UPPER MERION AREA SCHOOL DISTRICT

STUDENT SERVICES DEPARTMENT
200 Anderson Road, King of Prussia, PA 19406

STUDENT REGISTRATION INFORMATION

The Upper Merion Area School District requires children entering Kindergarten to be five (5) years of age by August 31st and children entering 1st Grade to be six (6) years of age by August 31st.

REQUIRED INFORMATION TO COMPLETE A STUDENT REGISTRATION

1. **PROOF OF STUDENT'S AGE** ***(one of the following)***
    a. State Certified Birth Certificate
    b. Certified Baptismal Certificate
    c. Duly-Attested Transcript of Birth Certificate

2. **STUDENT'S IMMUNIZATION RECORDS -** Written and signed documentation from a hospital, clinic or physician must verify that the child has received or is in the process of receiving immunizations for:
    a. Diphtheria and tetanus - 4 or more properly spaced doses of DTP, Dtap, Td, or DT, or any combination of the three with one dose administered on or after the fourth birthday
    b. Polio - 3 or more properly spaced doses of polio vaccine (IPV or OPV) one dose administered on or after the fourth birthday
    c. Measles (Rubeola), German Measles (Rubella), and Mumps – one dose of each, preferably given as MMR, on or after the first birthday
    d. Measles (Rubeola) – a second properly spaced dose, preferably given as MMR
    e. Hepatitis B - 3 properly spaced doses of Hepatitis B vaccine
    f. 2 doses of Varivax vaccine or history of disease
    g. One dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus immunization) (7th grade only)
    h. One dose of meningococcal conjugate vaccine (MCV) (7th grade only)

Please note: Once immunizations are reviewed by the Certified School Nurse, parents will be notified if immunizations are not complete. The student cannot attend school unless immunization requirements are met.

A Physical Examination is required for students upon entry into school. Any exam performed one year prior to the start of school is acceptable for the following school year. If your child has received this exam please bring documentation with you at the time of registration. If not, this requirement must be completed and returned to the school nurse by August 15th.

A Dental Examination is required upon original entry into school (kindergarten or first grade), in third grade and in seventh grade. A dental examination performed within the year prior to your child entering the required grade will be accepted.

During registration you will be given a tuberculosis assessment and health history form to complete. This will be reviewed by the school nurse. Parents will then be notified (by the school nurse) if the student will require tuberculin skin testing for entry into school.

3. **PARENT/GUARDIAN IDENTIFICATION (one of the following)**
    a. Valid PA driver's license
    b. Valid temporary PA driver's license (along with photo ID)
    c. Valid Out-of-state driver's license
    d. Other type of photo identification

4. PROOF OF RESIDENCY *(Choose your appropriate living situation)*

a. Homeowners - ***ANY one of the following***
   i. Deed
   ii. Property Tax Bill
   iii. Settlement Papers
   iv. Mortgage Bill/Statement

b. Lease ***(if the parent/guardian has a lease in their name) - ALL items required***
   i. Notarized Lessee Affidavit form.
   ii. Copy of your current dated Lease (or) a letter from your landlord listing all the individuals who reside at your address, the expiration date of your lease agreement and the landlords' contact information.

c. Multiple Occupancy ***(the parent/guardian and student lives with a friend or family member)***
   i. Notarized Multiple Occupancy Affidavit.
   ii. Copy of the homeowner's deed, tax bill, property settlement papers, current dated Lease (or) a letter from the landlord listing all the individuals who reside at your address, the expiration date of your lease agreement and the landlord's contact information.
   iii. Copy of the homeowner or lease holders Driver's License.

d. Guardianship ***(the parent(s) listed on the student's birth certificate have given up parental rights on a permanent basis)***
   i. Notarized Guardianship Affidavit.
   ii. Release of Claim to Exemption of Child
   iii. Copy of the guardian's deed, tax bill, property settlement papers, current dated Lease (or) a letter from the landlord stating the individuals who reside at your address, the expiration date of your lease agreement and the landlord's contact information.
   iv. Copy of the Parent(s) Driver's License.

****IN ADDITION to the requirements listed above, ALL parents/guardians must present two (2) of the following items showing a valid current address within our district boundaries.****

1. Current PENNDOT ID or Driver's License (also counts for Identification as listed above)
2. PENNDOT vehicle registration
3. Current Utility Bill
4. Current Credit Card Bill
5. Current Bank Statement
6. State or Federal Program Enrollment
7. Paystub (with name of employer and employee present)

5. SCHOOL RECORDS *(one of the following if transferring from a private or other public school)*

** This is required for students entering grades 1-12**

a. School Transfer/Withdrawal Form
b. Report card
c. Transcript
d. Individual Education Plan (IEP) ***(must provide if the student has one)***

6. CUSTODY ARRANGEMENT *(for divorced, separated or single parents)*

If a written custody agreement exists, a copy should be filed with the school district. Furthermore, if there is a change in status regarding the custodianship/guardianship of the student, it is the responsibility of the parents/guardians to notify the school district of any special accommodations to be made concerning emergency contact and the report of pertinent academic information. Please note that if no legal custody agreement is in place, then a written letter from the non-registering parent will be accepted.

HELPFUL RESOURCES

IMMUNIZATIONS MAY BE COMPLETED BY YOUR FAMILY PHYSICIAN OR BY VISITING ANY OF THE FOLLOWING…

Montgomery County Health Department
55 East Marshall Street
Norristown, PA 19401
(610) 278-5145

Walgreens Pharmacy Health Care Clinic
699 West Germantown Pike
Norristown, PA 19403
(610) 630-5819

CVS Pharmacy Minute Clinic
3125 Henderson Road
King of Prussia, PA 19406
(610) 205-1264

Norristown Regional Health Center *(Sliding fee scale available)*
1401 DeKalb Street
Norristown, PA 19401
(610) 278-7787

TO OBTAIN A BIRTH CERTIFICATE FOR CHILDREN BORN IN PENNSYLVANIA…

Bureau of Vital Statistics
PA Department of Health
P.O. Box 1528
New Castle, PA 16103
(412) 656-3100
http://www.health.pa.gov/MyRecords/Certificates/

TO OBTAIN NOTARY SERVICES…*CALL BEFORE ARRIVAL*

Rep. Tim Briggs
149th Legislative District
Montgomery County
554 Shoemaker Road, Suite 149
King of Prussia, PA 19406
(610) 768-3135
(610) 768-3112

UPPER MERION AREA SCHOOLS…

Upper Merion Area High School – (grades 9-12) –610-205-3800
Upper Merion Area Middle School – (grades 5-8) – 610-205-8800
Bridgeport Elementary – (grades PK-4) – 610-205-3600
Caley Elementary – (grades K-4) – 610-205-3650
Candlebrook Elementary – (grades K-4) – 610-205-3700
Gulph Elementary – (grades K-4) – 610-592-2020
Roberts Elementary – (grades K-4) – (610) 205-3750

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P T C

Your child's Parent Teacher Committee (PTC) would like to include you and your child in all forms of their communications. If you would like to be contacted by a PTC representative, please complete this form and submit it at the time of a new student registration or to your child's building secretary in an envelope marked "PTC".

Student's Full Name _____

School _____

Grade _____

Parent(s) and/or Guardian Name _____

Address _____

City_____ State _____ Zip Code _____

Home Phone Number _____Cell Phone Number _____

Parent Email Address _____

Parent/Guardian Signature: _____ Date: _____

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HEALTH EXAMINATIONS / SCREENINGS
SCHOOL HEALTH SERVICES

The School Health Act of the Commonwealth of Pennsylvania mandates that all children have a health examination upon entry to a Pennsylvania School as well as in grades six (6) and eleven (11).

Parent(s) and/or Guardian are encouraged to use their family physician for these examinations to provide continuity of care for the student. Family doctors are better able to detect physical changes, begin treatment if indicated, follow through with needed care and give immunization boosters. ***A physical performed within one year prior to September of the school year in which the physical is required is acceptable.***

The regional Health Center in Norristown, 610-278-7787 also provides primary care and immunization services with a sliding fee-scale for people without health insurance or without a family physician.

Private Physical Examination forms and Immunizations should be submitted at the time of a new student registration or to your child's School Health Suite by August 15th.

Bridgeport Elementary Health Suite - Fax: 610-205-3947
900 Bush Street, Bridgeport, PA 19405

Caley Elementary Health Suite - Fax: 610-205-3790
725 Caley Road, King of Prussia, PA 19406

Candlebrook Elementary Health Suite - Fax: 610-205-3798
310 Prince Frederick Street, King of Prussia, PA 19406

Gulph Elementary Health Suite - Fax: 610-592-2098
650 S Henderson Road, King of Prussia, PA 19406

Roberts Elementary Health Suite - Fax: 610-205-3799
889 Croton Road, King of Prussia, PA 19406

Upper Merion Area Middle School Health Suite - Fax: 610-205-8849
450 Keebler Road, King of Prussia, PA 19406

Upper Merion Area High School Health Suite - Fax: 610-205-3994
465 Crossfield Road, King of Prussia, PA 19406

Any questions can be directed to your child's school nurse.

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ORAL HEALTH EXAMINATION

The Commonwealth of PA **requires** dental examinations for all students in Kindergarten, 3rd grade, 7th grade and any student that is newly enrolled.

If your child **HAS** been evaluated at a dental office within the past year, after September 1st, kindly ask the dentist to complete the enclosed *PA Dentist Examination of Pupil* form and return to your child's school health suite by **August 15th**. *This form is also available on the district website.*

If your child **HAS NOT** been evaluated in a dental office within the past year, you will be required, at your own expense, to obtain a report from a licensed dentist. The report of examination is due by November 1st or 60 days after enrolling in the school district. If a PA *Dentist Examination of Pupil* report is NOT submitted to your child's school health suite by November 1st, a dental screening will be performed by a licensed, certified school dental hygienist using universal precautions.

Private Dental Report forms should be submitted at the time of a new student registration or to the School Health Suite by August 15th.

Bridgeport Elementary Health Suite - Fax: 610-205-3947
900 Bush Street, Bridgeport, PA 19405

Caley Elementary Health Suite - Fax: 610-205-3790
725 Caley Road, King of Prussia, PA 19406

Candlebrook Elementary Health Suite - Fax: 610-205-3798
310 Prince Frederick Street, King of Prussia, PA 19406

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465 Crossfield Road, King of Prussia, PA 19406

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:

Appendix F

H514.027 (2/2023)

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 STUDENT	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		M F		

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

		RIGHT								**LEFT**								
UPPER		1	2	3	4 A	5 B	6C	7 D	8 E	9 F	10 G	11 H	12 I	13J	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
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address of Dental Examiner