had any problem with his/her eyes (vision) or had a history of an eye injury?  ## Had any problem with his/her eyes (vision) or had a history of an eye injury?  ## Had an injury had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded burkins or AFER exercise?  ## Had an injury to a muscle, itgament, or tendon?  ## Had an		<del></del>									
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation 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:  42. Is there a family history of the following? If so, check all that apply:  High blood pressure   Kawasaki disease   Diabetes   Salzure disorder    Basen told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?  43. Is there a family history of only of the following heart-related problems? If so, check all that epply:  Had discomfort, pain, lightness or chest pressure during exercise?  43. Is there a family history of only of the following heart-related problems? If so, check all that epply:  Brugada syndrome   QT syndrome	+	1									
## HEART/LUNGS: ## Has student  ## HEART/LUNGS: ## Has student  ## WES NO  ## HEART/LUNGS: ## Has student  ## HEART/LUNGS: ## Has student  ## HEART/LUNGS: ## Has student  ## Heart murmur or teart infection  ## High cholesterol   Other:   Other:   Other:   Other    ## High cholesterol   Other:	-										
### HEART/LUNUS: Has fine storement  ### Record of Inhalar or taken asthma medicine?  ### Asthmallung problems   Inhartled disease/syndroma   I	+	+									
42. Is there a family history of the following? If so, check all that apply:   Heart murmur or heart infection   High blood pressure   Kawasaki disease   High cholesterol   Other:   Sebantical by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?   Behaviorat health issue   Selzure disorder   Olabetes   Skkle cell trait or disease   Diabetes   Other   43. Is there a family history of any of the following heart-related problems? If so, check all that apply:    Behaviorat health issue   Selzure disorder   Skkle cell trait or disease   Diabetes   Other   43. Is there a family history of any of the following heart-related problems? If so, check all that apply:    Brugade syndrome   QT syndrome   QT syndrome   Detrical trait or disease   Diabetes   Diabete	YES	NO									
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded buring or AFTER exercise?  20. Had discomfort, pain, tightness or chest pressure during exercise?  21. Felt his/her heart race or skip beats during exercise?  22. Had a broken or fractured bone, siress fracture, or dislocated joint?  23. Had an injury to a muscle, figament, or tendon?  24. Had an injury to a muscle, figament, or tendon?  25. Needed an x-ray, MR), CT scan, injection, or physical therapy following an injury?  26. Had joints that become painful, swollen, feel warm, or look red?  43. Is there a family history of ony of the following heart-related problems? If so, check all that epply:  Brugade syndrome  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy  Chiffic history of ony of the following heart-related problems? If so, check all that epply:  Cardiomyopathy											
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BONE/JOINT: Has the student YES NO  22 Had a broken or fractured bone, siress 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?  27 High blood pressure Injection of the content achycerdia Injection Injection of the content achycerdia Injection Injection Injection of the content achycerdia Injection I	1										
### BONE/JOINT: Has the student  ### As 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)?  #### As the student  #### As 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)?  #### As the student  #### As any family member / relative died of heart problems before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?  #### As any family member / relative died of heart problems before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?	1										
23. Had an injury to a muscle, figament, or tendon?  24. Had an injury to a muscle, figament, or tendon?  25. Had an injury that required a brace, cast, crutches, or orthotics?  26. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?  27. Had joints that become painful, swollen, feel warm, or look red?  28. Had an injury to a muscle, figament, or tendon?  49. 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)?  29. Had an injury to a muscle, figament, 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?  45. Has any femily 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 infent death syndrome)?  QUESTIONS OR CONCERNS		$\top$									
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?  50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infent death syndrome)?  QUESTIONS OR CONCERNS	<del>-</del>										
26 Had Joints that become painful, swollen, feel warm, or look red?  death syndrome)?  QUESTIONS OR CONCERNS											
QUESTIONS OR CONCERNS											
SKIN: Has the student 1 YES   NO   }	YES	NO									
Zi. Had any rashes, pressure sores, or other skin problems?  46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If											
28. Ever had herpes or a MRSA skin infection?  yes, write them on page 4 of this form.)	İ										
I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchaelth information between the school nurse and health care providers.  Signature of parent / guardian / emancipated student  Date	ange of	f									
Adapted in part from the Pre-participation Physical Evaluation History Form; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, Arr	dea - C										

			СН	ECKO	NE	The state of the s
Physical exam for K/1  6	grade:			*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: (	) ir	ches		<u>.</u> .		
Weight: (	) p	ounds	<u> </u>		_	
BMI:(	)					
BMI-for-Age Percent	iile: (	)%		_	<u> </u>	
Pulse: (	)					
Blood Pressure: (		)				
Hair/Scalp						
Skin						
Eyes/Vision	Correcte	<u> </u>				
Ears/Hearing						
Nose and Throat						
Teeth and Gingiva			L			
Lymph Glands			L,			
Heart						
Lungs						
Abdomen						
Genilourinary						
Neuromuscular Syste	em_					
Extremities						
Spine (Scoliosis)						
Other						
TUBERCULIN TEST	DATE	APPLIED	DA	TE RE	AD	RESULT/FOLLOW-UP
MEDICA		IIONS OR	CHRO	IIC DIS	EASE	S WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
exam	formed a 20	nt: Perso	nal He	alth C	Care P	No □ Provider's Office □ School □ Date of
Print examiner's o	ffice add	iress	<del></del> -			Phone
Signature of exam	lner					MD DD PAC B CRNP D

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record - OR - insert information below.

IMMUNIZATION EXEMPTION(S):												
Medical ☐ Date Issued: R	eason:		Date Rescinded;									
Medical Date Issued: R												
Medical Date Issued: R												
NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.												
VACCINE	DOCUMENT	: (1) Type of vaccin	e; (2) Date (month/	day/year) for each	immunization							
Diphtheria/Tetanus/Portussis (child) Type: DTaP, DTP or DT	10.000		3	1	3							
Olphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td		2	3	•	5							
Polio Type: OPV or IPV		,	3	•	5							
Hepatitis B (HepB)		.3	3	•	5							
Measles/Mumps/Rubella (MMR)	1	2	3	<del>*************************************</del>	5							
Mumps disease diagnosed by physician	Date:											
Varicella: Vaccine Disease	1		3	···	5							
Serology: (Identily Antigen/Date/POS or NEG) i.e. Hop B, Measles, Rubella, Varicella		7			-5							
Meningococcal Conjugate Vaccine (MCV4)		<del></del>	·3	4	2							
Human Papilloma Virus (HPV) Type: HPV2 or HPV4		2	3	-	3							
		2	-	4	5							
Influenza Type: TIV (injected) LAIV (nasal)	8	,	8		1-10							
	11-	12	12	14	15							
Haemophilus Influenzae Type b (Hib)	1	7	3	4	5							
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13		2	3	•	5							
Hepatills A (HepA)		2	3		5							
Rolavirus				4	3							
Other Vaccines: (Type and Date)												

# Page 4 of 4: ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER) STUDENT NAME: