WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

Welcome to Kindergarten!

This packet contains all forms needed to register your kindergarten student in the West Mifflin Area School District.

Please complete all forms prior to registration. Bring the following documents to your registration appointment.

- ☐ Completed Enrollment Packet
- ☐ Original Birth Certificate
- ☐ 3 Original Proofs of Residency
- ☐ Immunization Record
- ☐ Court Orders or Foster Papers

Call Ms. Janelle Kopay, 412-466-9131 x3028 to make an appointment or with any questions.

Clara Barton Elementary School
Mrs. Noelle Haney, Principal
Mrs. Kim McElroy, Secretary
412-466-9131
X 4001

Homeville Elementary School
Mr. Christopher Hanna, Principal
Mrs. Mary Beth Miller, Secretary
412-466-9131
X 7002

(New K)

WEST MIFFLIN AREA SCHOOL DISTRICT
PUPIL ENROLLMENT FORM

School Year 2022-2023

Student's Information: Date_____

_____ _____ _____
Legal Last Name First Name Full Middle Name Suffix Birth Date Birth City/State/Country Sex: M or F

Address_____ **(CHOOSE ONE)** ☐ Parent/Guardian Owns/Rents
OR
City/State/Zip Code_____ ☐ Parent/Guardian lives in Resident's Home

Ethnicity **(Circle One)** Hispanic Not Hispanic Latino

Race **(Circle all that apply)** White Black Asian American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander

Student Resides With: **(Circle One)** Both Parents / Mother / Father / Guardian - Court Order Y or N / Foster Parent - Court Order Y or N

Marital Status: **(Circle One)** Married Divorced Single Separated Widowed Parent/Guardian Email:_____

Mother's Full Name_____ Primary Phone:_____ Home - Cell - Work
Military Active Duty Y or N Secondary Phone:_____ Home - Cell - Work

Father's Full Name_____ Primary Phone:_____ Home - Cell - Work
Military Active Duty Y or N Secondary Phone:_____ Home - Cell - Work

Guardian's Full Name_____ Primary Phone:_____ Home - Cell - Work
Military Active Duty Y or N Secondary Phone:_____ Home - Cell - Work

Emergency Contact/Relation/Phone_____

Previous School/Address/Phone_____

Siblings Names/Birth Dates_____

Enrolled in: Regular Ed_____ Special Ed_____ IEP_____ Speech_____ 504 Plan_____ Gifted_____

Signature of Parent/Guardian_____ Date_____ Grade Entering _____

OFFICE USE ONLY:

Registration Completion Date_____ Entry Code_____ School_____ Grade_____ Resident: Y N Residency Code_____

Entry Date_____ Student #_____ District's Signature_____ Complete Y N_____

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road Suite 250 West Mifflin, PA 15122-1036
(412) 466-9131 Fax: (412) 466-9260
Mr. Jeffrey T. Soles
Superintendent of Schools

EMERGENCY INFORMATION

Authorization to Release Children in an Emergency

The West Mifflin Area School District has developed a safety plan to be used in case of an emergency. This plan was completed in compliance with the District's policy. The safety plan is devoted to the welfare and safety of your child during school hours. The plan is available for inspection in the school office.

The school is in specific need of your assistance at this time:

Should there be an emergency, such as a fire, tornado, explosion, etc., your child may be required to remain in the care of the school until it is deemed safe by the District administration that the students be released. At that point, children may be released **only to properly authorized parents, guardians, and/or designees who are listed on the EMERGENCY CARD!**

In an effort to update our records, we are asking you to complete your child's/children's emergency card contact information. Please provide us the most accurate information available including any new names (with local telephone numbers) and relationship of those persons to whom you would allow your child's release in the event of an emergency or illness. As you will see, we are asking that you identify the primary and secondary parent/guardian who will be contacted first, and in case they cannot be reached, two other emergency contacts. You **must list a minimum of 2** people and contact phone numbers. Be sure to notify those persons listed that you have authorized their assistance in case of emergency/illness. Please review and complete the entire form **(the top and bottom portions)** so that we can update your child's records. Without this information, we will not know the best way to contact you in the event of an emergency, illness and/or if your child needs released and you are unable to come pick them up. Your cooperation is vital in order for us to keep your child as safe as possible.

Please also note, we are asking for you to (✓) check **ONE** phone number that should be used for attendance reporting and (✓) check **ONE** phone number to be used to receive automated message calls. Both numbers can be the same. **If an additional attendance reporting number is needed**, please contact your child's principal for approval. **Also, new this year, if you are the primary and/or secondary parent/guardian and are Active Military, please check (✓) the appropriate box.**

If there is no specific authorization for the child's release on file, the child will only be released to the parent or legal guardian. Therefore, we need you to complete, sign, and return the attached form as soon as possible.

NO CHILD will be released to the care of unauthorized persons.

We appreciate your cooperation in this important matter.

Sincerely,

Jeffrey T. Soles, Superintendent

WEST MIFFLIN AREA SCHOOL DISTRICT **2022-2023** ***FOR NURSE and SCHOOL OFFICE USE ONLY***

Student Emergency Card

Name _____ Birth Date _____ Grade _____

Address _____ Homeroom _____

Home Phone _____ E-Mail: _____ Hospital preferred _____
(for Baldwin Ambulance transport)

In case of emergency, illness, accident or the need for early release for the above named student, the school is authorized to proceed as indicated. Write each emergency contact in the order of desired action.

Check **ONLY ONE** box per column	
Attendance Reporting	Automated Messages

1. Primary Parent/Guardian for Emergency Contact/Release: Active military? Check if yes ☐

_____ (cell work home)....Phone _____ ☐ ☐
(Name and relationship to student) ***(Circle one)***

2. Secondary Parent/Guardian for Emergency Contact/Release: Active military? Check if yes ☐

_____ (cell work home)....Phone _____ ☐ ☐
(Name and relationship to student) ***(Circle one)***

Other Emergency Contacts in case Primary/Secondary parent/guardian cannot be reached:
Note: You must have a minimum of 2 emergency contacts listed.

3. _____ (cell work home)....Phone _____ ☐ ☐
(Name and relationship to student) ***(Circle one)***

4. _____ (cell work home)....Phone _____ ☐ ☐
(Name and relationship to student) ***(Circle one)***

*Please identify any **school age siblings** in the WMASD: (use back of card if necessary)

Sibling's Name(s) _____ School(s) _____

ANNUAL HEALTH INVENTORY:

A complete health history contributes to keeping your child's school health records up to date and accurate. It also helps us better understand your child's health care needs. **Please indicate any of the following:**

Health Condition	Yes	No	Explanation:
Accidents/Serious Injury: (fractures, injuries)			
Activity Restrictions:			
Allergies: (Hay fever, bee sting, food, peanut, etc.)			
Asthma:			
Convulsions/Seizures:			
Emotional/Behavioral Problems:			
Glasses and/or Hearing Aid:			
Hospitalizations: (within the last year)			
Medical Conditions:(ADHD, Cardiac, Diabetes, High Blood Pressure, etc)			
Medications: (prescription and/or over-the-counter medication taken routinely or frequently)			
Special Examinations, Tests, or Studies within the last year: (vision, hearing, neurological, X-rays, EEG, Blood tests, etc.)			
Surgery:			
Other Concerns: (something you feel the nurse should know)			

Health History Consent: The disclosure of student health information within the school is limited to the information necessary to provide the student with the appropriate services to participate in school. Your signature gives permission for the nurse to inform school staff of precautions and procedures to protect your child in the classroom and to foster academic success. **Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for academic success and emergency plans, as determined by the school and nurse.**

Parent/Guardian Signature _____ Date _____

Your signature is an informed consent to share this emergency contact information with school staff on a need-to-know basis for academic success and emergency plans.

pennsylvania
DEPARTMENT OF EDUCATION

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

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

Student Photo Release Form

The West Mifflin Area School District includes photos and videos of students, teachers and school activities in its newsletters, calendar, other publications and website. Though the names of faculty, staff and administration will regularly be used, it is our policy that the full names of students will not be included on the web site, YOUTUBE or any publicly advertised commercials.

****

_____ We / I hereby **DENY** permission to the West Mifflin Area School District to use photos and/or video recordings of my child in any District publication, the District website, YOUTUBE, or any publicly advertised commercial.

_____ We / I hereby **ALLOW** permission to the West Mifflin Area School District to use photos and/or video recordings of my child in any District publication, the District web site, YOUTUBE, or any publicly advertised commercial.

Student's Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Address: _____

_____

Phone Number: _____

Date: _____

REQUEST FOR SCHOOL BUS TRANSPORTATION
2022~2023 SCHOOL YEAR
West Mifflin Area School District
TRANSPORTATION DEPARTMENT

School bus transportation is provided to students who meet the criteria as stipulated in the Laws of Pennsylvania Department of Education, and West Mifflin Area School District. Please carefully read over the information in the **last paragraph** and then complete all of the information called for on this form, sign it, date it and submit it directly to:

West Mifflin Area School District - Department of Transportation
1020 Lebanon Road, Suite 250, West Mifflin, Pa 15122

WALKERS OR PRIVATE TRANSPORTATION PLACE AN "X" IN THIS BLOCK.
FILL OUT STUDENT INFORMATION BELOW. ☐

Student Information Please Print Legibly

_____ Grade:_____ DOB:_____
Last Name First Name Middle Name

HOME PHONE (_____) _____ WORK PHONE (_____) _____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

ATTENDING SCHOOL_____ (School Assignment)

TRANSPORTATION ADDRESS_____
(If address is other than home address, please complete Alternate Transportation Request.)

PARENT/GUARDIAN (**Print** full name) _____

By my signature below, I make application for transportation services as outlined above. I attest that the home address listed above is the true residence of the student named above. I understand that acceptance of this application by the West Mifflin Area School District Transportation Department does not guarantee any service until this information is verified. I/we are obligated to file a new application if we change any of the above addresses. I also understand the rules for safe bus riding and accept the responsibility to ensure my child understands and abides by those rules.

X_____ **Date**_____
Signature of Parent/Guardian

West Mifflin Area School District
Internet Acceptable Use Policy Sign Off Form

All students and their parent or guardian are required to read and review the West Mifflin Area School District Internet Usage Policy. This policy can be found online at: www.wmasd.org/documents.cfm or you may request a printed copy. The Parent/Guardian signature below confirms that both the Parent/Guardian and Student have reviewed the West Mifflin Area School District Acceptable Use Policy and confirm the option below to allow or deny your Student Access to the Internet from School District Computers.

☐ Check Here to ALLOW your child to Access the Internet From School Computers.

When allowing your child access to the Internet from School Computers, you understand that the West Mifflin Area School District has taken precautions to eliminate the viewing of controversial material on the Internet by use of an Internet Filtering Device. However, you recognize it is impossible to guarantee all inappropriate material on the Internet will be filtered.

☐ Check Here to DENY your child Access to the Internet From School Computers.

If you chose to Deny your child access to the Internet, your child will receive a username and password that will allow access to use school computers, however no Internet access will be available for your student. Please note this option is not recommended.

_____
Student Name (Please print Full Legal Name)

_____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature

Date: _____

****Note: Default username for all students grades 2 and above is the Student's ID Number. Their default password is their first name.**

----------For Internal Use Only ----------

_____ _____ _____ _____
Student ID # School/Grade PS Accnt Created Network Accnt Created

West Mifflin Area School District
One-to-One Device Parent Consent
2022-2023

This official document certifies that I have received the West Mifflin Area School District 1:1 laptop handbook and Code of Conduct, read its contents carefully. If at any time, I am unsure of the practices, procedures, responsibilities, or expectations as explained in the handbook, I will meet with my guidance counselor, principal, or teacher to clarify the matter.

_____ I understand the contents of the handbook and I agree to abide by all of the school rules. *Parent initials confirming receipt of handbook only

Please sign acknowledging permission for student to pick up and utilize district laptop. If student withdrawals from West Mifflin Area School District laptop must be returned before leaving the district. If not, parent will be held responsible for replacing equipment.

My child, _____ and I have agreed to the usage of a West Mifflin Area School District 1:1 Laptop for the 2022-2023 school year.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Student Name: _____ Student ID: _____

Student Signature: _____

We strongly encourage families to purchase the district insurance plan for their student's 1:1 device. Please complete the insurance form available on the district website and in the 1:1 handbook. Make check payable to: WMASD

Office Use Only:

Asset Tag#: _____ Date: _____

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

Dear Parents and Guardians:

The Health Service Department of the West Mifflin Area School District, in compliance with Pennsylvania School Law, wishes to inform you that your child must have the following for Kindergarten:

Physical and Dental Exam: Completed within the past year. We recommend that you consult your family physician and dentist for these procedures since he/she is aware of your child's health history.

Lead Testing Documentation: Documentation that lead testing was completed at least once on your child before entry into kindergarten.

These immunizations are required by the Pennsylvania Department of Health as a condition of admission for the first time to any public, private or parochial school unless there is a written medical exemption signed by the physician or a written religious/philosophical exemption on file.

Before your child can attend kindergarten, he/she **must** have received the following immunizations:

- Four (4) Diphtheria and Tetanus (TD) – The fourth dose of Tetanus and Diphtheria **must** have been administered on or after the fourth birthday.
- Four (4) Polio Vaccines – The fourth dose **must** have been administered on or after the fourth birthday and at least 6 months after the previous dose was given.
- Three (3) Hepatitis B Vaccines - There should be one month between dose #1 and dose #2 and there should be at least two months between dose #2 and dose #3. In addition, dose #3 **must** be administered on or after six months of age.
- Two (2) Measles, Mumps and Rubella (German measles) Vaccines given **after** twelve months of age.
- Two (2) Varicella (chickenpox) – Vaccines given **after** twelve months of age or a written statement from the health care provider, physician or physician's designee indicating the month and year when the child had the varicella disease. Laboratory proof or immunity will also be accepted.

During your child's attendance in kindergarten, his/her vision, hearing, height and weight will be screened by the school nurse. You will be notified if the results do not fall within state recommended guidelines.

Entering school is one of the most important times in your child's life. He/she will be in contact with a large group of children from every environment. His/her association with other children will no longer be limited. The problem of preventing and controlling diseases which are prevalent among groups of children is impossible for the school to do alone. If your child should experience any symptoms of contagion, keep him/her away from other children, call your physician and notify the school. We earnestly seek your cooperation as it is most essential.

Thank you.

Sincerely yours,

Jeffrey Soles
Superintendent

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

HEALTH SURVEY

(To Be Completed by Parent)

Student's Name _____ Date of Birth _____

Please indicate if your child has any of the following conditions and list any medications he/she is taking at this time.

CONDITION	NO	YES	SPECIFY
Allergies			
Asthma			
Cardiac			
Chickenpox			
If child has had chicken pox please specify the month and year:			
Diabetes			
Ear Infections			
Epilepsy			
Rheumatic Fever			
Tuberculosis			
TB Contact			
Surgeries			
Restricted from physical activity			

Does your child have any problems or conditions which you believe the nurse or teacher should know about in order to help him/her? Please be specific:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

Physician's Name: _____ Phone Number _____

Voluntary Consent of Parents

To better meet your child's safety needs, we will share the health information listed above with staff members. Note that in case of food allergies, it may be necessary to inform parent groups (if they will be hosting a food event). If for some reason you do not want this information shared, please notify your building principal in WRITING!

Signature of Parent/Guardian _____ Date _____

Phone Numbers: Home _____ Work _____ Cell _____

WEST MIFFLIN AREA SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Dear Parent or Guardian,

The School Health Laws of Pennsylvania require **physical examinations** of all students in Kindergarten and promotion to 6th and 11th grades and **dental examinations** in Kindergarten and promotion to 3rd and 7th grades. *Regardless of the current grade, when the health records received from the previous school indicate your child has NOT had the most recently required physical/dental exam, an exam WILL need to be completed.*

These examinations may be done by your family physician/dentist at your expense, or may be completed by the school physician/school dentist at the expense of the school district. *If you choose to have school exams completed and wish to be present, please contact the school nurse and you will be notified of the date/time of the exams.*

Please indicate below how you intend to meet this requirement if an exam is needed. If you prefer your own physician/dentist, an exam form will be provided.

Thank you for your cooperation.
West Mifflin Area School District Nursing Staff

Student______________________________ School________________________ Grade_________

_____ I will have the **PHYSICAL** examination provided by my family physician and have the information forwarded to the school.

_____ I grant permission for my child to have a **PHYSICAL** examination done at school by the school physician (the school nurse will be present during the exam).

____ _______________

Signature of Parent or Guardian ***Date***

>>

Student______________________________ School________________________ Grade_________

_____ I will have the **DENTAL** examination provided by my family dentist and have the information forwarded to the school.

_____ I grant permission for my child to have a **DENTAL** examination done at school by the school dentist (the school nurse will be present during the exam).

____ _______________

Signature of Parent or Guardian ***Date***

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)

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 _____

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

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

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

Print name of examiner _____

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

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

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)					

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

Health Services Department
Private Dentist Report

Please have your dentist complete the following information and return this form to the school nurse.

Name of Child: _____

Grade and School: _____

Date of Examination: _____

Please check:

_____ Child is currently under treatment.

_____ Child's treatment is complete.

Signature of Dentist: _____

Dentist's Name (please print): _____

Address: _____

_____

Date: _____

WEST MIFFLIN AREA SCHOOL DISTRICT
1020 Lebanon Road
Suite 250
West Mifflin, PA 15122

****ONLY COMPLETE IF MEDICATIONS NEED ADMINISTERED DURING SCHOOL HOURS****

Dear Parent/Guardian,

Administration of medicine is a responsibility the West Mifflin Area School District views with considerable concern. In order to conform to State guidelines, **no medication can be dispensed during school hours without a physician first completing the attached form. This includes over-the counter medication** such as, Tylenol, Motrin, antacids, cough, cold, allergy medications, etc. A separate form is needed for each medication. Also, students **are not** permitted to carry medication to, from, or during school hours unless a physician specifically states it is medically necessary.

You will find the necessary form on the reverse side of this letter. After it is completed and signed by you and the prescribing physician and returned to the school, the medication **must** be brought to school by the parent or guardian. **Over-the-counter medication must be in its original bottle, and prescription medication must be properly labeled by a registered pharmacist and brought to school in its current bottle.**

The following is a list of the fax numbers for each of the district's schools to assist you and/or your physician in efficiently forwarding the necessary information:

Clara Barton Middle School	(412) 469-3357 (412) 466-0836	Homeville High School	(412) 461-5465 (412) 896-7906

Thank you for your cooperation.

Sincerely,

West Mifflin Area School District Nursing Staff

WEST MIFFLIN AREA SCHOOL DISTRICT
HEALTH SERVICE DEPARTMENT
PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Name of student _____

Date of birth _____/_____/_____ Grade _____ Date of order _____/_____/_____

Diagnosis _____

Name of medication _____ Route _____

Dosage _____ Frequency _____

* If an **inhaler**, may the student carry it with them? _____

****Has been instructed and shows competence for self-administration** _____

* If an **Epi-pen**, may the student carry it with them? _____

****Has been instructed and shows competence for self-administration** _____

How long do you expect medication to be given? _____

Can a reaction be expected? _____ If so, please describe & any emergency action that may be required _____

_____

Signature of physician _____ Date _____/_____/_____

Physician's name (please print) _____

Office and phone number _____ # _____

PARENTAL REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

I, _____ fully understand the directions that have been given to the school by the physician and agree to permit school personnel to administer the medication to my son/daughter _____, and/or have my child self-administer according to the directions given by the physician listed above.

I hereby release the West Mifflin Area School District, or any of its employees from any and all liability incidental to providing services as herein requested including that they bear no responsibility for ensuring that the medication is taken if my child is permitted to self administer.

At end of school year, I would like remaining medicine: *discarded_____ *kept in school _____

Signature of parent/guardian _____ Date _____/_____/_____

Phone Number: Home # _____ Cell# _____ Work #:_____