Northern Lehigh School District

1201 Shadow Oaks Lane • Slatington, PA 18080
(P): 610-767-9800 x1004 • (F): 610-767-9826
(E): enrollment@nlsd.org • www.nlsd.org

Student Enrollment Information Sheet

Who may enroll students in NLSD?
Natural/Adopted Parents, Guardians, or Foster Parents who reside in Northern Lehigh School District may enroll a student.

What is the process to enroll a student in NLSD?
Enrollment takes place **by appointment** during the regular school calendar Monday through Friday 8:30am – 3:00pm at the District Office. ***Please note: Summer Days/Hours may vary.*** The average appointment to enroll (1) student takes approximately 15-20 minutes. Prior to scheduling an appointment, you must complete an enrollment packet and bring the required documents along with proofs of residency to the appointment.

What is included in the enrollment packet?

Kindergarten:
Enrollment Form
Parent Questionnaire
Health Questionnaire
Immunization Requirement
Medical Exam Form (**Kindergarten**)
DOH Physical Form
Dental Exam Form (**Kindergarten**)
DOH Dental Form
Medical Transportation Letter / Form
Transportation Request Form
Home Language Survey
Records Request (*if transferring mid-school year*)

Grades 1-12:
Enrollment Form
ACT 26 – Parent Affidavit regarding Safe Schools
Health Questionnaire
Immunization Requirement
Medical (**6th,11th**)
Dental Form (**3rd / 7th grade**)
Records Request
Medical Transportation Letter / Form
Transportation Request Form
Home Language Survey

In addition to the complete enrollment materials, you will need to bring the following to your appointment:

- **Original** Birth Certificate **If trouble obtaining, contact District in advance of appointment for further instructions*
- Immunization / Shot / Vaccination Records
- Legal Custody / Guardianship / Adoption / Foster documentation (*if applicable*)
- Any Educational records from previous school including:
  - For Special Education or Gifted Students: a copy of most recent IEP or GIEP or 504 Plan
- Valid photo ID: State Issued ID, Driver's License, Passport. ****Note: Cannot be not expired***
- Two (2) **different** proofs of residency (listing current address) within the district for parent/legal guardian:
  - Driver's license or State Issued ID – with updated address or address change card
  - Vehicle Registration / Insurance - with updated address
  - Current Utility / Credit card bill
  - Current Property Tax Document / Receipt
  - Moving Permit: *Contact Boro of Slatington, Walnutport or Washington Township – whichever applies.*
  - Signed Lease / Deed / Property Sales Contract / Mortgage Document
  - Current Bank Statement
  - Copy of **State/Federal Program** Enrollment / Medical Insurance Information
  - Multiple Occupancy Notarized Form – *if necessary. Inquire for further information*

NORTHERN LEHIGH SCHOOL DISTRICT
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K-12 GRADE ENROLLMENT FORM

STUDENT NAME: _____
LAST FIRST MI SUFFIX

ADDRESS_____

PHONE #_____ SEX: ___MALE ____FEMALE ____OTHER:

IDENTIFIES AS: _____

DATE OF BIRTH_____ CITY & STATE (OR COUNTRY) OF BIRTH_____

GRADE_____ REQUESTED START DATE_____ PREVIOUSLY ATTEND NLSD? __YES __NO

ARE PARENT/S **ACTIVELY** SERVING IN ANY BRANCH OF THE MILITARY? ___YES ___ NO
HAVE PARENT/S **PREVIOUSLY** SERVED IN ANY BRANCH OF THE MILITARY? ___YES ___ NO

ETHNICITY: IS THIS STUDENT HISPANIC OR LATINO? _____YES _____NO
RACE (Please check all that apply regardless of ethnicity):
_____AMERICAN INDIAN / NATIVE ALASKAN _____ ASIAN
_____BLACK / AFRICAN AMERICAN _____WHITE/CAUCASIAN
_____NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER _____ OTHER (specify): _____

PENNSYLVANIA SCHOOL ENTRY DATE_____

NAME OF PREVIOUS SCHOOL_____

ADDRESS OF PREVIOUS SCHOOL_____

_____

IS STUDENT A MIGRANT? _____ YES _____NO

INITIAL U.S. ENTRY DATE (IF FIRST TIME ENROLLING IN U.S. SCHOOL) _____

WHAT IS THE STUDENT'S FIRST LANGUAGE? _____

PREFERRED COMMUNICATION FROM SCHOOL ____ ENGLISH _____OTHER(LIST)_____

HAS STUDENT ATTENDED ANY US SCHOOL IN ANY 3 YEARS DURING THEIR LIFETIME? ____YES ____ NO

NAME OF OTHER PREVIOUS SCHOOL(S)	STATE	DATES ATTENDED

DOES STUDENT CURRENTLY HAVE AN IEP? _____ YES _____NO
DOES STUDENT CURRENTLY HAVE A GIEP? _____ YES _____NO
DOES STUDENT CURRENTLY HAVE A 504 PLAN? _____ YES _____NO

DO YOU HAVE A COPY?
___ YES ____NO
___ YES ____NO
___ YES ____NO

IS STUDENT A FOSTER CHILD? (*If **YES**, attach Certificate of Entrance that names foster parents.*) ___YES___NO

CONTINUED ON OTHER SIDE → → →

NORTHERN LEHIGH SCHOOL DISTRICT ENROLLMENT FORM CONTINUED:

___PARENT ___LEGAL GUARDIAN ___ FOSTER PARENT	___PARENT ___LEGAL GUARDIAN ___FOSTER PARENT
_____RESIDES WITH ___ CUSTODY DOCUMENTATION	_____RESIDES WITH ____ CUSTODY DOCUMENTATION
NAME	NAME
DAY PHONE	DAY PHONE
EMPLOYER	EMPLOYER
CELL PHONE	CELL PHONE
EMAIL	EMAIL
ADDRESS IF DIFFERENT FROM ABOVE _____ _____	ADDRESS IF DIFFERENT FROM ABOVE _____ _____
IF APPLICABLE:	**IF APPLICABLE:**
STEP-PARENT NAME	STEP-PARENT NAME
STEP-PARENT PHONE#	STEP-PARENT PHONE#
STEP-PARENT CELL #	STEP-PARENT CELL #
PERMISSION TO ACCESS STUDENT INFO ___ YES___ NO	PERMISSION TO ACCESS STUDENT INFO___ YES___ NO

If Guardian is other than Parent, additional documents will be required. Limitation of contact or correspondence to non-custodial parent must be supported with court order. *

EMERGENCY CONTACT	EMERGENCY CONTACT	
RELATIONSHIP	RELATIONSHIP	
NAME	NAME	
PHONE #	PHONE #	

OTHER CHILDREN LIVING IN HOUSEHOLD	OTHER CHILDREN LIVING IN HOUSEHOLD
NAME	**NAME**
DOB	DOB
SCHOOL ATTENDING	SCHOOL ATTENDING
NAME	**NAME**
DOB	DOB
SCHOOL ATTENDING	SCHOOL ATTENDING

PRINT PARENT / GUARDIAN NAME: _____

PARENT / GUARDIAN SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

LOCAL ID#_____ STATE ID#_____ PS ID#_____

DATE_____ ENTERED BY _____ 01/2023

Northern Lehigh School District

_____

Student's Name

KINDERGARTEN PARENT/GUARDIAN QUESTIONNAIRE

1. Has the student participated in any educational programs prior to Kindergarten? (i.e. Preschool, IU, Nursery School, Early Intervention, Head Start, other)
   ____YES ____ NO If YES, where:_____

   Was it a positive or a negative experience for the student and why?

   _____

   _____

2. Activity Level (Please check words that describe the student)

___always active	___slow in responding
___restless	___generally calm
___generally consistent in behavior	__generally inconsistent in behavior

3. Personality Traits: (please check words which usually describe the student's **HOME** behavior)

___shy	___outgoing
___quiet	___argumentative
___energetic	___self-confident
___stubborn	___talkative
___apprehensive	___cries easily
___independent	___exhibits self-control
___waits for help	___has temper tantrums

   Comments on activity level or personality traits:_____

   _____

4. Does your child receive any home or school-related services? If so, what services and through which agency?

   _____

5. Does your child have an IEP through the Early Intervention Program? ___ YES ___ NO
6. Is the student able to use the bathroom independently? ___YES ___NO
7. How often does the student have bathroom accidents? ___Frequently ____Sometimes ___Never
8. Do you have any concerns related to your child's transition into Kindergarten? If so, please use the back of this form to provide details:

If you would like to discuss your concerns, please call the Main Office at Peters Elementary School at (610)767-9827 and ask to speak to the principal

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SCHOOL HEALTH QUESTIONNAIRE

To Parent(s) / Guardian(s):

The information request on this form will be of assistance to the school district in determining the health status of the student and assisting them to receive maximum benefits from this education opportunity.

Student's Name: _____

Date of Birth: _____Sex: ___ M ___F _____Other, Identifies as: _____

Student's Address: _____

Parent(s) / Guardian(s) Name(s): _____

Phone number(s): _____

_____
SIGNATURE OF PARENT / GUARDIAN COMPLETING FORM Date

ATTACH COPY OF IMMUNIZATION RECORD

Name of Student's Physician: _____ Phone: _____

Name of Student's Dentist: _____ Phone: _____

1. Was the student's hearing ever tested? ___YES ____NO
   If YES, when? _____ Name of Examiner: _____
   Results: _____
2. Has the student ever had an eye examination? ___YES ___ NO
   If YES, when? _____ Name of Examiner: _____
   Were glasses prescribed? ___YES ____NO Must the child wear them constantly? ___YES____NO
3. List Medications, herbal supplements/home remedies currently being taken:

Medication Name	*Dosage*	*How often*

4. List Hospitalizations and/or Surgeries:

Date	*Description of why hospitalized / type of surgery*

5. Tuberculosis Skin Test: ____ Never had one ____ Negative Test _____ Year ____Positive Test _____ Year
6. Does the student have an Epi Pen / Epi Pen Jr. ___YES ___ NO

CONTINUE ON OTHER SIDE → → →

7. Was there any complication during pregnancy and / or labor / delivery? ___YES ___NO
   If YES, Explain: _____
8. Is the student presently under medical treatment? ___YES ____NO
9. Has the student had any serious accidents? ___YES ____NO
   If YES, explain: _____
   _____
10. Describe briefly, any traumatic events that the student has experience (for example: death of close relative, divorce, family crisis, etc.): _____
    _____
    _____
11. List specific Allergies and Treatment: _____
    _____
    _____
    _____

Health History, Include Infancy & Early Childhood History

Check below any of the following illnesses / conditions the student has had. Indicated approximate date of onset (first symptoms) and explain, treatment and health professionals involved.

Check		Check		Check	
	Arthritis		Difficulty with dressing self		Mumps
	Asthma		Diphtheria		Nail biting
	Bedwetting		Ear Infections		Negative reaction to affection
	Bladder Infection		Eczema		Pneumonia
	Blood disorder		Extremely tired		Polio
	Blood pressure – HIGH		Fainting		Poor coordination
	Blood pressure – LOW		Frequent headaches		Rheumatic Fever
	Bowel / Bladder problems		Frequent stumbling / falling		Rubella (German Measles)
	Broken Bones		Headaches / Migraines		Scarlet Fever
	Bronchitis		Heart Murmur		Seizures / Convulsions
	Cancer		Heart Problems		Short Attention Span
	Chickenpox		Hepatitis		Speech is not clear
	Concussion		High Fever		Stuttering
	Defiance of authority		Hives		Temper tantrums
	Diabetes		Hyperactivity		Thyroid Disease
	Difficulty cutting with scissors		Influenza		Tonsilitis
	Difficulty expression needs		Kidney Disease		Tuberculosis
	Difficulty holding a pencil		Malaria		Typhoid
	Difficulty playing with peers		Measles		Unusual fears
	Difficulty separating from parent(s) / guardian(s)		Meningitis		Unusual tics / twitches
	Difficulty understanding directions		Mono		Whooping Cough
	Other:		Other:		Other:

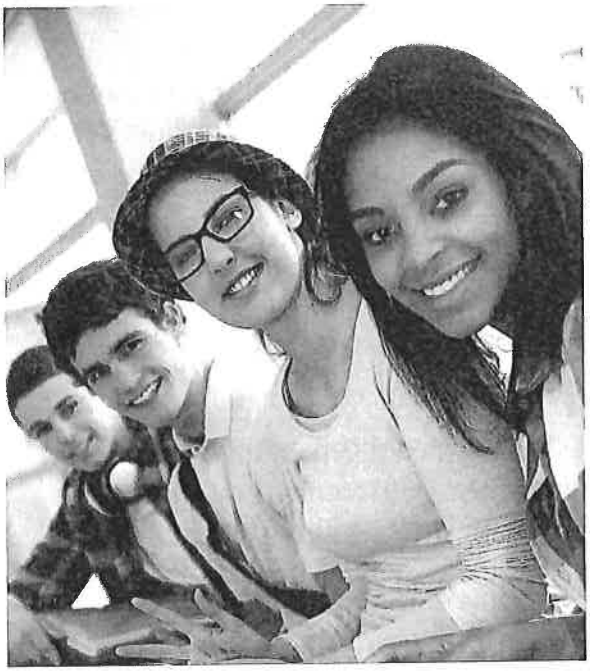
Comments: _____
_____

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*



ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

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

pennsylvania
DEPARTMENT OF HEALTH

REQUISITOS DE VACUNACIÓN ESCOLAR
PARA ASISTIR A LAS ESCUELAS DE PENSILVANIA

PARA ASISTIR A TODOS LOS GRADOS, LOS NIÑOS NECESITAN LAS SIGUIENTES VACUNAS:

- 4 dosis de la vacuna contra el tétanos, la difteria y la tos ferina acelular* (1 dosis a partir de cumplir los 4 años)
- 4 dosis de la vacuna antipoliomielítica (4ta dosis a partir de cumplir los 4 años y, al menos, 6 meses después de la dosis anterior)**
- 2 dosis de la vacuna contra el sarampión, las paperas y la rubéola***
- 3 dosis de la vacuna contra la hepatitis B
- 2 dosis de la vacuna contra la varicela o evidencia de inmunidad

** Por lo general, se aplica como DTP o DTaP o, si es recomendable desde el punto de vista médico, como DT o Td.*

*** No es necesaria una cuarta dosis si la tercera dosis se administró a partir de los 4 años de edad y, al menos, 6 meses después de la dosis anterior.*

**** Por lo general, se aplica como MMR.*

EL PRIMER DÍA DE ESCUELA, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido, al menos, una dosis de las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

• Si el niño no tiene todas las dosis antes mencionadas, si necesita dosis adicionales y la siguiente dosis es apropiada desde el punto de vista médico, debe recibir dichas dosis en el transcurso de los primeros cinco días de clases o corre el riesgo de ser excluido de la escuela. Si la siguiente dosis no es la dosis final del esquema, debe presentar también un plan médico (tarjeta roja y blanca), en el transcurso de los primeros cinco días de clases, para recibir las vacunas obligatorias o corre el riesgo de ser excluido de la escuela.

• Si el niño no tiene todas las dosis antes mencionada, si necesita dosis adicionales y la siguiente dosis no es apropiada desde el punto de vista médico, debe presentar un plan médico (tarjeta roja y blanca), en el transcurso de los primeros cinco días de clases, para recibir las vacunas obligatorias o corre el riesgo de ser excluido de la escuela.

• Se debe cumplir con el plan médico o el niño corre el riesgo de ser excluido de la escuela.

PARA ASISTIR A 7° GRADO:

• 1 dosis de la vacuna contra el tétanos, la difteria y la tos ferina acelular (Tdap) el primer día de 7° grado.
• 1 dosis de la vacuna antimeningocócica conjugada (MCV) el primer día de 7° grado.

EL PRIMER DÍA DE 7° GRADO, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

PARA ASISTIR A 12° GRADO:

• 1 dosis de MCV el primer día de 12° grado. Si se administró una dosis a partir de los 16 años de edad, dicha dosis será considerada como la dosis de 12° grado.

EL PRIMER DÍA DE 12° GRADO, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

Las vacunas obligatorias para el ingreso escolar, 7° grado y 12° grado siguen siendo obligatorias cada año escolar posterior.

Estos requisitos permiten las siguientes exenciones: motivos médicos, creencia religiosa o firme convicción filosófica, moral o ética. Incluso si su hijo está exento de la vacunación, podría ser excluido de la escuela durante un brote de una enfermedad evitable mediante vacunas.

Código de Pensilvania n.° 28, capítulo 23 (Vacunación escolar).
Comuníquese con su proveedor de atención médica o llame al 1-877-PA-HEALTH para obtener más información.

pennsylvania
DEPARTMENT OF HEALTH

Northern Lehigh School District

Medical Examination Form

Dear Parent(s) / Guardian(s):

The Pennsylvania School Health Act requires a medical examination of every student entering school for **the first time in Kindergarten, Sixth grade, and Eleventh grade**.

The Law gives you a choice of having the examination done by the school physician or by your family physician at your own expense. Because your family physician has a better knowledge of the student's past physical history than the school physician and is in the best position to recommend necessary remedial treatment, and give necessary immunizations, we urge you to consider having the examination done by your family physician.

If you choose to take the student to your family physician, the attached Family Physician Report must be returned to the school by December 31st of the current school year. The private physician examination must have been completed no earlier than July 1st of the previous school year.

If the physician examination, as required through the Department of Health, is not completed and proof submitted to the appropriate school nurse, the student may be excluded from school.

If you choose to have the examination done by the school physician during the school year, you will be advised of any condition requiring the attention of your family physician.

****Please complete and sign the lower portion of the form and return to the school nurse. ****

Sincerely,

Superintendent of NLSD

****

(COMPLETE, SIGN, & RETURN THIS PORTION TO THE SCHOOL NURSE)

STUDENT'S NAME: _____

SCHOOL BUILDING: _____ GRADE: _____

CHOOSE ONE OF THE FOLLOWING:

_____ I CHOOSE TO HAVE THE STUDENT'S PHYSICAL EXAMINATION DONE BY MY FAMILY PHYSICIAN. Date of Exam by Family Physician: _____

_____ I CHOOSE TO HAVE THE STUDENT'S PHYSICAL EXAMINATION DONE BY THE SCHOOL PHYSICAN AND GIVE MY PERMISSION BY SIGNING BELOW.

_____

Parent(s) / Guardian(s) Signature Date

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

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

Signature of parent / guardian / emancipated student _____ Date _____

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

STUDENT NAME:

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

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

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____ 20_____

Print name of examiner _____

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

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

 STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

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

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

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

Northern Lehigh School District

Dental Form

Dear Parent(s) / Guardian(s):

The Pennsylvania School Health Act requires a dental examination of every student entering school for **the first time in Kindergarten, Third grade, and Seventh grade**.

The Law gives you a choice of having the examination done by the school dentist or by your family dentist at your own expense. Because your family dentist has a better knowledge of the student's past dental history than the school dentist and is in the best position to recommend necessary remedial treatment, we urge you to consider having the examination done by your family dentist.

If you choose to take your child to your family dentist, the attached Family Dentist Report must be returned to the school by December 31st of the current school year. The private dental examination must have been completed no earlier than July 1st of the previous school year.

If the dental examination, as required through the Department of Health, is not completed and proof submitted to the appropriate school nurse, your child may be excluded from school.

If you choose to have the examination done by the school dentist during the school year, you will be advised of any condition requiring the attention of your family dentist.

****Please complete and sign the lower portion of the form and return to the school nurse. ****

Sincerely,

Superintendent of NLSD

****

(COMPLETE, SIGN, & RETURN THIS PORTION TO THE SCHOOL NURSE)

STUDENT'S NAME: _____

SCHOOL BUILDING: _____ GRADE: _____

CHOOSE ONE OF THE FOLLOWING:

____ I CHOOSE TO HAVE THE STUDENT'S DENTAL EXAMINATION DONE BY MY FAMILY DENTIST.

Date of Exam by Family Dentist: _____

____ I CHOOSE TO HAVE THE STUDENT'S DENTAL EXAMINATION DONE BY THE SCHOOL DENTIST AND GIVE MY PERMISSION BY MY SIGNATURE BELOW.

_____

Parent(s) / Guardian(s) Signature Date

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD			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	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

Northern Lehigh School District

Transportation Department 610-767-9846 / 610-767-7706

1201 Shadow Oaks Lane • Slatington, Pa • 18080

CONFIDENTIAL

TRANSPORTATION EMERGENCY CONTACT / MEDICAL INFORMATION RELEASE FORM

►This form is used for TRANSPORTATION ONLY◄

PLEASE PRINT

EMERGENCY CONTACT INFORMATION FOR STUDENT

Student's Last Name First Middle

Date of Birth ☐Male ☐Female ☐Other: Identifies as_____

Parent / Guardian's Name

Telephone: ☐Cell ☐Home ☐Work (check all that apply)

Street Address

City, State, Zip Code

Employer

Email Address

Parent / Guardian's Name

Telephone: ☐Cell ☐Home ☐Work (check all that apply)

Street Address

City, State, Zip Code

Employer

Email Address

MEDICAL INFORMATION FOR STUDENT

List Allergies / Chronic Issues Driver Should Be Aware of: (i.e. Allergies, Asthma, Diabetes)

List Medications Student is **CURRENTLY** taking

Student's Physician / Pediatrician Name

Student's Physician / Pediatrician Telephone

PERMISSION TO RELEASE EMERGENCY FORM

I give permission for this Emergency Medical Form to be given to Van/Bus Drivers and Emergency Responders.

Parent or Guardian Printed Name / Signature Date

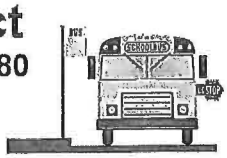
NOTE: FORM IS VALID FOR THE CURRENT SCHOOL YEAR AND EXPIRES AT THE END OF THE SCHOOL YEAR.

❑ NEW

❑ CHANGE

Northern Lehigh School District

1201 Shadow Oaks Lane • Slatington, PA 18080
(P): 610-767-9846 • (F): 610-767-9809
(E): transportation@nlsd.org



REQUEST FOR TRANSPORTATION

Student's Name: _____ D.O.B. _____ Grade: _____

NLSD Building: ❑Peters Elem ❑Slatington Elem ❑NL Middle School ❑NL High School ❑ Other

Student Home Address: _____

_____

Parent(s) / Guardian Name: _____

Parent(s) / Guardian Email address: _____

Parent(s) / Guardian(s) ❑Home ❑Work❑Cell# _____

Transportation Request is for:

❑ Both Morning AND Afternoon ❑ Morning ONLY ❑Afternoon ONLY

Other Stop Address / Location Requested if not home address ❑Daycare ❑Babysitter ❑ Other

_____

Requested Start Date _____ Stop Date: _____

Name / Relationship / (Cell) Phone Number of Primary Person Meeting the Bus:

_____

*Northern Lehigh School District **requires three (3) working business days after the Transportation Department receives the request form** to update the necessary required rosters and put into place the proper transportation arrangements. Adding new stops may require additional days because of the evaluation of the safety of the stop location, route adjustment and the proper communication of the change to all students affected. The completed form can be returned to student's school building or emailed to transportation@nlsd.org .

Parent / Guardian Signature: _____ **Date:** _____

KINDERGARTEN PARENTS/GUARDIANS: Must complete other side

*****FOR OFFICE USE ONLY*****

❑Add ❑Change

Remove From:

Bus # _____**(AM)** **Pickup Time** _____

Bus # _____

Location

Bus # _____**(PM) Drop off Time**

Location

Approved by_____

Effective date: _____

>> KINDERGARTEN PARENTS/GUARDIANS MUST COMPLETE THIS SIDE OF THE FORM <<

Northern Lehigh School District Kindergarten students will not be permitted to exit the bus at their designated bus stop unless a parent / guardian or other authorized individual listed below is present to meet the child. For the student's safety, NL kindergarten students will be returned to the Y-Care Program at Peters Elementary. The school will contact the parent/guardian to pick up the student at Peters Elementary.

Early Intervention students, Non-Public, or Charter School Kindergarten students also will not be permitted to exit the bus at their designated bus stop unless a parent or other authorized individual listed below is present to meet the student. For the student's safety, they will be returned to their school.

The following people are authorized to meet:

_____

(Student's name)

NAME	ADDRESS/TELEPHONE #	RELATIONSHIP TO STUDENT

All authorized individuals listed must provide photo identification to the bus driver upon request. Additions or changes to your list of authorized individuals can only be made through the District Office – Transportation Department by calling 610-767-9846 or emailing transportation@nlsd.org. **NOTE: Bus drivers do not have the authority to make changes and cannot accept notes.** Detailed bus rules and regulations are included in your student handbook or listed under the Transportation Policy on www.nlsd.org .

rev04/2021

NORTHERN LEHIGH SCHOOL DISTRICT

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

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

Student's first name:_____

Student's last name: _____

Student's Date of Birth: _____
(Month / Day / Year)

Questions for Parents or Guardians:

1. Is a language other than English spoken in the Student's home? ☐ No ☐ Yes
(If Yes, Specify Language): _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes
(If Yes, Specify Language): _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature:_____ **Date:** _____

Interpreter Provided: ☐ No ☐ Yes

Adapted from No. 138-AR-2
Revised April 2021
From PDE 2017

Northern Lehigh School District
Centralized Registration

1201 Shadow Oaks Lane • Slatington, PA 18080
(P): 610-767-9800 Ext. 1004 • (F): 610-767-9826
Email: Enrollment@nlsd.org

Authorization for Release of Records to:			
☐Peters Elementary 4055 Friedens Rd Slatington, Pa 18080 (E): PERegistration@nlsd.org (P): 610-767-9827 (F): 610-767-9857	☐ Slatington Elementary 1201 Shadow Oaks Ln Slatington, Pa 18080 (E): SERegistration@nlsd.org (P): 610-767-9821 (F): 610-767-9808	☐ NL Middle School 600 Diamond St Slatington, Pa 18080 (E): MSRegistration@nlsd.org (P): 610-767-9812 (F): 610-767-9850	☐ NL High School 1 Bulldog Ln Slatington, Pa 18080 (E): HSRegistration@nlsd.org (P): 610-767-9837 (F): 610-767-9853

Student Name:_____ Date of Birth:_____ Grade:_____

I hereby authorize release of educational, medical, and health information records regarding the above-mentioned student to Northern Lehigh School District from:

Previous School / Physician, or Entity Name: _____

Address: _____

Phone # _____ Fax # _____

The following documents are being requested **IMMEDIATELY to continue processing initial enrollment. **Please email to ENROLLMENT@NLSD.ORG or if necessary, Fax to: 610-767-9826**

Please release all records that applies to the student to the NLSD Building checked above:

- ☐ Birth Certificate / Date of Birth documentation
- ☐ Immunizations / Medical Records
- ☐ Academic Records
- ☐ Standardized Test Scores (i.e: PSSA's, KEYSTONES)
- ☐ IQ Tests
- ☐ Attendance Records
- ☐ Transcripts/ Report cards
- ☐ Discipline Records
- ☐ Individual Education Plans
- ☐ IEP / NOREP / ER / RR
- ☐ GWR / GIEP / NORA
- ☐ Section 504 Service Agreement
- ☐ Any other pertinent education records

I understand and acknowledge that to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this consent is limited for the purposes and to the person listed above and will be effective for one (1) year after the date of my signature, unless otherwise specified. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

_____

(Parent / Guardian Signature) (Date)

FOR OFFICE USE ONLY

NLSD ID #_____ PA SECURE ID #_____ DATE_____ INITIALS:_____

rev 04/21