

COUNCIL ROCK SCHOOL DISTRICT STUDENT REGISTRATION

OFFICE USE ONLY	Student ID _____	Census # _____
	School _____	Entry Date _____
	Reg for School Year _____	Grade _____
	<input type="checkbox"/> MO <input type="checkbox"/> Guardianship <input type="checkbox"/> Legal Guardianship	
	<input type="checkbox"/> Foster <input type="checkbox"/> Custody Agreement <input type="checkbox"/> _____	
	Registered by _____	Reg Date _____

PLEASE PRINT

STUDENT INFORMATION:

Has this student registered at any Council Rock school in the past? Yes No
 If so, which school? _____ Dates enrolled: ____/____/____ to ____/____/____

Student's Legal First Name _____ Middle Name _____ Last Name _____ Generation (Jr. / Sr. etc) _____
 Gender: Male Female Date of Birth: ____/____/____ DOB verification type: Birth Certificate Baptismal Certificate

IS STUDENT OF HISPANIC/LATINO ETHNICITY → check one: Yes No

IF NON-HISPANIC → check one: 1-American Indian/Alaskan Native 3-Black 5-White 9-Asian 10-Native Hawaiian/Pacific Is

Subgroup (for Spanish or Arabic speaking students, only): _____

What language(s) is/are spoken daily in your home? _____

Initial Pennsylvania school enrollment date: ____/____/____ US enrollment date: ____/____/____

Student's Home Address _____ City _____ State _____ Zip _____
 Mailing Address (if different than physical address, example PO Box) _____ City _____ State _____ Zip _____

Do you: own your home lease your home other _____

PARENT/GUARDIAN INFORMATION: (COMPLETE SECTIONS I AND II AS APPLICABLE)

In cases of divorce/separation, either a current custody agreement must be provided at registration OR both parents must sign registration form to acknowledge that child will attend school in Council Rock School District.

I. Parent/Guardian Full Name _____

Address (if different than student) _____

Email Address _____ Home Phone # _____ Mobile Phone # _____ Work Phone # _____

Name of Stepparent (if applicable) _____ Email Address _____ Mobile Phone # _____ Work Phone # _____

II. Parent/Guardian Full Name _____

Address (if different than student) _____

Email Address _____ Home Phone # _____ Mobile Phone # _____ Work Phone # _____

Name of Stepparent (if applicable) _____ Email Address _____ Mobile Phone # _____ Work Phone # _____

With whom does the student reside (Check all that apply) mother father stepparent guardian

other (please explain) _____

MISCELLANEOUS STUDENT INFORMATION:

Birth City: _____ Birth State: _____ Birth Country: _____ Migrant

FOR HIGH SCHOOL STUDENTS ONLY: Date entered 9th Grade: ____/____/____

I understand that credit for course work earned at a previous school will not be awarded unless an official transcript is received by CRSD.

Parent Signature _____

Former School: _____ Date last attended: ____/____/____

Address: _____ Grade last attended: _____

Principal/Counselor: _____ Phone #: _____

Does your child have a significant health problem of which the school should be made aware? Yes No

If you answered "YES" - please communicate the problem to the school nurse immediately on the health forms provided.

Does child have a hearing problem, sight problem, etc.? _____

Does child presently have an IEP? Yes No Does child presently have a GIEP? Yes No

If you answered "YES" - please provide the district with a copy of current evaluation report and IEP/GIEP.

BROTHERS AND SISTERS: *(Please list full name, date of birth and school for children ages 0-18 years)*

NOTES/COMMENTS:

Please list any special programs this student has participated in at previous schools(s) or include other comments you wish to make:

STUDENT REGISTRATION AFFIDAVIT / SIGNATURE REQUIRED

(Please check one)

This is to certify that I am the PARENT GUARDIAN of the pupil registered on this form.

Signature

Date

(Please check one)

This is to certify that I am the PARENT GUARDIAN of the pupil registered on this form.

Signature

Date

***In cases of divorce/separation, either a current custody agreement must be provided at registration OR both parents must sign registration form to acknowledge that child will attend school in Council Rock School District.**

**COUNCIL ROCK SCHOOL DISTRICT
PARENTAL REGISTRATION STATEMENT**

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

To be completed by the Parent or Guardian:

Student: _____ DOB: _____

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

<i>Please complete this section if student has been or is presently suspended or expelled from another school:</i>	
Name of school from which student was suspended or expelled:	
Dates of suspension or expulsion: (Please provide additional schools and dates of suspension/expulsion)	
Reason for suspension/expulsion: (optional)	

Signature of Parent or Guardian

Date

Any willful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.
24 P.S. §13-1317-2

**COUNCIL ROCK SCHOOL DISTRICT
HOME LANGUAGE SURVEY***

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

(Please Print)

School District: COUNCIL ROCK SCHOOL DISTRICT Date: _____

School: _____ Grade: _____

Student's Name: _____

Parent/Guardian Name: _____

Phone number with area code: (_____) _____

Country of Birth: _____

1. Initial US entry date: ____/____/____ Immigrant: Yes No

2. What is/was the student's first language? _____

Does the student speak a language(s) other than English? Yes No (Do not include languages learned in school)

If yes, specify the language(s): _____

3. What language(s) is/are spoken daily in your home? _____

4. Number of years in US schools: _____

a. Has the student attended any United States school in any 3 years during his/her lifetime? Yes No

If yes, complete the following:

<u>Name of School</u>	<u>State</u>	<u>Dates Attended</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person completing this form (if other than parent/guardian): _____

Parent/Guardian Signature: _____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in school district/charter school/full day AVTS in the future.

OFFICE USE: Student ID# _____
English Proficiency Level: _____ Program Start Date: _____
If one of the answers is a language other than English or the country of origin is other than the United States, send a copy of this form to the District ELL Coordinator and the school's ELL teacher. Place the original in the child's cumulative folder. This form remains in the folder throughout the child's school career.

**COUNCIL ROCK SCHOOL DISTRICT
CENSUS ENUMERATION FORM**

(Please Print)

Parcel # _____ Date: _____

Current Address: _____ Boro/Twp: _____

Former Address: _____ Boro/Twp: _____

Do you: Own your home Rent (name of landlord _____)

How long have you been a resident at your current address? _____

PLEASE LIST ALL RESIDENTS OVER 18 YEARS OF AGE

*Failure to note occupation will result in being taxed at the highest rate

Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
*Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
*Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
*Occupation	Employer	Employer Address
Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Total Years Education
*Occupation	Employer	Employer Address

PLEASE LIST ALL CHILDREN UNDER 18 LIVING AT YOUR ADDRESS (FROM OLDEST TO YOUNGEST)

Name (Last, First, Middle)	Sex	Date of Birth (Month/Day/Year)	School	Grade

Please state intention of pre-school children to attend public, private or parochial school

THIS INFORMATION IS REQUIRED FROM ALL RESIDENTS OF COUNCIL ROCK SCHOOL DISTRICT

EARNED INCOME TAX INFORMATION FOR RESIDENTS OF THE COUNCIL ROCK SCHOOL DISTRICT

As you may know, school districts in Pennsylvania have tax revenue sources other than real estate taxes from which they may obtain funds to support schools and education. Authority for levying these additional taxes was granted to local school districts and municipalities by the Pennsylvania General Assembly in 1965 through passage of the Local Tax Enabling Act (LTEA), commonly referred to as *Act 511*. The Earned Income Tax or "Wage Tax" is usually a tax of one percent (1%) on gross wages and/or net profits from a business or profession.

Berkheimer Associates is the appointed earned income tax officer for the Council Rock School District and the municipalities which comprise the School District. As the appointed earned income tax collector, Berkheimer Associates is charged with the duty of administering the school district's, township's, and/or borough's taxes. This includes collecting the tax, establishing rules and regulations to fairly enforce such tax and creating accurate tax records and accounts for each taxpayer.

Below is an Earned Income Tax Registration Form. A completed registration form will fulfill your registration requirements under the Earned Income Tax rules and regulations adopted by the Council Rock School District and your resident municipality. More importantly, this information will ensure that your tax dollars are sent to your home taxing jurisdiction. All residents should complete this form, regardless of employment status (unemployed, retired, college student, military personnel, or homemaker). If you have recently moved, please give your current and former address.

Most resident taxpayers will have this tax deducted by their employers. Although, if you work in a jurisdiction where it is not withheld, or you are self-employed, you will have to pay the tax directly to Berkheimer Associates. Your completed registration form will be forwarded to Berkheimer Associates, who will create an accurate tax account reflecting your correct reporting status and send you the necessary tax forms.

We appreciate your cooperating in completing the registration form. Kindly refer to the back of this letter for general questions and answers about the Earned Income Tax. If you have any additional questions, contact Berkheimer Associates at 610-588-0965, extension 2, or in person at your local Berkheimer Office.

COUNCIL ROCK SCHOOL DISTRICT EARNED INCOME TAX REGISTRATION FORM

(Please Print)

	Your information	Spouse's Information
Name		
Social Security #		
Employer		
Working Jurisdiction (Twp/Boro/City)		
Is Earned Income Tax withheld from pay?		
Are you self-employed?		
If you have no earned income, please record reason why (retired/homemaker/temporarily unemployed/disabled/student/minor (state age)/other (please specify)		
Resident Address		
City/State/Zip		
Please check Township or Borough in which you reside		
<input type="checkbox"/> Newtown Borough <input type="checkbox"/> Northampton Township <input type="checkbox"/> Wrightstown Township <input type="checkbox"/> Newtown Township <input type="checkbox"/> Upper Makefield Township		
Date you moved to above address		
Did you move here from another Pennsylvania location? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list previous address and resident school district.	
Signature(s)		Date

QUESTIONS AND ANSWERS ABOUT THE EARNED INCOME TAX

WHAT IS THE "EARNED INCOME TAX?"

The Earned Income Tax, commonly called a "Wage Tax", is usually a tax of one percent (1%) on gross wages and/or net profits from a business or profession. In Home Rule communities, the tax rate may vary and can even be higher than one percent (1%). Typically, individuals who receive "earned income" including salaries, wages, commissions, bonuses, incentive payments, fees, tips and/or other compensation for services rendered, whether in cash or property, are subject to the tax. In addition, those who conduct businesses, professions and other activities for profit must pay tax on the net profit derived from their operation after deductions have been made of all costs and expenses incurred in conducting said businesses.

WHAT INCOME IS SPECIFICALLY EXEMPT FROM THE EARNED INCOME TAX?

Unearned income such as dividends, interest, income from trusts, bonds, insurance and stocks is exempt. Also exempt are payments for sick or disability benefits, old age benefits, retirement pay, pensions – including social security payments, public assistance or unemployment compensation payments made by any governmental agency, and any wages or compensation paid by the United States for active service in the forces of the United States including bonuses or additional compensation for such service. In addition, net profits of corporations are exempt under state law.

IF THE TAX IS WITHHELD IN ANOTHER COMMUNITY WHERE I WORK, DO I ALSO PAY THE DISTRICT IN WHICH I LIVE? No, the tax withheld by your employer will be remitted to your resident taxing jurisdiction. It is still required that our Registration Form be answered by ALL residents.

WHOSE EARNED INCOME TAX WILL BE WITHHELD BY THEIR EMPLOYER?

Any individual working in a jurisdiction that levies the tax will have the tax withheld by their employer. Occasionally, employers located in a jurisdiction where the tax is not levied will volunteer to withhold if your resident jurisdiction levies the tax.

FROM WHOM WILL THE EARNED INCOME TAX BE COLLECTED DIRECTLY?

The earned income tax will be collected directly from those who are: 1) self-employed; 2) salaried but self-employed in a side business; or 3) work in a municipality where the tax is not in place. Those persons must file a declaration of the total of such estimated net profits or income, together with the total estimated tax due, with the Earned Income Tax collector. Proper forms for reporting the quarterly payments will be sent to each person so liable.

MUST ALL TAXPAYERS FILE A FINAL RETURN? Yes

WHAT HAPPENS IF I NEITHER FILE A RETURN NOR PAY THE TAX DUE?

State law, as well as the local tax resolutions and/or ordinances, make it a summary criminal offense if a taxpayer fails to file a tax return as required, and subjects the taxpayer to a fine not to exceed \$500.00 per offense, plus the cost of prosecution; in default of payment of said fine and costs, the taxpayer may be imprisoned for a period not exceeding thirty (30) days per offense. In addition, distress sale, wage attachment and/or civil suit proceedings may be used to collect any unpaid tax found to be due, and penalties and interest may also be assessed.

DAY CARE TRANSPORTATION REQUEST FORM

If your child is to be transported to and/or from school to a location other than your designated home area bus stop, please complete the Transportation Request Form on the reverse side of this notice and return it to the Transportation Office located in the Chancellor Center or mail the form to the address below. Forms may also be picked up at each school.

Requests for Council Rock School District bus transportation from locations other than the student's home will be considered only if the student is eligible for transportation and the stop is on an existing bus run located in the school attendance area to which the student is assigned.

Students will be assigned to bus stops only on a consistent basis. This schedule must be consistent. We cannot honor requests for transportation that will vary day by day.

Requests for a change in transportation will become effective only after adequate time has been given to properly notify all persons concerned and make the necessary changes. Approximately (3) three School Days.

Building principals may approve temporary changes for emergencies such as illness in the family, parent out of town, etc. Telephone requests will not be taken for permanent changes. Requests must be submitted on a "Transportation Request Form" and submitted to the Transportation Office. Notes requesting transportation changes signed by parents will not be accepted by bus drivers.

Requests for transportation to a child care provider will be granted only if the child care provider is on an established bus route in the school's attendance area.

Students will be permitted to ride only the bus to which they are assigned. In addition, they will be permitted to get on or off the bus only at the stop to which they are assigned for safety reasons.

Special Note: Child Care Day Care Transportation Request Forms should be submitted **BEFORE August 1st** of each school year. Student bus stops revert back to the home location at the end of each school year. Requests for transportation to child care providers must be made annually.

While this may cause parents temporary inconvenience, we're sure you can understand our rationale. We are very serious about our responsibility for transporting students to and from school safely. We need to know at all times what children are on our buses.

We appreciate your cooperation in this matter.

If you have any questions you may call the Transportation Office at 215-944-1010.

Council Rock School District Transportation Office
30 N. Chancellor Street, Newtown, PA 18940

E-mail : Transportation@CRSD.org

Fax : 215-944-1011

**COUNCIL ROCK SCHOOL DISTRICT
DAY CARE TRANSPORTATION REQUEST FORM**

SCHOOL YEAR _____ Requests must be submitted each school year. Transportation will revert back to student's home address at the end of the School year.

Student(s) Name: _____

Home Address: _____

School Attending: _____

Grade: _____ Home Telephone: _____

Please fill in the blanks where indicated and provide us with accurate information and the required signatures. Please return this form to the Council Rock School District Transportation Office, 30 N. Chancellor Street, Newtown, PA 18940 This form may also be faxed to 215-944-1011.

Daycare Provider: _____

Daycare Provider Address: _____

Phone Number: _____

Bus Stop Location (For Child Care Provider Location if Known): _____
(Must be an existing bus stop.)

Student Transported TO SCHOOL FROM:

Child Care Provider / Day Care Facility _____

(Must be 5 days a week, if not, parent is responsible for transportation to school from home).

Student Transported FROM SCHOOL TO:

Child Care Provider / Day Care Facility _____

(Must be 5 days a week, if not parent is responsible for transportation home on days not attending day care.)

Signature of Parent or Guardian: _____ Phone Nr. _____

TRANSPORTATION DEPARTMENT USE ONLY

Effective Date: _____

_____ Approved

_____ Not Approved

Transportation Director _____ Date _____

PLEASE NOTE: This request can only be approved by the Transportation Office. Building principals can approve temporary changes in transportation for emergency reasons.

Copies: School Office: _____ Parent Notified via _____ E-Mail _____ Telephone Date _____ Time _____.

COUNCIL ROCK SCHOOL DISTRICT

Dear Physician,

In order to comply with Pennsylvania Immunization Law, we request that you complete this form and return it to the parent or guardian of the child named below so that they may register in our school district.

Student _____ Date of Birth _____ Entering Grade _____

IMMUNIZATIONS AND TESTS (shading represents required immunizations)

VACCINE	Enter Month, Day, and Year each immunization was given			BOOSTERS & DATES	
	DOSES				
Diphtheria and Tetanus (Circle): DTap, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
MMR 1 st dose after 1 yr of age	1 / /	2 / /			
Measles 1 st dose after 1 yr of age	1 / /	2 / /			
Mumps 1 st dose after 1 yr of age	1 / /	2 / /	2nd dose of Mumps		
Rubella after 1 yr of age	1 / /				
Hepatitis B	1 / /	2 / /	3 / /		
Hepatitis A (not required)	1 / /	2 / /	3 / /		
HIB (not required)	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	2nd dose of Varicella	Varicella Disease or Lab Evidence Date: _____	
Children Attending 7th Gr:				Tetanus, Diphtheria and Acellular Pertussis	
Meningococcal Conjugate (MCV)	_____ / _____ / _____			Tdap _____ / _____ / _____	
Other	_____ / _____ / _____				

These requirements allow for medical reasons and religious beliefs. If your child is exempt from immunizations, he/she may be removed from school during an outbreak.

- MEDICAL EXEMPTION The physical condition of the above named child is such that Immunization would endanger life or health.
- RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

FOR ATTENDANCE IN ALL GRADES:

Children need the following:

- 4 doses of tetanus* (1 dose on or after the 4th birthday)
- 4 doses of diphtheria* (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles** (MMR)
- 2 doses of mumps ** (MMR)
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of Varicella (chickenpox) vaccine or history of disease

*Usually given as DTP or DtaP or DT or Td

**Usually given as MMR

CHILDREN ATTENDING 7TH GRADE NEED THE FOLLOWING:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (MCV)

Pennsylvania's school immunization requirements can be found in 28 PA.CODE CH.23 (School Immunization)
Contact your health care provider or 1-877 PA HEALTH for more information

Date _____

Physician Signature _____

Physician Address _____

37(11/11)

Physician Telephone _____

**Council Rock School District
Bucks County Pennsylvania**

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ DATE OF BIRTH _____ SEX _____
M F

ADDRESS _____
Last First Middle

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

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter month, day & year each immunization was given DOSES			BOOSTERS & DATES		
	1	2	3	4	5	Tdap 7 th gr / /
Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /	
Polio (circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /	
MMR 1 st dose after 1 yr of age	1 / /	2 / /				
Measles 1 st dose after 1 yr of age	1 / /	2 / /				
Mumps 1 st dose after 1 yr of age	1 / /	2 / /				
Rubella after 1 yr of age	1 / /					
Hepatitis B	1 / /		2 / /		3 / /	
Hepatitis A (not required)	1 / /		2 / /		3 / /	
HIB (not required)	1 / /		2 / /		3 / /	
Varicella	1 / /		2 / /			Varicella Disease or Lab Evidence Date: _____
Entering 7 th grade: Meningococcal Conjugate (MCV)			1 / /			
Other	1 / /		2 / /		3 / /	

- MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.
- RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

If Applicable:

Tuberculin Tests	Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)			Signature		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on _____ (Date)

Result of Diagnostic Studies: _____ (Date)

Preventive Anti-Tuberculosis - Chemotherapy ordered: NO YES _____ (Date)

Significant Medical Conditions (√)

	Yes	No	If Yes, Explain
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

COUNCIL ROCK SCHOOL DISTRICT

FAMILY HEALTH HISTORY

Child's Name _____ M F Birth Date _____

Address _____

Telephone _____ Birth Place _____

Father's Name _____ Mother's Name _____

Family Doctor _____ Telephone _____

Name of Pre-School Program _____

CHILD'S HISTORY

Does your child have:	Yes	No	Has your child had:	Yes	Date (yr)
Allergies	_____	_____	Chickenpox	_____	_____
If yes, explain _____			Head Injury/Concussion	_____	_____
Asthma	_____	_____	Febrile Convulsions	_____	_____
Ear Infections	_____	_____	Hepatitis	_____	_____
Convulsions	_____	_____	Measles, German	_____	_____
Frequent Colds	_____	_____	Measles, Regular	_____	_____
Frequent Sore Throats	_____	_____	Mononucleosis	_____	_____
Speech Difficulties	_____	_____	Mumps	_____	_____
Vision Problems	_____	_____	Polio	_____	_____
Other Concerns	_____	_____	Rheumatic Fever	_____	_____
Is your child on any medications _____			Scarlet Fever	_____	_____
List medications _____			Whooping Cough	_____	_____
			Other _____		

If your child has a history of Head Injury/Concussion – Please explain: _____

Did mother have measles or other serious illness during pregnancy? _____

Was oxygen administered to your child at birth? _____

Any serious illnesses or surgery? _____ If yes, what? _____

Is your child under medical treatment? _____ If yes, explain _____

State any other information which would aid the school in a better understanding of your child.

Family History

Is there a history of:	Yes	Relationship
Allergies	_____	_____
Asthma	_____	_____
Color Deficiency (Blindness)	_____	_____
Convulsive Disorders	_____	_____
Diabetes	_____	_____
Hearing Disorders	_____	_____
Reading Disorders	_____	_____
Tuberculosis	_____	_____
Visual Disorder	_____	_____
Other	_____	_____

Child's Developmental History

Birth Weight _____

Age Walked _____

Age Talked _____

Age Toilet Trained _____

Age Stopped Bed-Wetting _____

_____ Date

_____ Signature of Parent/Guardian

**COUNCIL ROCK SCHOOL DISTRICT
STUDENT HEALTH & EMERGENCY CONTACT INFORMATION**

COMPLETE THIS SECTION FOR ELEMENTARY SCHOOL STUDENTS

Student Name: _____ School: _____ Grade: _____

Student Health & Emergency Contact Information:					
Local persons to be called in case of emergency (accident, illness or dismissal) if a parent cannot be reached, in order of preference:					
Last Name:	First Name:	Relationship:	Home Phone:	Work Phone:	Cell Phone:
Physician's Name: _____		Office Phone: _____		Office Fax: _____	
Significant Health Problems: _____					
Permanent childcare arrangements (circle one): AM PM					
Name of Care Giver: _____		Phone: _____		Cell Phone: _____	
The school nurses have standing orders from the school district medical advisor to administer acetaminophen (generic Tylenol) when necessary with parental consent. Please initial** below if you permit your child to receive this medication.					
My child may receive acetaminophen according to the standing orders. **Initial here _____					
In the event that all named persons on this form (guardians, physicians, emergency and other contacts) cannot be reached, I authorize the officials of Council Rock School District to take whatever action is deemed necessary, in the event of a health emergency for my child.					
_____		_____		_____	
<i>Parent / Guardian Name (Please Print)</i>		<i>Date</i>		<i>Parent / Guardian Signature</i>	

COMPLETE THIS SECTION FOR SECONDARY SCHOOL STUDENTS

Student Name: _____ School: _____ Grade: _____

Student Health & Emergency Contact Information:					
Local persons to be called in case of emergency (accident, illness or dismissal) if a parent cannot be reached, in order of preference:					
Last Name:	First Name:	Relationship:	Home Phone:	Work Phone:	Cell Phone:
Physician's Name: _____		Office Phone: _____		Office Fax: _____	
Significant Health Problems: _____					
The school nurses have standing orders from the school district medical advisor to administer acetaminophen (generic Tylenol) when necessary with parental consent. Please initial** below if you permit your child to receive this medication.					
My child may receive acetaminophen according to the standing orders. **Initial here _____					
My child may receive ibuprofen according to the standing orders. **Initial here _____					
In the event that all named persons on this form (guardians, physicians, emergency and other contacts) cannot be reached, I authorize the officials of Council Rock School District to take whatever action is deemed necessary, in the event of a health emergency for my child.					
_____		_____		_____	
<i>Parent / Guardian Name (Please Print)</i>		<i>Date</i>		<i>Parent / Guardian Signature</i>	

COUNCIL ROCK SCHOOL DISTRICT
Bucks County, Pennsylvania

Dear Parent or Guardian,

Prescribed medications which are necessary for the health of a child may be administered during the school day. It is recommended that, whenever possible, all medications be administered at home by the parent or guardian. The first dose of any new medication should always be administered at home to ensure close observation of any adverse reaction. If your physician decides it is necessary for your child to receive a medication during school hours, the parent or guardian may request that the school nurse administer the physician prescribed medication at scheduled times. The following school district policies apply to all medications brought to school:

- The "Permission to Administer Medications in School" form below must be completed and signed by the physician and the parent or guardian for all medications - both prescribed and over-the-counter.
- Medication must be sent to school in the original pharmacy container with the current prescription label. Upon request, pharmacies can prepare a duplicate container to be used for school.
- All medications must be brought directly to the health office by the parent, guardian, or a responsible adult designated in writing by the parent or guardian.
- Students who have medications of any kind in their possession (in lunch boxes, school bags, etc.) may be considered in violation of the school district drug and alcohol policies and may be subject to disciplinary action.
- A licensed registered nurse employed by the school district shall be the only district employee responsible for the administration of medications.
- If a licensed registered nurse is unavailable to administer the medication on a time schedule determined by the student's physician, the school nurse and parent or guardian will develop a care plan to ensure that the dosage is administered as scheduled.
- All medications are kept in the health office in a locked cabinet.
- Acetaminophen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of parent or guardian as noted on the student's emergency information form.
- Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to students in grades 7-12 with the signed permission of parent or guardian as noted on the student's emergency information form.

Please take this form to your physician and have the instructions recorded below regarding the administration of your child's medication.

Permission to Administer Medications in School

Date medication to start _____ Date to discontinue _____

Name of student _____ Grade/teacher _____

Diagnosis _____

Name of medication _____ Strength _____ Dosage _____

Frequency of administration _____ Recommended time of administration _____

Special instructions/effects to observe _____

Other medications this child is presently taking _____

Signature of physician _____

Telephone number of physician _____

I hereby give permission for the school nurse to administer this medication to my child during the school day.

Date _____ Signature of parent or guardian _____