KINDERGARTEN REGISTRATION

HOME & HEALTH PACKET

This packet includes the home and health forms that parents/guardians of incoming Kindergarten students are to complete and bring with them to their child's Kindergarten screening appointment in May. Please have as many of these forms as possible completed by your child's screening appointment. This will ensure an efficient, successful registration process for your child. Any uncompleted forms or documents can be dropped off at the elementary center office from 10 a.m. to 2 p.m. on school days and on Mondays-Thursdays during the summer. Welcome to Kindergarten!

South Park Elementary Center
2001 Eagle Pride Lane
South Park, PA 15129
(412) 655-3111, option 3

South Park School District Health History

To Parent/Guardian: The information requested on this form will be of help to the school in determining the health status of your child and assisting him/her to receive the maximum benefits from his/her educational opportunity.

Name of Child:_____ Birthdate: _____ Grade: _____
Father's Name: _____ Work #_____ Cell #_____
Mother's Name: _____ Work #_____ Cell#_____
Child Lives with:(check one) Both Parents_____ Mother_____ Father_____ Guardian_____

Medical Information

Name of Doctor _____ Phone#_____
Has your child been diagnosed with any of the following? If so please explain and list limitations that should be known to the school.

ADD/ADHD_____ Cancer_____ Cerebral Palsy_____ Diabetes_____
Eating Disorder_____ Emotional Problem_____ Heart Disorder_____
Hypoglycemia_____Seizure Disorder_____Spina Bifida_____Urinary Problems_____
Gastrointestinal disorders_____
Allergies _____Treatment:_____
Asthma _____ Symptoms_____ Medications?_____
Orthopedic Problem _____Devices/ Limitations_____
Vision Problems _____ Wears lenses? _____
Hearing Problems _____Hearing Aids?/Which ear?_____

Recurring illness or any other medical condition not listed above _____
_____
Please list any medication that your child is taking:_____
_____
*****PLEASE KEEP THE SCHOOL NURSE INFORMED OF ANY CHANGES DURING THE YEAR.

MEDICATION POLICY

Please note SPSD medication policy states that no medication can be given at school without the proper prescription and parental release on file in the school health office. Students are not allowed to carry their own medication (except EpiPens and inhalers, with proper forms on file) or transport medication to and from school. Please see our medication policy for further information.

IMMUNIZATIONS

Please attach a copy of your child's immunizations.
(A list of the required immunizations is on the front page of this packet)

REQUIRED EXAMS

The School Health Law requires a medical examination for all children entering school and in grades 6, and 11, and a dental exam for all children entering school and in grades 3 and 7. Please indicate below if you will be having these done by your own physician/dentist or the school physician/dentist.

I want the school dentist to do the required dental examination. _____
I want my family dentist to do the required dental examination. _____

I want the school physician to do the required medical examination. _____
I want my family physician to do the required medical examination. _____

_____ _____
Signature of Parent/Guardian Date

H511.336 (Rev. 9/2012) **STUDENT HISTORY**

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

PHYSICAL EXAM **STUDENT NAME:**

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

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

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, health department staff)

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

 Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/_____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/_____/____
(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/_____/____
(Physician)

South Park School District
Central Administration Offices
2005 Eagle Ridge Drive
South Park, PA 15129
412-655-3111 • Fax: 412-655-2952
www.sparksd.org

South Park School District

AFFIDAVIT OF RESIDENCY
SWORN STATEMENT UNDER 24 PS §13-1302

AND NOW, comes the affiant, and, after having been duly sworn according to law, does depose and state the following:

1. I, _____{name}, am the parent and/or legal guardian of _____{child}, and we reside at_____ {address} within the South Park School District ("District").

2. We have resided at the said address from _____{date} and continue to reside there as of the date of this affidavit. Neither I nor _____{child} has any plans to move to any other residence.

3. In the event that _____{child} and I move from the residence stated above, I will notify the District within five (5) days of when the decision to move has been made, or the move has actually been made, whichever occurs first. I understand that a new affidavit and new proof of residency must be submitted to the District once _____{child} or I move from the residence stated above. I understand that an inter-district transfer may not be accepted by the District.

4. I have attached to this affidavit two proofs of residency. Acceptable proofs of residency for the District include and is limited to:

    a. a property tax bill or a mortgage statement in my name showing the residence property or a copy of a deed or lease/rental agreement, and
    b. proof of residency from the Allegheny County Registrar of Voters, or
    c. a current vehicle registration showing the residence property address, or
    d. a utility bill in my name for the current month showing the residence property address, or
    e. such other documentation acceptable to the District.

5. I understand that in the event that it is determined that I or _____{child} do not reside at the residence stated above, and in accordance with 24 PS 13-1302 of the Pennsylvania School Code of 1949, as amended, I will be liable for payment of tuition from the initial date of non-residency. _____{child} will be withdrawn from school unless tuition payments are made and, then, paid in advance for the remainder of the

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year. Tuition payments for the 20_____ - 20_____ school year are estimated to be $8,000 to $11,000.

6. I make these statements in order to induce the District to enroll _____{child} as a student in the District.

7. I will assume all personal obligations related to school requirements for _____{child} that may include providing for required immunizations, fees, fines, citations, fines for truancy, attending parent-teacher conferences, attending meetings and/or hearings concerning discipline, and fulfilling any special education requirements. I assume the responsibility and obligation for making all education decisions.

8. I grant the District permission to investigate the information I have presented in this affidavit by discussing the information herein with all appropriate parties, as necessary to confirm the factual accuracy.

9. I understand that a person knowingly providing false information in this sworn statement for the purpose of enrolling a child in the District for which the child is not eligible commits a summary offense and shall, upon conviction of such violation, be sentenced to pay a fine of no more than three hundred dollars and no/100 ($300.00) for the benefit of the District, or to perform up to two hundred forty (240) hours of community service, or both. In addition, the person shall pay all court costs and shall be liable to the District for an amount equal to the amount of tuition calculated in accordance with 24 PS 25-2561 of the Pennsylvania School Code of 1949, as amended, during the period of enrollment.

I MAKE THESE STATEMENTS PURSUANT TO 18 Pa.C.S. §4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES AND UNDERSTAND THAT FALSE STATEMENTS MAY SUBJECT ME TO CRIMINAL PENALTIES UNDER THAT STATUTE.

IN WITNESS WHEREOF, the Affiant has caused this Affidavit to be executed on this

_____ day of _____, 20_____.

_____ WITNESS/ATTEST

_____ Affiant's Name

South Park School District
Central Administration Offices
2005 Eagle Ridge Drive
South Park, PA 15129
412-655-3111 • Fax: 412-655-2952
www.sparksd.org

South Park School District

Commonwealth of Pennsylvania

SS.

County of _____{county}

Sworn and subscribed to before me on this _____ day of _____, 20_____{year},

by _____ {name of affiant}, known to me (or is satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that {he, she} executed the same for the purposes therein contained.

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

_____

NOTARY PUBLIC

{Notary Seal}

My Commission Expires:

SOUTH PARK SCHOOL DISTRICT
2023-2024 REQUEST FOR TRANSPORTATION

The South Park School District Transportation Office has started to plan for the 2023-2024 school year. Please complete this form with your transportation request for the 2023-2024 school year and return it to the school office as soon as possible. This transportation request will be reflected on the transportation assignment your child will receive via email in August.

RETURNING FAMILIES: Even if your child's assigned stop will not be changing next year, please complete this form.

If at any time you need to change this request prior to the first day of school, please complete a transportation change form and submit it to your school office. If your child will be a car rider next year, please check the appropriate box.

Student's Name _____ Grade (in 2023-2024 School Year) _____

Home Address _____
(street address with zip code)

Parent/Guardian Name _____ Primary Phone Number _____

1. Your child's caregiver/daycare must be in South Park Township in order for the South Park School District to provide transportation.
2. If your child/children will be picked up and/or dropped off at another location, other than the home address, the responsible party's information must be included below.
3. The requested transportation schedule must be CONSISTENT throughout the school year.
4. This form must be signed and returned to the school office.

Will your child be a car rider every morning and every afternoon? ☐ **YES** ☐ **NO**

If yes, you may sign and submit the form. No other information is required. If no, please continue.

Will your child be transported to/from the approved bus stop for the home address listed above every morning and afternoon? ☐ **YES** ☐ **NO**

If yes, you may sign and submit the form. No other information is required. If no, please continue.

Please provide the address and required information for up to two transportation locations, including your home address if applicable, for the 2022-2023 school year. A student may have no more than two (2) bus stops. The Transportation Department will assign an approved bus stop closest to the address(es) listed below.

TRANSPORTATION REQUESTED ADDRESS #1

Address with Zip Code _____

Name of Responsible Party _____

Phone Number _____

TRANSPORTATION REQUESTED ADDRESS #2
(Leave blank if you are not requesting a second address)

Address with Zip Code _____

Name of Responsible Party _____

Phone Number _____

Please check one box per trip, indicating your child's transportation schedule for the 2022-2023 school year.

MORNING TRANSPORTATION	Requested Address #1	Requested Address #2	Car Rider
Monday AM	☐	☐	☐
Tuesday AM	☐	☐	☐
Wednesday AM	☐	☐	☐
Thursday AM	☐	☐	☐
Friday AM	☐	☐	☐

AFTERNOON TRANSPORTATION	Requested Address #1	Requested Address #2	Car Rider
Monday PM	☐	☐	☐
Tuesday PM	☐	☐	☐
Wednesday PM	☐	☐	☐
Thursday PM	☐	☐	☐
Friday PM	☐	☐	☐

Parent/Guardian Signature _____ Date _____

Assigning bus stops is the responsibility of the South Park School District. Parents must recognize bus stop assignments cannot be customized to meet every individual need and still be part of an efficient and economical transportation system. Please remember the South Park School District cannot consider factors associated with individual family or parental situations. Such concerns are expected to be resolved by the family or parent/guardian. For further information concerning the request and/or regulations of bus stops, please review School Board Policy 810 on www.sparksd.org or contact your building principal for a copy.