DUNMORE SCHOOL DISTRICT
DUNMORE ELEMENTARY CENTER

KINDERGARTEN Registration

BUS STOP________________ BUS # TO SCHOOL________________

BUS STOP________________ BUS # FROM SCHOOL________________

SCHOOL YEAR________________ DATE________________

CHILD'S NAME____
(LAST) (FIRST) (MIDDLE) (SEX)

ADDRESS________________ PHONE #________________

PARENT EMAIL ADDRESS ________________

PROOF OF DUNMORE RESIDENCY________________

DATE OF BIRTH________________ BIRTH CERTIFICATE________________

PLACE OF BIRTH____
CITY STATE COUNTRY

RACE - PLEASE CHECK ALL THAT APPLY:

____American Indian/Alaskan Native ____Asian ____Black
____Hawaiian/Pacific Islander ____Hispanic/Latino ____White

FATHER'S NAME________________ OCCUPATION________________

GRADE COMPLETED BY FATHER______ EMPLOYED BY________________

MOTHER'S MAIDEN NAME________________ OCCUPATION________________

GRADE COMPLETED BY MOTHER______ EMPLOYED BY________________

CHILD IS LIVING WITH________________ CHILD'S LEGAL NAME________________

HAS YOUR CHILD BEEN RECEIVING ANY EDUCATIONAL SERVICES/EARLY INTERVENTION FROM ANY PUBLIC OR PRIVATE AGENCY OR SCHOOL? ___YES ___NO
IF YES, PLEASE PROVIDE NAME AND ADDRESS:________________

OTHER CHILDREN IN FAMILY (LIST OLDEST TO YOUNGEST)

NAME	AGE	GRADE

ENTRY DATE STUDENT ENTERED STATE OF PENNSYLVANIA________________
ENTRY DATE STUDENT ENTERED THE UNITED STATES OF AMERICA________________
NUMBER OF YEARS IN U.S. SCHOOLS (INCLUDING KINDERGARTEN)________________

PLEASE NOTIFY OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE ____

Parents must present the following items at the time of registration:

1. **Birth Certificate**
2. **Immunization Records**
3. **Proof of Dunmore Residency (lease agreement, tax bill, mortgage statement, or gas or electric bill)**
4. **Special Education Records (I.E.P., N.O.R.E.P., ETC.) if applicable**
5. **Custody Papers (if applicable)**

DUNMORE ELEMENTARY CENTER

300 W. Warren St. - Dunmore, PA 18512
(570) 207-9572 - FAX (570) 207-6765

Matt Quinn
Principal

Michelle Kokindo
Dean of Students

Student Name ____

Date of Birth ______________________________ Grade ____________

Parent or Guardian Name ____________________________________

Address ____

Telephone Number ____

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act of offense involving weapons, alcohol or drugs, or for the wilful infliction of injury to another person or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child was _____ was not _____ previously suspended or expelled, or is ______ is not ______ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the wilful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A.§4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

____

Dates of suspension or expulsion: ______________________________
(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) ______________________________

____
(Signature of Parent or Guardian)

____
(Date)

Equal Opportunity Employer

Any wilful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

24 P.S. §13-1317.2

Dunmore Elementary Center

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RESIDENCY REQUIREMENT

In order to have your son or daughter educated by the Dunmore School District, they, and you as a parent or legal guardian, must be full-time residents.

So as not to delay the registration process, we are accepting the information you are supplying at the time of registration. This information may or may not be sufficient for us to satisfy our residency requirements. This form, along with your registration form, will be forwarded to my office and given to an administrator for further research and verification, if necessary.

By signing this form, you are declaring that to the best of your knowledge the address you are supplying is within the Dunmore School District boundaries and you and the student you are registering are full-time residents at that address. If our verification reveals that the address you supplied is not within our boundaries, or you are not living full-time within this District, you understand that you will be notified, the student will be removed in an appropriate manner, and you will be directed to the proper school district, if known.

If, for any reason, you choose not to sign this form, your son or daughter will not be registered.

Thank you, and welcome to the Dunmore School District!

Signed: ______________________________

Address: ______________________________

____

Date: ______________________________

Dunmore School District is an equal opportunity institution and will not discriminate on the basis of race, color, religion, national origin, age, marital status, sex, or non-relevant disability in activities, programs, or employment practices.
Equal Opportunity Employer

EQUAL OPPORTUNITY EMPLOYER

DUNMORE SCHOOL DISTRICT
300 WEST WARREN STREET
DUNMORE PA 18512

It is the intent of the Dunmore School District to remain neutral toward families split by divorce or separation, we do not want to take sides with one parent against the other where there may be possible conflict over children attending school in this district. If you have a court decree, which established you as a legal guardian, you will want to provide the district a copy of such document for attachment to your child's permanent record. We will use this as a legal base for working with the custodial parent.

In the absence of such a document, you must be aware that we cannot deny either parent access to his/her child. We cannot withhold information or refuse to see or work with the other parent. We cannot keep the other parent from picking up his/her child from school.

The Dunmore School District wants to protect all children from emotionally upsetting situations. Whatever the parents can settle outside the school to forestall any confrontations should be pursued.

I have read and discussed the above with a Representative of the Dunmore School District.

Parent: ______________________________

Address: ______________________________

Name of Student: ______________________________

Date: ______________________________

Office Use:
Legal Document on file
Yes ________
No ________
Date ________

PARENT NOTIFICATION

By law, if parents are legally separated or divorced, each parent has equal rights to the custody of the child/children UNLESS a parent has a court order that indicates which parent has custody of the child/children.

THE SCHOOL MUST HAVE A COPY OF THE COURT ORDER ON FILE.

Otherwise, either parent may check the child/children out of school with proper identification.

I HAVE READ THE ABOVE STATEMENT OF THE LAW.

______ The above statement IS applicable for my child/children.

______ The above statement IS NOT applicable for my child/children.

Father's Signature (Guardian) ____ Date:_________

Mother's Signature (Guardian)____Date:_________

DUNMORE ELEMENTARY CENTER

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Student Name____________________________ Date______________ GradeEntering__________ SchoolYear___________

Please list the schools that your child previously attended.
School ___________________________________ Grades ______________________________

____
____
____
____

Has your child ever repeated a grade? Yes________ No_____________ If yes, what grade (s)________ ________
When:_______________________ Where:____

Has your child ever been in a transitional or readiness class? ___________Grade (s)_______________________
When:_______________ Where:_______________________________________

Has your child ever been enrolled in a special education program?_________ Type of program_________________
When:___________________ Where:____

Is child currently enrolled in special education program?_______Please list primary disability_____________________

IEP status: Has IEP________Exited IEP less than 2 years________No IEP or exited IEP greater than 2 years__________

Has your child ever received any of the following services: Gifted Class_____________Speech________________
Remedial Class___________Please list subjects____

Has child ever been in ESL/ELL or LEP class? Yes__________ No______________

If yes, child: is currently in program____________ exited ELL and in 1st year of monitoring__________
exited ELL and in 2nd year of monitoring________________ former ELL and no longer monitored______________

Is child: Homeless_____________ Immigrant_____________ Migrant___________ 504 Student_____________

Foster Child_______________ Court/Agency Placed_____________ Gifted______________

____
Parent or Guardian's Signature Date

Equal Opportunity Employer

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. 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.

Student Information (Parents/Guardians should complete this section):

Child's first name: ______________________________

Child's family name: ______________________________

Child's Date of Birth: ______________________________
(Month/Day/Year)

Questions for Parents or Guardians

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

Parent/Guardian Signature: ______________________ Date: ____________

Interpreter Provided ☐ No ☐ Yes

Revised February 2017

D.E.C. STUDENT RECORD

STUDENT ID NUMBER________________ DATE________________________

STUDENT INFORMATION

LAST NAME__________________________GRADE_______HOSPITAL OF CHOICE________________

FIRST NAME__________________________SEX______PHYSICIAN______________________________

BIRTHDATE______/______/______MEDICAL COND. (ALLERGIES, ETC.)________________________

MEDICATIONS____

PARENT/GUARDIAN CONTACT

FIRST NAME______________________LAST NAME______________________RELATIONSHIP______________

ADDRESS____________________________________CITY________________STATE________ZIP__________

HOME PHONE____________________WORK PHONE____________________CELL PHONE________________

EMAIL ADDRESS ____

PARENT/CONTACT PERSON #2

NAME________________________________RELATIONSHIP____________________PHONE________________

EMAIL ADDRESS____

CONTACT PERSON #3

NAME________________________________RELATIONSHIP____________________PHONE________________

If at any time the above emergency contacts change please notify the office in writing.

Brief medical history if applies to your child:____

Indicate by circle if any apply:

Asthma

Diabetes

ADHD

Seizures

Vision Deficit

Hearing Deficit

Surgeries

In Counseling

Had Chicken Pox

Other____

Parent Signature____

Date____

Last School District Attended________________________________

______________I AGREE TO GIVE PERTINENT MEDICAL INFORMATION TO ALL APPROPRIATE STAFF.

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

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

Student's name ______________________ Today's date__________

Date of birth ______________ Age at time of exam________ Gender: ☐ Male ☐ Female

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

____

____

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

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

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

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

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

Signature of parent / guardian / emancipated student______________________ Date__________

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

STUDENT NAME:

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

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam__________20____

Print name of examiner ____

Print examiner's office address______________________________ Phone__________

Signature of examiner______________________________ MD ☐ DO ☐ PAC ☐ CRNP ☐

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:__________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

You most hand in to nurse before the first day of school

DUNMORE SCHOOL DISTRICT

State Required Physical Exam

As per Pennsylvania School Code all: New Entrants, **KG, First, Sixth and Eleventh** Grade Students are required to have a physical health exam. It is recommended that you have an examination done by your private physician. However, if you prefer, the school examiner, will perform an examination in the Health Suite free of charge.

Student Name:______________________________ Grade_______Section_____

Choose ONE only and Sign

- **I give my consent for my child to be examined by the school physician. I will complete the health history form attached and return it to the school.**
  (This will include a hernia check for all male students)
  I would like to be present for the school exam________

  ____**Date:**__________
  Signature

- **I will have my private physician complete the physical form and return it to the medical room by May 1st of this school year.(   )**

__________________________________**Date:**_________________
Signature

All forms are available on the school website or in the main office

11

Dunmore School District

300 West Warren Streets
Dunmore, Pennsylvania 18512

DEC 207-9572
DMS/DHS 346- 2043

Mandated Dental Exam

Dear Parent/ Guardian:

In accordance with Pennsylvania School Code, dental examinations are required on all students in grades **Kg. or 1st, 3 and 7**. Parents are encouraged to have this examination done by their private dentist to provide continuity in dental care of your child. If you would prefer a school dental exam free of charge you may indicate so below. All forms must be completed and returned by May 1st of the school year.

Student______________________________________Grade______________________

Choose Only One and Sign and return this permission form, keep the attached private dental form if having a private dental exam.

____________________I give consent for my child to be examined by the **school** dentist

Signature_______________________________________Date________________

____________________I will have my private dentist complete the **private** dental form and return it by May 1St.

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

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

Student Questionnaire

Has your child demonstrated academic difficulties in the past? ☐ no ☐ yes (If yes, please describe)

____

____

____

Has your child demonstrated behavioral difficulties in the home, school, or community setting? ☐ no ☐ yes (If yes, please describe)

____

____

____

Has your child demonstrated social or emotional difficulties in the home, school, or community setting? ☐ no ☐ yes (If yes, please describe)

____

____

____

Student's Name: ____________________

Completed by: ____________________ Date: __________

REGISTRATION CHECKLIST

________Registration Form________

________Parental Registration Statement

________Home Language Survey

________DEC Student Record

________Birth Certificate

________Other (i.e. Custody Papers)

________PA State Law/Immuniz.

________Health Services Form

________Private Physician's Report

________Private Dentist Report

________Proof of Residency

________Special Ed Survey

STUDENT'S NAME____________________________DATE__________________

Checked By______________________