W E S T S H O R E S C H O O L D I S T R I C T

Registration Checklist

The administration, teachers, and staff of the West Shore School District would like to welcome you as a parent of a future West Shore student!

Following is a list of items necessary to register your child for school. Please check off each item as you gather it and be certain to bring them with you to your registration appointment.

☐ **Completed Registration Packet** - completed in blue or black ink

☐ **Child's Original Birth Certificate**

☐ **Most Current Immunization Records** - bring even if an appointment is scheduled for a doctor visit between registration and the start of school

☐ **Parent Identification** - driver's license, PA ID, or military ID with current address

☐ **Proof of Residency** - Acceptable documents: lease if you rent (must be signed by you and the landlord), closing disclosure or settlement statement if you purchased your home, deed or property tax statement if you own your home.

If you are not listed on the lease, deed, or settlement statement, and are residing with someone else, that individual must accompany you to the appointment, bring their driver's license with current address, one of the acceptable proof of residency documents listed above, and complete a Multiple Occupancy Affidavit (this form is available at registration but must be notarized elsewhere).

☐ **Court Ordered Custody Agreement** (if applicable) - Only biological parents or court appointed guardians are permitted to register a child for school. If there is a court ordered custody agreement or divorce decree in effect, by state law, only the parent who has primary physical custody or a court appointed guardian may enroll the child (Step parents may not enroll a step child).

We look forward to meeting you and your child during registration.
If you have questions, please contact the registration office at 717-938-9577.

West Shore School District • Information Sheet

District Office Use ONLY
Ent. Grade: _____ Student ID: _____ Date of Entry: _____ Code: _____
School: _____ Date of W/D: _____ Code: _____

Please print all information:

Student: _____ _____ _____
Last Name *First Name* *Middle Name*

Nickname: _____ Date of Birth: _____ ☐ Male ☐ Female

Ethnicity (choose only one):
☐ Hispanic/Latino
☐ NOT Hispanic/Latino

Race (check all that apply):
☐ White ☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Pacific Islander

Home Phone: (717) _____ Unlisted? ☐ Yes ☐ No

Special Education Required? ☐ Yes ☐ No Type _____

Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Township/Borough: _____ PA Entry Date: _____

☐ York County ☐ Cumberland County Ninth Grade Entry: _____

Previously a student in the West Shore School District? ☐ Yes ☐ No Last Year Attended: _____

Date first enrolled in US school (English Language Learners Only): _____

Is student over 18 years of age and enrolling as an independent student? ☐ Yes ☐ No

Student lives with (check all that apply): ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father
☐ Other (specify) _____

Mother / Guardian Information:

Name: _____
Date you moved into the District: _____
Employer: _____
Home Phone: _____
Work Phone: _____ Ext. _____
Cell Phone: _____
E-Mail: _____
Only list address if different than student address.
Street Address: _____
City/State/Zip: _____

Father / Guardian Information:

Name: _____
Date you moved into the District: _____
Employer: _____
Home Phone: _____
Work Phone _____ Ext. _____
Cell Phone: _____
E-Mail: _____
Only list address if different than student address.
Street Address: _____
City/State/Zip: _____

Emergency Contacts (adults to be contacted if parent/guardian cannot be reached):

	Contact 1	***Contact 2***	***Contact 3***
Name:			
Relationship:			
Home Phone:			
Work Phone:			
Cell Phone:			

Student Medical Information:

Physician/Practice Name: _____ Phone: _____

Health problems: _____

If health accommodations are required, please briefly explain: _____

West Shore School District
Home Language Survey

This survey meets the requirements of Equal Educational Opportunity Act 20 USC: 1703 and is applicable for all students in kindergarten through twelfth grade. A copy of this survey shall be placed in the student's permanent folder.

Please print all information:

Student Name: _____ School: _____

Date of Birth: _____ Age: _____ Grade: _____

Parent/Guardian Name: _____ Home Phone: _____

What was the first language your child learned to speak? _____

What other language(s) does your child speak? _____
(Do not include languages learned in school)

What language is used to communicate in your home? _____

How much English does your child speak? ☐ No English ☐ Little English ☐ Much/Fluent

How much English does your child read? ☐ No English ☐ Little English ☐ Much/Fluent

How much English do you (the parent/guardian) speak? ☐ No English ☐ Little English ☐ Much/Fluent

How much English do you (the parent/guardian) read? ☐ No English ☐ Little English ☐ Much/Fluent

Initial US entry date of student:
(if student born in United States, use the date of birth) ____/____/____
(month / day / year)

City/State/Country of Birth: _____ / _____ / _____

Survey conducted/completed by: _____

Parent/Guardian Signature: _____

For students identified as having a primary home language other than English (PHLOTE), the district ESL Coach or ESL staff members will administer the Woodcock-Muñoz Language Proficiency Test and begin ESL instruction within 30 days at the beginning of the school year. For students entering the district after the first 30 days of the school year, the district will administer the Woodcock-Muñoz Language Proficiency Test and begin ESL instruction within 14 days.

West Shore School District
Registration Identification

Student Name _____ Parent/Guardian Name _____

Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

I, _____ , hereby verify that I am a primary custodial parent or legally appointed guardian of _____ , and that I am completing all required registration information for enrollment in the West Shore School District. I further verify that I do, in fact, reside at the residence address listed above in the West Shore School District. I will notify the West Shore School District of any information that changes, such as but not limited to, a change in telephone number, residence address, or custodial parent change. I further verify that I have not misled, withheld, or falsified any information.

18 PA.C.S.A. Section 4904. Unsworn falsification to authorities

(a) In general. -A person commits a misdemeanor of the second degree if, with intent to mislead a public servant in performing his official function, he: (1) makes any written false statement which he does not believe to be true; (2) submits or invites reliance on any writing which he knows to be forged, altered or otherwise lacking in authenticity; or (3) submits or invites reliance on any sample, specimen, map, boundary mark, or other object which he knows to be false.
(b) Statements "under penalty". - A person commits a misdemeanor of the third degree if he makes a written false statement which he does not believe to be true, on or pursuant to a form bearing notice, authorized by law, to the effect that false statements made therein are punishable.
(c) Perjury provisions applicable. - Section 4902(c) through (f) of this title (relating to perjury) applies to this section.

I verify that the statements made herein are true and correct; I understand that false statements are made subject to the penalties of 18 PA.C.S.A. section 4904 relating to unsworn falsification to authorities, additionally, **I have read and understand all of the above information.**

Signature of Parent/Guardian: _____ Date: _____

Commonwealth of Pennsylvania)
) SS
County of York)

Before me, the undersigned officer, personally appeared the above-named resident of the West Shore School District, who being duly sworn according to law, deposes and says that the items set forth in the foregoing statement are true and correct.

Sworn to and subscribed before me

this _____ day of _____, _____

_____
Signature and Seal of Executing Officer

West Shore School District
Automated Phone Call & Email Notification
Contact Information

The West Shore School District utilizes an automated phone call and email notification system. Through this system the District is able to communicate with parents about school closings/delays, school events, important issues impacting your child and, if needed, emergency situations.

The District will be using three basic call types for communication: informational calls, time sensitive calls (urgent), and emergency calls. It is necessary that we have your current phone numbers and email addresses in order to make this valuable tool a success.

Please be sure to provide a primary contact number so you will not miss out on any important communications. The home phone number may be chosen as the primary contact number. Please be sure to include the area code in all phone numbers listed.

Please complete the information below.

Contact Information for: _____

Parent Name(s): _____

Home Phone: **(** _____ **)** _____

The home phone number will be used for all informational calls.

Primary Contact Number: **(** _____ **)** _____

You may choose to use your home phone number.
The primary contact number will be used for all time-sensitive calls including emergencies. If you are listing a work number, the system cannot dial extensions or transfer from a switchboard - please use direct lines only.

Alternate Number 1: **(** _____ **)** _____

Alternate Number 2: **(** _____ **)** _____

The alternate numbers will be used for emergencies. If you are listing a work number, you may only use direct lines.

Email Address 1: _____

Email Address 2: _____

Do you wish to receive text messages on a cell phone? ☐ Yes ☐ No

Note: Your cellular provider may assess charges for the receipt of text messages.

Cell Phone Number to receive text messages: **(** _____ **)** _____

West Shore School District
PowerSchool Registration Form

The West Shore School District uses a student management system called PowerSchool. PowerSchool has a fully integrated parent portal, providing online access to student information.

A letter with your student's login and password will be mailed directly to you from your student's school.

Please provide the following information:

Student Name: _____

Student's Grade (check one):

☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Student's School (check one):

ELEMENTARY SCHOOLS	MIDDLE SCHOOLS	HIGH SCHOOLS
☐ Fairview School	☐ Allen	☐ Cedar Cliff
☐ Fishing Creek	☐ Crossroads	☐ Red Land
☐ Highland	☐ New Cumberland	
☐ Hillside		
☐ Lower Allen		
☐ Newberry		
☐ Red Mill		
☐ Rossmoyne		
☐ Washington Heights		

_____

Parent/Guardian Name(s)

Signature of Parent/Guardian: _____ Date: _____

District Office Use ONLY

Child Accounting: ☐ Identification verified

Technology & Media: ☐ Account generated and forwarded to appropriate school

School: ☐ Letter mailed to parent/guardian ☐ File copy

WEST SHORE SCHOOL DISTRICT

Todd B. Stoltz, Ed.D.
Superintendent of Schools

Dear Parent/Guardian:

As per Pennsylvania State Law, the Modified Health Program of the West Shore School District, requires a **physical examination** for all students in **kindergarten**, **sixth, ninth grades and for any transfer students** without a record of a physical from their previous school. The physical examination must be done **AFTER September 1, 2016** or within one year prior to the student's entry into school. These grades are chosen because they are critical periods in the growth and development of children. We want to ensure that our West Shore School District students enter each building level "ready to learn".

It is important that the school have a record of your child's health status. This knowledge enables the school staff to help children achieve maximum benefits from their educational opportunities. Have your child's physician/primary care provider complete and sign the attached private physical form. Please return this form to your child's school nurse via the mail or at the start of the school year. You may refer to the recommended immunization schedule on the reverse side of this letter.

If your child will need to take any medication at school, please refer to the medication letter and take the medication order and request form with you to be completed and signed by the physician/primary care provider. The parent/guardian also needs to sign the form.

We are looking forward to working with your family and wish your child every success in the coming years.

Thank you,

The WSSD Health Services

*Be sure to visit our web site at www.wssd.k12.pa.us/healthservices

Are Your Kids Ready for School?

Getting kids ready to go back to school can be a frantic time. Make it easier on yourself this year, by scheduling an appointment early for your kids to get the immunizations that are required for school in Pennsylvania.

Immunizations Required for Children Entering ALL Grades

Number of Doses	Vaccine
1 2 3 4	Tetanus* (1 dose on or after the 4th birthday)
1 2 3 4	Diphtheria* (1 dose on or after the 4th birthday)
1 2 3	Polio
1 2 3	Hepatitis B
1 2	Measles**
1 2	Mumps**
1 2	Varicella (Chickenpox) Vaccine or history of disease
1	Rubella** (German Measles)

* Usually given as DTaP, DT, or Td

** Given as MMR (Measles, Mumps, and Rubella)

Additional Immunizations Required for 7th Grade Students

1	Tetanus, Diphtheria, Pertussis (Tdap)
1	Meningococcal Vaccine (MCV)

Learn about other immunizations that are recommended for your child at: www.cdc.gov/vaccines/recs/schedules/default.htm.

These immunization requirements apply to children attending ALL Pennsylvania schools.
Children not up to date with all the required immunizations may be removed from school during a disease outbreak.
Pennsylvania's school immunization requirements can be found in **28 PA CODE CH. 23 (School Immunizations).**

Contact your health care provider, school, or local health department for more information.

www.immunizepa.org

3/2011

West Shore School District
Student Entry Health History

Please print all information:

Student: _____ _____ _____
Last Name *First Name* *Middle Name*

School: _____ Date of Birth: _____ ☐ Male ☐ Female

Pregnancy and Birth:

1. Did the mother have any illness during the pregnancy? ☐ Yes ☐ No
   If yes, please give details: _____
2. Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? ☐ Yes ☐ No
   If yes, what medicines/drugs? _____
3. Was the mother or the family under any unusual strain during the pregnancy? ☐ Yes ☐ No
   If yes, what? _____
4. Did the baby come on time? ☐ Yes ☐ No
5. Was it a difficult birth? ☐ Yes ☐ No
   If yes, how was it difficult? _____
6. What was the baby's birth weight? _____
7. Did the baby have any trouble while in the hospital? ☐ Yes ☐ No
   If yes, what kind of trouble? _____
8. How many days did the baby stay in the hospital? _____

Early Childhood:

1. Would you describe the baby as average, quiet, or active? ☐ average ☐ quiet ☐ active
2. Did the baby have any special problems in the first six months? ☐ Yes ☐ No
   If yes, what problems? _____
3. How old was the baby when breastfeeding stopped? _____
4. How old was the child when bottle feeding was stopped? _____
5. At what age did the child sit alone without support? _____
6. At what age did the child walk alone without support? _____
7. At what age did the child begin to say two or three words together? _____
8. Can the child use the toilet without help now? ☐ Yes ☐ No
9. If the child has stopped wetting the bed, at what age did he/she stop? _____
10. Has your child been diagnosed with any medical or behavioral problems? ☐ Yes ☐ No
    If yes, please describe: _____
    Does your child take daily medication? ☐ Yes ☐ No
11. Has your child received intermediate unit services or special pre-school services such as from CAIU? ☐ Yes ☐ No
    Does your child have an IEP? ☐ Yes ☐ No

Family Health History:

1. Check any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters, have had:

☐ Allergy ☐ Asthma ☐ Cancer ☐ Drug/Alcohol Addiction
☐ Diabetes ☐ Heart Disease ☐ Seizures ☐ Mental Health Concerns
☐ Tuberculosis ☐ Lead Poisoning ☐ Intellectual Disability ☐ Sickle Cell Anemia
☐ Sickle Cell Trait ☐ Other inherited/family disease(s) _____

2. Have any members of the family died? (not miscarriages) ☐ Yes ☐ No
3. How many household members smoke? _____
4. Are there any family needs such as with housing, employment, food, etc.? ☐ Yes ☐ No
5. Who generally looks after your child during the day? _____
6. Family Members (Note any special relationships such as step-parent, adopted, foster-child, etc.)

Relationship	Age	Name	State of Health	Occupation/School	Grade Reached in School	Check if lives with child
Mother						☐
Father						☐
Brothers						☐
						☐
						☐
Sisters						☐
						☐
						☐

Health History:

1. Check any of the following illnesses that this child has had:

☐ "Red" Measles ☐ German or "3 day" Measles ☐ Mumps
☐ Chicken Pox ☐ Whooping Cough ☐ Pneumonia
☐ Rheumatic Fever ☐ Asthma

2. Has your child had more than six colds or throat infections, with a fever, a year? ☐ Yes ☐ No
3. Has your child had any trouble with ears or hearing? ☐ Yes ☐ No
4. Has your child had any trouble with eyes or seeing? ☐ Yes ☐ No
5. Has your child had any trouble with teeth? ☐ Yes ☐ No
6. Has your child ever been seen by a dentist? ☐ Yes ☐ No

   Name of Dentist: _____
7. Does your child need to take antibiotics prior to dental care? ☐ Yes ☐ No
8. Has your child ever had a convulsion or seizure? ☐ Yes ☐ No

9.	Has your child ever had a fainting spell?	☐ Yes	☐ No
10.	Does your child complain of headaches?	☐ Yes	☐ No
11.	Has a doctor ever said your child had a heart murmur?	☐ Yes	☐ No
	Has the doctor restricted your child's activity due to murmur?	☐ Yes	☐ No
12.	Does your child have trouble keeping up with other children?	☐ Yes	☐ No
	If yes, in what way? _____		
13.	Does your child often complain of bellyaches?	☐ Yes	☐ No
14.	Does your child often have diarrhea?	☐ Yes	☐ No
15.	Is constipation a problem for your child?	☐ Yes	☐ No
16.	Have you ever seen blood in your child's stools (bowel movements)?	☐ Yes	☐ No
17.	Has your child ever had yellow jaundice or trouble with the liver?	☐ Yes	☐ No
18.	Does your child have any problem with passing water (urination)?	☐ Yes	☐ No
19.	Does your child have any skin problems?	☐ Yes	☐ No
	If yes, what: _____		
20.	Has your child ever had eczema or psoriasis?	☐ Yes	☐ No
	If yes, what: _____		
21.	Has your child ever had asthma or reactive airway disease or wheezing?	☐ Yes	☐ No
22.	Is your child currently taking asthma medications?	☐ Yes	☐ No
23.	Has your child ever had an allergy or reaction to any medicines or injections?	☐ Yes	☐ No
	What was the medicine/ injection? _____		
24.	Does your child seem to have trouble breathing through the nose?	☐ Yes	☐ No
25.	Does your child snore at night?	☐ Yes	☐ No
26.	Has your child ever complained of pain in the arms or legs?	☐ Yes	☐ No
27.	Has your child ever had swelling of any joints or limping?	☐ Yes	☐ No
28.	Has there ever been any trouble with your child's blood?	☐ Yes	☐ No
29.	Has your child ever eaten paint or plaster or anything else which is not food?	☐ Yes	☐ No
30.	Has your child ever had lead poisoning?	☐ Yes	☐ No
31.	Does your child have any trouble sleeping?	☐ Yes	☐ No

Check any of the following which worry you about your child:

☐ Bed wetting	☐ Feeling easily hurt	☐ Lying	☐ Wetting during the day
☐ Wanting too much attention	☐ Selfish in sharing	☐ Daydreams	☐ Thumb sucking
☐ Stammering or stuttering	☐ Fighting with other children	☐ Nightmares	☐ High strung or easily upset
☐ Purposely destroys things	☐ Too restless	☐ Feeding	☐ Temper tantrums
☐ Shy	☐ Contrary or stubborn	☐ Sad or sulky	☐ Bowels
☐ Wanting too much comfort or support from parent		☐ Jealous of brothers/sisters	☐ Disobedient

Other problem not mentioned, explain: _____

Current Functioning of Your Child:

1. How would you describe your child as a person?

2. How does your child get along with brothers and sisters?

3. How does your child get along with neighborhood friends?

4. How does your child feel about coming to school?

5. What does your child like to do?

6. What kinds of things scare or worry your child?

7. What are some of the things your child does that upset you or make you angry?

8. What do you do to discipline your child? How does he or she react?

9. What are some of the things your child does which please you or make you proud?

Comments:

Student's Health History completed by: _____

Signature of Parent/Guardian: _____ Date: _____

West Shore School District
Information for Medical Emergencies

Please print all information:

Student: _____ _____ _____
Last Name *First Name* *Middle Name*

School: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Student lives with (check all that apply): ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father
☐ Other (specify) _____

Mother / Guardian Information:

Name: _____
Employer: _____
Home Phone: _____
Work Phone: _____ Ext. _____
Cell Phone: _____
E-Mail: _____
Only list address if different than student address.
Street Address: _____
City/State/Zip: _____

Father / Guardian Information:

Name: _____
Employer: _____
Home Phone: _____
Work Phone _____ Ext. _____
Cell Phone: _____
E-Mail: _____
Only list address if different than student address.
Street Address: _____
City/State/Zip: _____

Student Medical Information:

Physician/Practice Name: _____ Phone: _____
Dentist/Practice Name: _____ Phone: _____
Medical Insurance (Type and Carrier): _____

Emergency Transportation Permission:

I give permission to the staff of the West Shore School District to transport or to make arrangements for transportation of my child to emergency medical care in the event that my child is ill or injured and emergency services are warranted.

Signature of Parent/Guardian: _____ Date: _____

IN AN EMERGENCY, if a choice is possible, which hospital would you prefer for your child?

Hospital Preference: _____

Special Health Needs:

Please check yes or no:

1. Has the student ever had any serious illness, operations, or been hospitalized overnight? ☐ Yes ☐ No
   What: _____
   When: _____

2. Has the student had any other illnesses, accidents, broken bones? ☐ Yes ☐ No
   What: _____
   When: _____

3. Has the student had any convulsions (fits, seizures)? ☐ Yes ☐ No
   How many: _____ When: _____
   Treatment: _____

4. Is the student currently going to a hospital, clinic or specialized doctor for a specific health concern? ☐ Yes ☐ No
   Where: _____
   What for: _____

5. Apart from vitamins, is the student taking any medicine, tablets or drugs? ☐ Yes ☐ No
   What: _____
   Why: _____

6. List any medications your child takes (include over-the-counter medicines and vitamins)
   _____

7. Which of these medications will need to be taken at school?
   _____

8. Is the student allergic to anything, such as foods, plants, insects, medicine? ☐ Yes ☐ No
   What: _____
   Reaction: _____

9. Does the student need a special diet or have any food problem?
   (Please contact your student's school nurse if food substitutions are required.) ☐ Yes ☐ No
   Explain: _____

10. Has your child had early intervention services for academic or health reasons? ☐ Yes ☐ No
    Type: _____

11. Does the student have an Individual Education Plan (IEP)? ☐ Yes ☐ No

12. Does the student have any special health needs or problems the school should know about? ☐ Yes ☐ No
    Describe: _____

West Shore School District
Department of Health Services

Nature and Purpose of This Health Record

I understand that the information I give to the School Nurse is important for the school staff to understand and help the health and education of my child.

I understand that the information will be kept confidential by the School Health Staff and will be shared with other professionals in the school and in other institutions only when the School Nurse and/or the School Physician believe that it is in the best interest of my child's health and education. Copies of this health record will be sent to other agencies who request it only with my written consent.

Signature of Parent/Guardian: _____ Date: _____

Permission for Examinations and Tests

I give permission for my child to receive medical and dental examinations and tests as provided by the School Health Services of the West Shore School District.

I understand that state law requires:

- physical examination
- dental examination
- screening tests for:
  - growth
  - vision
  - hearing
  - scoliosis
  - tuberculosis

or an approved equivalent program.

I understand that the West Shore School District has obtained approval from the Pennsylvania Department of Health to provide expanded health services.

I understand that I will be informed of any abnormal results of examination and tests given my child.

I give permission for the following:

- health history
- physical examination
- teacher assessment of health and progress
- screening tests for:
  - growth
  - vision
  - hearing
  - scoliosis
  - tuberculosis
  - dental health

Signature of Parent/Guardian: _____ Date: _____

Student Name: _____

WEST SHORE SCHOOL DISTRICT

Dear Parent/Guardian:

A healthy child is a productive child. Our goal in the West Shore School District is to make your child's school experience as healthy as possible. Despite all efforts to minimize illness, any place where children are in close proximity to one another (sporting events, dance classes, play-dates, sleep-overs, church activities, scouting events, local parks and playgrounds, shopping centers and schools) allows for the exposure of your child to contagious illnesses and the dreaded incursion of head lice.

Unfortunately, head lice have been in existence for thousands of years and will continue to be commonly found in all locations where humans reside, including all of our schools. The good news is, armed with some basic knowledge and by carrying out a few easy steps; a proactive parent can lessen the likelihood of their child developing a lice infestation. As parents, we are always on the lookout for the obvious sneezes, sniffles and coughs, but often forget to do a weekly inspection of our child's head for lice. Research shows that the average head has been infested with lice for at least one month prior to the development of symptoms. Therefore, a weekly head check is key in the early detection and treatment of head lice. As such, the health services department would like to share some important reminders about head lice.

The head louse lays its nits (eggs) on the hair shaft near the scalp. A live louse and its nits are most often found behind a child's ears, in bangs and at the base of the neck. The adult louse is about the size of a sesame seed (2-3 mms) in length. The nits look like a fleck of dandruff; they do not brush off the hair shaft, but instead need to be scraped off with your fingernail. To help you deal with this common problem, the following preventative measures are suggested.

photo enlarged

1. ***Always check your child's head at least once a week throughout the school year. Be vigilant; do not wait to hear that another child has lice before you begin to check your own child for lice.*** Please remember there always have been and always will be lice anywhere children gather, including our schools.
2. Remind your children to avoid head-to-head contact with other children and not to share their hats, combs, brushes, barrettes, and headphones with others.
3. Be sure to wash your child's hair frequently.
4. Be mindful of the early warning signs such as head scratching or the appearance of white specks that remain in the hair.
5. Wash hats, scarves, hair ribbons, combs, brushes, and other hair accessories at least once a week.
6. Outer clothing that comes in contact with the head or neck should be washed frequently.
7. Inspect your child's head especially before and after a group activity such as a slumber party or camping activity.
8. If lice are found, have a high index of suspicion that many, if not all, family members may also be infested and treat accordingly.
9. Stop the spread of lice. Notify neighbors, friends, and playmates that have been in contact with your child.

In spite of all these precautions, your child may still get head lice if the appropriate conditions occur. A head louse's only requirement is a warm host on which to live and breed. Head lice do not discriminate by socioeconomic class and are just as happy living in "clean" as well as "dirty" hair. If your child happens to acquire lice, don't panic, head lice are pests, but do not carry any diseases. Our best advice to parents is to treat ALL family members that are infested with a commercially approved louse killing shampoo, remove ALL nits so they do not hatch and re-infest the head, and treat all surfaces that a head or hair may come in contact with in the home. Despite all your efforts, lice can be very frustrating and difficult to eradicate. Through years of experience in dealing with lice, school nurses have found that the more effort you put into their initial removal, the better chance you have of totally eliminating a reoccurrence of lice.

On the school front, please be assured that if the school district becomes aware of a case of head lice we will follow the latest expert recommendations from the Center of Disease Control and Prevention and the American Academy of Pediatric Physicians on the management of head lice in the school environment. If you have questions about your child's head lice, or if you find head lice in your child's hair, please contact the school nurse. We understand that some parents may fear the perceived stigma that can be associated with head lice, therefore, may be hesitant to report this information to the school. Please be assured that the school will not share this information with others, as is our practice with any non-life threating condition, and will maintain your child's medical privacy. Your child's school nurse would like to be a trusted resource and hopes parents/guardians are comfortable coming to us so we can convey our knowledge and help you eradicate head lice in your home, and thus our schools. For more information on this and many other health related topics, please visit our Health Services Webpage at:
http://www.wssd.k12.pa.us/webpages/HealthServices/

Respectfully, WSSD Health Services Staff

West Shore School District
Kindergarten Registration – Vision Screening

As part of your child's registration, he/she will receive a vision screening. Unless you are informed otherwise, your child will have passed this examination. Please be aware this is only a screening and there is always a possibility other eye problems could be present which may only be diagnosed by an eye care specialist, ophthalmologist, or optometrist. The Academy of Ophthalmology & Otolaryngology recommends children have an eye exam by the age of three.

Please complete and bring with you to Kindergarten Registration.

Student Name: _____ Date of Birth _____

Signature of Parent/Guardian: _____ Home Phone: _____

Does your child ever complain:		
• that he/she cannot see well?	☐ Yes	☐ No
• that objects "run together"?	☐ Yes	☐ No
• of headaches, dizziness or even nausea following close eye work?	☐ Yes	☐ No
• of double vision?	☐ Yes	☐ No
Has your child ever had or has:		
• eyelids that are red-rimmed, encrusted or swollen?	☐ Yes	☐ No
• recurring styes or lid inflammations?	☐ Yes	☐ No
• inflamed or watery eyes?	☐ Yes	☐ No
• crossed eyes?	☐ Yes	☐ No
Does your child ever:		
• have difficulty with tasks requiring close vision?	☐ Yes	☐ No
• frown, blink excessively, scowl or squint?	☐ Yes	☐ No
• hold objects or books too close or too far?	☐ Yes	☐ No
• rub eyes frequently or attempt to brush away blur?	☐ Yes	☐ No
• shut or cover one eye, tilt or thrust head forward when looking at near/distant objects?	☐ Yes	☐ No
• stumble or trip over small objects?	☐ Yes	☐ No
• not do well in activities requiring distant vision?	☐ Yes	☐ No
1. Is your child unduly sensitive to light?	☐ Yes	☐ No
2. Has your child ever been examined by an eye specialist, ophthalmologist/optometrist?	☐ Yes	☐ No
3. Is your child presently under the care of an eye specialist?	☐ Yes	☐ No
Physician's name: _____		
4. Does your child wear glasses?	☐ Yes	☐ No
5. Do you feel your child has a problem with vision?	☐ Yes	☐ No

Please explain on the back of this form if you have a concern that has not been addressed above.

District Office Use ONLY

Visual Inspect	_____	EOM	_____	O.D.	_____	with glasses	_____
PERRLA	_____	Corneal Light	_____	O.S.	_____	with glasses	_____
Muscle Balance	_____	Cover N/F	_____	Both	_____	with glasses	_____

☐ Referred _____ ☐ Not Referred _____

West Shore School District
Kindergarten Registration – Hearing Screening

Please complete and bring with you to Kindergarten Registration.

Student Name _____ School _____

1.	Does your child have a permanent hearing loss?	☐ Yes	☐ No
2.	In the past year, has your child had frequent ear infections or middle ear fluid (3 per season or lasting 2 months)?	☐ Yes	☐ No
3.	Does your child have an ear infection now?	☐ Yes	☐ No
4.	Do you think your child has difficulty hearing?	☐ Yes	☐ No
5.	Is there a history of hearing loss in your immediate family?	☐ Yes	☐ No
6.	Is your child inconsistent in listening? *Example: At times he/she seems to hear well, then other times seems not to hear well.*	☐ Yes	☐ No
7.	Does your child need to watch you when you speak in order to understand what you say?	☐ Yes	☐ No
8.	Does your child become confused when following directions? *Example: He/She does not understand, or confuses words or phrases.*	☐ Yes	☐ No
9.	Does your child have difficulty listening in a group situation or when background noise is present?	☐ Yes	☐ No

District Office Use ONLY

Questionnaire indicates:	Screen	_____
	Passed	_____
	Failed	_____
Questionnaire indicates:	No Screen	_____
Speech and language screen indicates hearing screen needed:	Passed	_____
	Failed	_____

WEST SHORE SCHOOL DISTRICT

Todd B. Stoltz, Ed.D.
Superintendent of Schools

Dear Parent/Guardian:

When it is necessary for your child to receive medication during school hours the following procedure is required:

1. A written physician's order and parent/guardian signature consent form must be completed for each medication order and once every school year for a chronic condition. This form is available on the reverse side of this letter, from the school nurse or you may also download it from the district website at www.wssd.k12.pa.us/healthservices. Forms may be requested at any time to have on hand for non-scheduled doctor visits.

2. All medications must be in the original container labeled with the student's name, medication name, dosage, duration and the time to administer the medication. Please request a duplicate bottle from the pharmacist so that a labeled bottle is maintained both at school and at home.

3. Any change in type, dosage, or discontinuance of the medication must be reported to the school immediately with a written physician/practitioner order stating the directive in place for the nurse's office.

4. Medications **must** be brought to school **by the parent/guardian or a responsible adult**. Medications may **not** be sent to school on the person or property of a student as this may be considered a WSSD drug policy violation.

All these requirements must be met before the school will administer any medication.

If the health of the child is substantially impaired when the medication is forgotten, or administered early or late, parents/guardians should keep their child at home or be responsible for administering the medication. A parent/guardian designee is permitted to come to school to administer the medication.

Most medications should be scheduled so that they may be given at home, but it is understood that this is not always possible.

If there is a concern regarding this matter, please call your child's school nurse.

Thank you,

The WSSD Health Services

West Shore School District
Medication Order and Request

Please print all information:

Student Name: _____ Grade/Section: _____

Diagnosis: _____ Duration of Administration: _____

Medication Name: _____ Dosage: _____

Route (oral/injection/drops): _____ Time: _____

Side Effects: _____

_____ Physician: If ordering a rescue inhaler or injectable Epinephrine, please initial if the student is permitted to self-carry/self-administer the prescribed medication.

Curtailment of specified school activities (sports, shop, driver training, etc.):

_____

Other medication student is taking: _____

Health Care Provider's Name: _____ Phone: _____

Health Care Provider's Signature: _____ Date: _____

I request that school personnel administer this prescribed medication. I hereby release West Shore School District and all its employees from any and all liability for damages my child may suffer as a result of this request.

Any discontinued medication not removed from the school by a parent/guardian or a responsible adult within a two-week period will be disposed of by the nurse.

It is the policy of the West Shore School District to administer prescribed medication during school hours only when absolutely necessary.

Prescription medication must be sent to school in a container with the prescription label by a pharmacist or a Health Care Provider. If the parent/guardian does not want to send the prescription medication in its original container, (s)he should ask the pharmacist/physician for a separate, properly labeled container for school use.

If ANY medication is not in the original container, it CANNOT be given.

I grant permission for the Health Care Provider to release medical information from my child's records to the West Shore School District. It is my understanding that these records will be used for purposes of planning an appropriate educational program for my child and will not be released to any outside agency or person without my permission.

Signature of Parent/Guardian: _____ Date: _____

West Shore School District
Consent For Release of Information
(For use by Health Services)

I, _____ , a custodial parent or guardian of
print parent or guardian name

_____ , whose date of birth is _____ ,
print student's name *child's date of birth*

grant my consent for _____ _____
name of physician/physician's office *address of physician's office*

to release the following information concerning my child's medical condition (check all that apply):

___ Current Physical Records

___ Vaccination Records

___ Medical Evaluations regarding the diagnosis of: _____

___ Other: _____

Please forward all records to:

School Name: _____

Nurse's Name:: _____

Address: _____

Phone Number: _____

Signature of Parent/Guardian: _____ Date: _____

FOR USE BY SCHOOL NURSE ONLY

Record Requests:

1. Spoke to: _____ Date: _____ Time: _____
2. Spoke to: _____ Date: _____ Time: _____
3. Spoke to: _____ Date: _____ Time: _____

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**			***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)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME: