



Mountain View School District
11748 State Route 106
Kingsley, PA 18826

Registration Procedures

Welcome to the Mountain View School District, home of the Eagles!

Registration packets can be picked up in advance at the guidance office (high school) or the main office (elementary). Or you it can be downloaded from the district webpage at www.mvsd.net.

Hours of registration are 8:30 am to 2:00 pm, Monday thru Friday, excluding emergency closures or holidays. Please use the following guidelines to make sure you have all the necessary documents.

What to bring when you register your child:

- **Two Proofs of Residency in the Mountain View School District**

Proof of residency acceptable documentation includes: a deed, a lease, current utility bill, current credit card bill, property tax bill, vehicle registration, driver's license, DOT identification card. A district may require that more than one form of residency confirmation be provided. However, school districts and charter schools should be flexible in verifying residency and should consider what information is reasonable in light of the family's situation. See the paragraph on Homeless Students for guidance in that situation.

A parent/adoptive parent, guardian, foster parent or a district resident having care or charge of a child may enroll a student in MVSD and the parent/guardian/resident must come into the office in person to complete the enrollment process. If a resident of the District requests that a student be enrolled whose parent(s) live outside the District, an Affidavit must be completed.

- **Proof of Guardianship**

Legal custody agreement (if applicable) a copy to be placed in the student's file.

- **Proof of Age**

Birth certificate, notarized copy of birth certificate, baptismal certificate or record of baptism (notarized or duly certified) showing date of birth, valid passport, and paper from parent or relative signed in front of a notary (affidavit) showing date of birth or previous school record indicating date of birth.

- **Record of Immunizations Required by Law**

State law requires that a complete record of immunizations be provided. You can get a copy of your child's health records from the school you are withdrawing from. Immunization records are also available from you doctor's office. Your former district or medical office can also provide a written statement regarding required immunizations or required series are in progress, with records to follow.



Mountain View School District

11749 State Route 106

Kingsley, PA 18826

570-434-8525

Registration Procedures

In order to establish and verify your residence within the Mountain View School District, documentation is required. All paperwork in the new student enrollment packet must be completed and notarized where indicated. All forms must be signed by a parent, guardian, placement agency or responsible party (indicated by a 1302 or 1305 form). If you are a parent relying on a custody agreement or court order for the basis of enrolling your child, please provide verification of the custody agreement/court order. All procedures are in accordance with the Pennsylvania School Code and Regulations 11.11 and 11.19 of the Pennsylvania State Board of Education, Sections 1301 and 1302, which authorize Mountain View School District to request proof of residence or guardianship prior to admission to our school programs.

Student Registration Requirements

Two Proofs of Residency in the Mountain View School District

- May be any of the following: Deed, lease, sales agreement, mortgage information, driver's license, automobile registration, bank accounts, utility bills, property tax bill, etc. indicating a physical address within the Mountain View School District. A post office box will not be accepted.

Proof of Child's Age

- Birth certificate, or notarized copy of birth certificate of the student, passport, baptismal certificate, prior school records, etc. can be utilized.

Proof of Immunizations Required by Law

- You may provide a copy of your child's health records from the school you are leaving or a statement regarding required immunizations, with records to follow. Immunization records are also available from your doctor's office.

Home Language Survey

- This form is included in the enrollment packet and is required by law.

Parental Registration Statement

- Discipline Records, upon request as per Act 26.

Proof of Guardianship, If Applicable

- Legal custody agreement or order to be placed in the student's file

I have read and I understand the information listed above.

Parent/Guardian Signature

Date

McKinney-Vento Act Residency and Educational Rights Information

(Questionnaire must be completed for each student.)

The McKinney-Vento Act was created with the goal of ensuring the enrollment, attendance, and success of homeless children and youth in school. The McKinney-Vento Act provides certain rights for homeless students. This includes waiving certain requirements such as proof of residency when students are enrolling and allowing eligibility for certain services.

When families and students find themselves in transition due to their housing situation, it is important that they know their rights regarding education. If students meet the requirements as stated in the McKinney-Vento Act (42 U.S.C 11431 et seq., Title VII, Subtitle B), their rights are as follows:

- Students may attend their school of origin or the school where they are temporarily residing.
- Students must be provided a written statement of their rights when they enroll
- Students may enroll without school, medical or similar records that might not be readily available
- Students have a right to transportation to school
- Students must be provided a statement explaining why they are denied enrollment or any other services.
- Students must receive services, such as transportation, while disputes are being settled.
- Students are eligible for Title I services. *Educational services for which the homeless student meets eligibility criteria including services provided under Title I of the Elementary and Secondary Education Act or similar State or local programs, educational programs for students with limited English proficiency.*

According to the U.S. Department of Education, people living in the following situation are considered homeless:

**Doubled-Up with family or friends due to loss of housing or economic hardship*

-Sharing housing of other persons implies that the child or youth is staying in someone else's residence

-Due to the loss of housing-implies that the student has no personal housing available

-Economic hardship-implies that financial resources have forced the family or youth to leave the personal residence and share housing due to an inability to pay the rent/mortgage and other bills

Cooperative living arrangements among families or friends, even where people are living together to save money, are not considered to be a homeless situation.

**Living in motels and hotels for lack of other suitable housing*

**Runaway and displaced children and youth- Unaccompanied Youth*

**Living in a shelter*

**Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, housing not fit for habitation*

Please complete the attached form and return it to your school office. Questions may be directed to the Principal or Director of Special Services/McKinney-Vento Liaison at 570-434-8525.

McKinney-Vento Residency Form

Student Name _____

Date of Birth _____

Grade Level _____

The McKinney-Vento Homeless Assistance Act defines "homeless" as individuals who lack a fixed, regular, and adequate nighttime residence. This includes children who are temporarily sharing the housing of other persons due to the loss housing or economic hardship.

Does not apply; student is not homeless

Please check one of the following statements if your family is experiencing temporary homelessness:

Living in a shelter, including transitional housing shelters

Please provide the name of the shelter- _____

Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, housing not fit for

habitation- Please provide information regarding area in which student is living- _____

Living in hotels/motel for lack of other suitable housing- Please list the name and address of hotel/motel:

Doubled-Up; Temporarily living with family or friends due to lack of adequate housing or financial conditions. Please provide address of where the student is living:

Please answer the following if you checked one of the four boxes above:

How long to you expect to be at this address? _____

Are you seeking permanent housing? _____

Date student moved to this address? _____

Is a parent living in the home with the student? _____

If no, with whom is the student living? _____ Relationship _____

Place an "X" indicating the appropriate precipitating event resulting in the loss of housing.

Abandonment		Left Home	
Act of Nature		Parent/Guardian Hospitalized	
Death of Parent/Guardian		Parent/Guardian Incarcerated	
Domestic Violence		Parental Job Loss/Loss of Income	
Eviction		Other Poverty-related situation	
Fire		Other	

The School may contact you if clarification or transportation is needed.

Please proceed to the back of this page to complete the form.

We have read the information provided and indicated our living circumstances above with regard to the McKinney-Vento Act. I affirm that the information is true and accurate. I have been advised of my rights and my child's rights under the McKinney-Vento Act.

Signature of Parent/Guardian/Unaccompanied Youth

Date

Office Use Only:

_____ Does qualify under McKinney-Vento Act

_____ Does NOT Qualify

McKinney-Vento Liaison/Appointee Signature

Date

District Liaison and Information:

Erica Loftus
Director of Special Services/McKinney-Vento Liaison
11748 State Route 106
Kingsley, PA 18826
Phone: 570-434-8439
Fax: 570-434-8357

PA ECYEH Region 7 Coordinator
Jeff Zimmerman
Luzerne Intermediate Unit 18
368 Tioga Avenue
Kingston, PA 18704
Phone: 570-718-4613
Fax: 570-287-5721
<http://www.liu18.org/index.php/ecyeh>



Mountain View School District
11748 State Route 106
Kingsley, PA 18826
Ph. 570.434.8625 - HS
Ph. 570.434.8433 - Elementary

Parental Registration Statement

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

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 action of offense involving a weapon, alcohol or drugs, or for the willful infliction or injury to another person or for any act of violence committed on school property."

Please complete the following:

I herby 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 the Commonwealth or any other state for an act or 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.

If this student has been or is presently suspended or expelled from another school, please complete:
Name of the school from which student was suspended or expelled:

Dates of suspension or expulsion: _____
(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion: _____

Notice: Any willfully 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.

Parent/Guardian Signature

Date



Mountain View School District
11748 State Route 106
Kingsley, PA 18826
Ph: 570-434-2180

Mountain View School District Residency Affidavit

Instructions to Resident: This form is to be completed by the student's parent or legal guardian. This form must be signed/witnessed by a school district employee. You must submit a separate Residency Affidavit for each child enrolled in the district.

Student Information:

Student Name: _____
Legal First Name Legal Middle Name Legal Last Name

Student Date of Birth: ____/____/____

Do you live in the Mountain View School District and does the child live with you? Yes No

Student Lives With: *(Print Name(s) and check relationship to student.)*

Parent or Guardian Name: _____
Legal First Name Legal Middle Initial Legal Last Name

Relationship to Student: Father Stepfather Guardian Foster Parent Other _____

Parent or Guardian Name: _____
Legal First Name Legal Middle Initial Legal Last Name

Relationship to Student: Mother Stepmother Guardian Foster Parent Other _____

Address: Please note that post office boxes are not acceptable as a residence address but may be used as a mailing address below.

Physical Address: _____

Mailing Address: _____

Phone Number: _____

Parent/Guardian Signature Date



Mountain View School District

Student Information Sheet

(Please print legibly)

*Today's Date: ____/____/____

* Enrollment Date: ____/____/____

Resident District of Parent/Guardian: _____

School Student ID #: _____ * Grade: _____ * Gender: _____ * Birth Date: ____/____/____

*Last Name: _____ * Suffix: _____ * First: _____ * Middle: _____

*Phone: _____ *9th grade entry date ____/____/____ * City of Birth: _____

Does this student have a prior enrollment record at Mountain View? Yes No

Are you as the parent/guardian an ACTIVE member of the military? Yes No

Student's E-mail: _____

Other siblings that live in the same household & their grade level: _____

*Student's Physical Address: _____ *City: _____

*State: _____ *Zip Code: _____ *Twp: _____ *County: _____

*Student's Mailing Address (if different than physical address): _____ *City: _____ *State: _____ *Zip Code: _____

1st Contact

*Relationship to Student: _____ *Last Name: _____ *First: _____

*Mailing Address (Rural Mailbox or P.O. Box): _____

*City: _____ *State: _____ *Zip Code: _____

*Home Phone: _____ *Work Phone: _____ *Cell Phone: _____

E-mail: _____ Employer: _____

Student lives with: Yes No

2nd Contact

*Relationship to Student: _____ *Last Name: _____ *First: _____

*Mailing Address (Rural Mailbox or P.O. Box): _____

*City: _____ *State: _____ *Zip Code: _____

*Home Phone: _____ *Work Phone: _____ *Cell Phone: _____

E-mail: _____ Employer: _____

Student lives with: Yes No

3rd Contact (Emergency Contact)

*Relationship to Student: _____ *Last Name: _____ *First: _____

*Mailing Address (Rural Mailbox or P.O. Box): _____

*City: _____ *State: _____ *Zip Code: _____

*Home Phone: _____ *Work Phone: _____ *Cell Phone: _____

E-mail: _____ Employer: _____

4th Contact (Emergency Contact)

*Relationship to Student: _____ *Last Name: _____ *First: _____

*Mailing Address (Rural Mailbox or P.O. Box): _____

*City: _____ *State: _____ *Zip Code: _____

*Home Phone: _____ *Work Phone: _____ *Cell Phone: _____

E-mail: _____ Employer: _____

Ethnicity: (choose one) Hispanic/Latino Not Hispanic/Latino

Race: (choose one or more, regardless of ethnicity):

- White American Indian/Alaskan Native Asian Black/African America
- Native Hawaiian or other Pacific Islander

*Home Language: _____

*Migrant: Yes No

By Signing below, I verify that the information above and on the front of this sheet is complete and accurate.

Parent/Guardian Name (Please Print)

Parent/Guardian Name (Signature)

Date

Office Use Only

*Type of Residency: District Paid Tuition Fee Waived Tuition by District Tuition Paid/Parent
 Resident Non Resident 1305 (non-resident) Yes No If so, placing agency _____
 1305 (Resident) Yes No If so, placing agency _____ 1302 Yes No

*Resident District: _____ * District Funding Code _____ (AUN number)

*PA Secure ID #: _____ *Location Code of Residence: 4049 (HS) 7339 (Elem.) Other -- Code # _____

Birth Information:

*Country: _____ *State/Province: _____ *City: _____

*Birth Verification (Birth Certificate) Yes No

Additional Info: Date Registered _____ District Entry Date*: _____ Grade 9 Entry Date*: _____

School Entry Date*: _____ Guardian Relationship*: _____

Citizenship Information: (this information is required if student was NOT born in the U.S)

First Date Enrolled in State: _____ First Date Enrolled in US: _____

US Entrance Date: _____

*Entry Date: _____ *Entry Code: _____ *Percent Enrolled: _____

* Last School Attended: _____ Last Date Attended (Former School): _____

*PIMS Assessment Participation: _____ (Testing codes for grade levels)

Codes for Keystone Testing: Keystone testing (winter) _____ Keystone testing (spring) _____

Elementary Bldg. & Summer: Z Code _____

Signature of Principal: _____ Date: _____

STUDENT REGISTRATION BUS FORM

Student Name: _____

Parent Name: _____ Phone Number: _____

Grade: _____ Circle One: Male Female

Address: _____

Township: _____

Driving direction from the ELEMENTARY SCHOOL BUILDING to your home:

Does a Mountain View School District Bus go by your house? _____
If yes, do you know the bus number? _____

If there are any other students in your household that attend Mountain View School District please list them: _____

If there is a neighbor that has students that attend Mountain View School District, please list the students names: _____

For Business Office use only: Bus Assigned: _____ Roster Addition: _____ Versa Tran Addition: _____ Bus Assignment Sheet Sent to driver and Offices:
--



Educational Background Form

To assist us in serving the needs of your student, please read over all of the services listed below. Place a check next to any and all that apply or have applied to your student at any point in his/her academic career. If your student does not need any special services, please check the appropriate item. Thank you for providing this information.

Student Name: _____

Student Age: _____

Student Grade Level: _____

My student does not need any special services.

<input type="checkbox"/>	Child Study	<input type="checkbox"/>	Gifted Classes
<input type="checkbox"/>	Title I Math	<input type="checkbox"/>	Help in Regular Class
<input type="checkbox"/>	Title I Reading	<input type="checkbox"/>	Help in Special Class
<input type="checkbox"/>	Vision	<input type="checkbox"/>	504
<input type="checkbox"/>	Hearing	<input type="checkbox"/>	IEP
<input type="checkbox"/>	Speech	<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	
<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	
<input type="checkbox"/>	Counseling Services	<input type="checkbox"/>	
<input type="checkbox"/>	Wrap Around Services	<input type="checkbox"/>	

Previous School Attended: _____

Contact Person At Previous School: _____

Parent/Guardian Signature: _____

Date: _____



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 the responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

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

Child's First Name: _____

Child's Family Name: _____

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

Questions for Parents or Guardians

Is a language other than English spoken in the child's home?

Yes No

Does your child communicate in a language other than English?

Yes No

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

Parent/Guardian Signature: _____

Date: _____

Interpreter Provided Yes No

Administrative Signature: _____

MOUNTAIN VIEW SCHOOL DISTRICT

Elementary School
11748 State Route 106
Phone (570) 434-2181
Fax (570) 434-2755

Superintendent/Business Office
11748 State Route 106
Kingsley, Pennsylvania 18826-6941

Jr./Sr. High School
11749 State Route 106
Phone (570) 434-2501
Fax (570) 434-9582

Phone (570) 434-2180

Fax (570) 434-2404

Date _____

Berkheimer Tax Administrator
50 North 7th Street
Bangor, PA 18013

To Whom It May Concern:

Listed below are the name(s) of the parent(s) of a student(s) who have recently entered the Mountain View School District. By sending this information to you, we assume that it will be used for the sole purpose of updating the Earned Income Tax rolls for the Mountain View School District. If you intend to use this information for anything other than Earned Income Tax purposes, we would require this intent in writing.

Name _____

Address _____

Occupation (Specific) _____

Township or Borough _____

Name _____

Address _____

Occupation (Specific) _____

Township or Borough _____

Sincerely,

Dr. Michael S. Elia, Superintendent

MSE:bm

Student Name _____

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Fax (570) 434-2404

Date _____

Chief Assessor
Susquehanna County Board of Assessment
Court House
Montrose, PA 18801

Listed below are the name(s) of the parent(s) of a student(s) who have recently entered the Mountain View School District. By sending this information to you, we assume that it will be used for the sole purpose of updating the tax rolls for the Mountain View School District. If you intend to use this information for anything other than tax purposes, we would require this intent in writing.

Name _____

Address _____

Occupation (Specific) _____

Name _____

Address _____

Occupation (Specific) _____

Township or Borough _____

Sincerely,

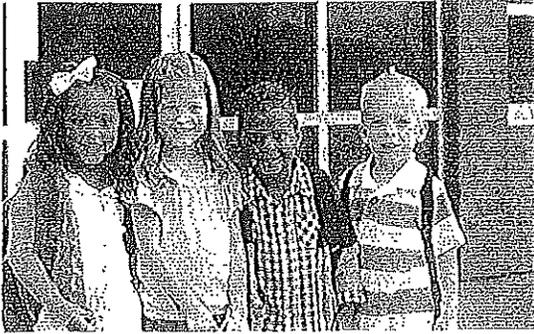
Dr. Michael S. Elia, Superintendent

MSE:bm

Student Name _____

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.

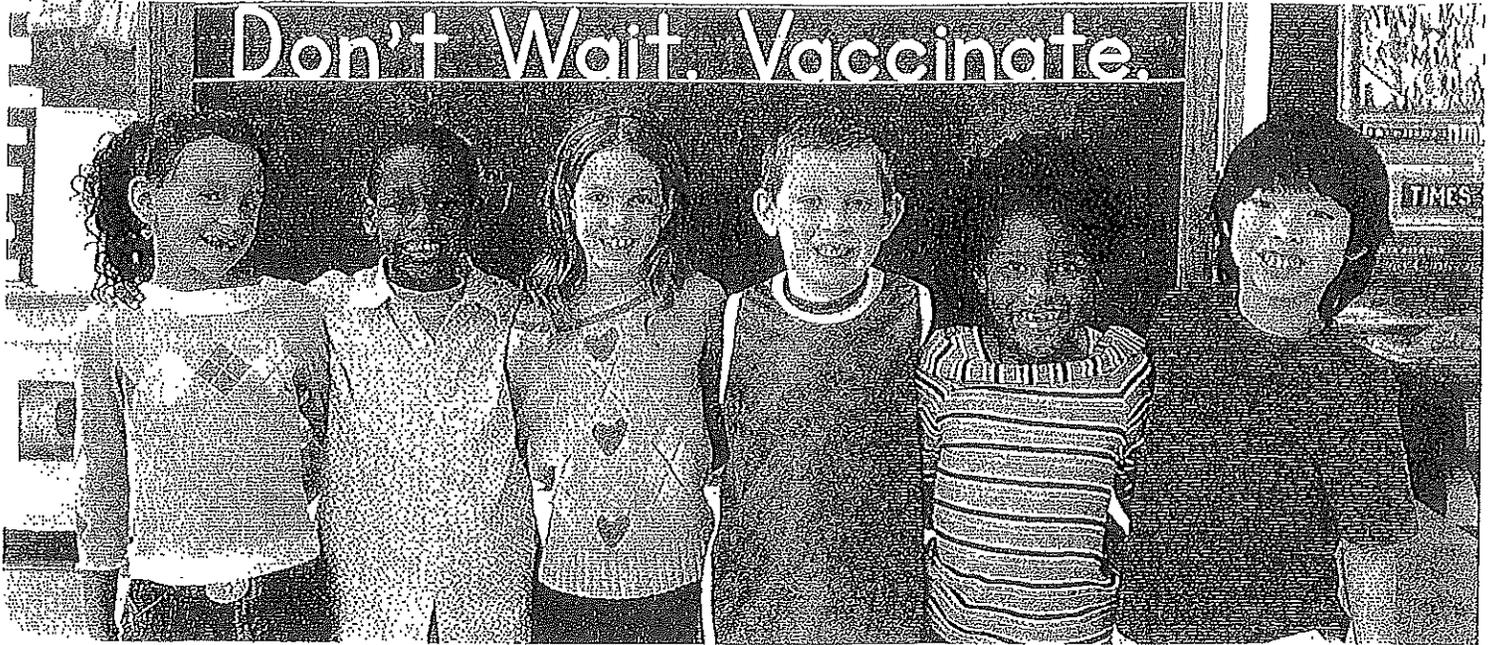
These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

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.



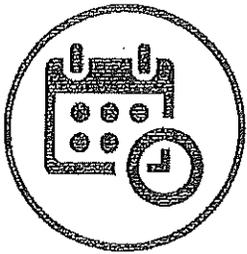
pennsylvania
DEPARTMENT OF HEALTH

Don't Wait. Vaccinate.



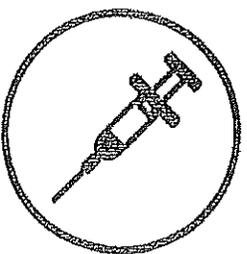
SCHOOL VACCINATION INFORMATION FOR PARENTS

The Department of Health is changing school immunization regulations beginning in August 2017. The regulations are intended to ensure that children attending school in the commonwealth are adequately protected against potential outbreaks of vaccine preventable diseases.



A CHILD MUST HAVE REQUIRED VACCINES OR RISK EXCLUSION FROM SCHOOL.

A child must have the required medically-appropriate vaccines or a plan to complete those vaccines or risk exclusion from school. A child may still obtain medical, religious or philosophical exemption from meeting the immunization requirements. Talk to your child's pediatrician about the vaccines your child needs to attend school.



NEW VACCINATION REQUIREMENTS:

- combination form for diphtheria and tetanus;
- pertussis vaccination;
- combination form for measles, mumps and rubella; and
- meningococcal conjugate vaccine for entry into 12th grade, or in an ungraded school, in the school year the child turns 18.

For more information on the vaccines your child needs to attend school, visit dontwaitvaccinate.pa.gov or talk to your child's pediatrician.

dontwaitvaccinate.pa.gov



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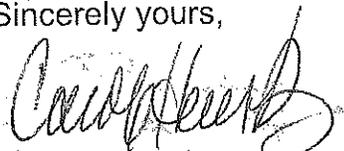
Dear Parent/Guardian,

Part of the kindergarten registration process involves an interview with the School Counselor. The Parent Interview form is included if you would like to complete it prior to Kindergarten Registration. Please bring the form with you on registration day and submit to Carole Heier-Rainey.

The total time required for this interview is usually fifteen minutes and is with the parent(s)/guardian(s). The information obtained in the interview is confidential and will remain in the Guidance Office. It may be shared with faculty and professional staff on an as needed basis for educational purposes.

We are looking forward to meeting you and your child. Please call if you have any questions or concerns.

Sincerely yours,



Carole Heier-Rainey,
MVES School Counselor

CR:ec

Kindergarten Parent/Guardian Interview

Please complete and bring with you to Kindergarten registration, or if you prefer, you can complete during your interview with the School Counselor. The information provided will remain in the Guidance Office and shared only with the appropriate staff working with your child on a need to know basis, for educational purposes.

Today's Date: _____

Child's Name: _____

Date of Birth: _____

Name of Person Completing Form: _____

Relationship to the Child: _____

Parent/Guardian Name: _____

Custody Agreement: _____

(May need to obtain a copy)

Siblings:

Please circle the response that best applies:

1. Child has participated in the following activities:
 - Preschool/day care
 - In home childcare
 - Play group
 - Creative activities (art, music, dance)
 - Organized Sports

2. Child will ask for help when needed from a familiar adult.
 - Often Sometimes Seldom/never

3. Child separates easily from a parent
Often Sometimes Seldom/never

4. Child takes care of bathroom needs independently
Often Sometimes Seldom/never

5. Child enjoys playing alone
Often Sometimes Seldom/never

6. Child enjoys playing with other children his/her own age.
Often Sometimes Seldom/never

7. Child invites others into his/her play.
Often Sometimes Seldom/never

8. Child is cooperative
Often Sometimes Seldom/never

9. Child stay interest in self-chosen activities for
5-10 minutes 10-20 minutes 20-30 minutes

10. What might be some fears your child has (dogs, being alone, storms, etc.)? _____

11. What helps to comfort your child when he/she is upset?

12. What are some things your child likes to do (interests/strengths)?

13. What are some needs or areas your child may need assistance on?

14. Are there any recent life events that have occurred in your family that were significant or upsetting?

Move

New Sibling

Divorce

Other _____

15. Is there anything you would like us to know about how your child expresses his/her feelings?

16. How does your child react when stressed?

Cries

Headache

Stomachache

Aggression

Other

17. How would you describe your child?

Friendly

Determined

Cooperative

Very Active

Independent

Self-Motivated

Shy/Quiet

18. Has your child ever received counseling or therapy services?

Counseling

Speech Therapy

Occupational Therapy

Physical Therapy

Other _____

Notes:

School Health Services

Dear Parent/Guardian,

I would like to take this opportunity to tell you about the health services offered to assist you in keeping your child as healthy as possible, so that school is both a valuable and an enjoyable experience.

Mountain View School District adheres to all the school health services mandated by the Pennsylvania School Code:

- growth measurement annually, all grades
- vision screening annually, all grades
- hearing screening grades K, 1, 2, 3, 7, and 11
- physical examinations upon first entry to school, grades 6 and 11
- dental examinations upon first entry to school, grades 3 and 7
- services of school nurse

Enclosed you will find a copy of a "Student's Health History". Please take a few minutes to read the questions and answer them to the best of your ability. If you have difficulty understanding some, or if you feel uncomfortable in answering particular questions, leave them blank and we can discuss them when we review the history together at the time of your registration appointment. If there are any changes in your child's health status after kindergarten registration, or at any time during his or her school career, please notify the school nurse of these changes immediately.

Please bring the health history form with you to registration along with your child's official immunization record, birth certificate, and social security number. **Registration can not be completed without these documents.** State law requires that in order to be admitted to school, a child must have had the following minimum immunizations:

- four doses of tetanus, diphtheria, and acellular pertussis (**1 dose on or after the 4th birthday**).
- four doses of polio (**4th dose on or after 4th birthday** and at least 6 months after previous dose given).
- two doses of measles, mumps, and rubella vaccine (first dose administered at 12 months of age or older).
- three properly spaced doses of hepatitis B
- two Varicella (first dose administered at 12 months of age or older), or evidence of immunity.

The Pennsylvania School Code requires that each child have a medical examination in Kindergarten, or upon original entry into the school system. Parents are urged to have the required physical examination done by their family physician because immunizations will be given as necessary, and immediate steps can be recommended for any needed care. A physical examination done by a family physician within **one year** prior to the opening day of school will be accepted as the required examination.

Pennsylvania School Code requires each child to have a dental examination in Kindergarten, or upon entry into school. Parents are encouraged to have the dental examination performed by their family dentist for continuity of the dental health of their child. A dental exam done by a family dentist within **one year** prior to opening day of school will be accepted as the required examination.

Parents of children with special needs, medical or psychological diagnoses, and/or those who require medication during school hours, are asked to seek a conference with the school nurse prior to the first day of school.

I look forward to seeing you and meeting our "newest pupil".

Sincerely,

Allison Bluhm B.S., B.S.N., R.N.,
C.S.N.
School Nurse
570-434-8420
abluhm@mvsd.net

MOUNTAIN VIEW SCHOOL DISTRICT

MEDICAL HISTORY FORM

Child's Name: Last First Middle Sex Grade Birth date: Month Day Year

Address: Number Street Town Phone Number Date

Father's Name: Last First Middle Mother's Name: Last First Maiden

Family Physician Address Phone Number

Dentist Address Phone Number

Hospital Preference City

In case of an emergency and no one can be contacted, I give my permission for my child to receive emergency treatment in the nearest hospital. I will be responsible for charges incurred from this treatment. I understand this information may be made available to the appropriate school/emergency personnel if deemed necessary to promote the health and education of my child.

Signature of parent or guardian

Is your child subject to: (Please circle Yes or No)

Frequent Colds	Yes - No	Chronic Cough	Yes - No
Bronchitis	Yes - No	Vision Problems	Yes - No
Frequent Sore Throats	Yes - No	Poor Posture	Yes - No
Speech Difficulties	Yes - No	Emotional Problems	Yes - No
Earaches or Infections	Yes - No	Extreme activity or restlessness	Yes - No
Heart Murmur	Yes - No		

Has your child had:

Eye Disease	Yes - No	Temper Tantrums	Yes - No
Eye Injury	Yes - No	Head Injury	Yes - No
Eye Glasses Prescribed	Yes - No	Severe Fall	Yes - No
Difficulty Sleeping	Yes - No	Frequent Falls	Yes - No
Special Diet	Yes - No	Broken Bones	Yes - No
Type Diet _____		Hearing Problems	Yes - No

Birth of Child:

Long Labor	Yes - No	Illness of mother during pregnancy	Yes - No
Premature	Yes - No	Medications during pregnancy	Yes - No
# of weeks premature	_____	Name _____	
Gestational Diabetes	Yes - No		
Breech Birth	Yes - No	Toilet Trained - bladder	Yes - No
		- bowel	Yes - No
Complications after pregnancy	Yes - No		
Development: Age Crawled _____		Age Talked _____	
Age Walked _____			

Does Your Child Have a History of: (Please circle or complete year)

Allergy (specify) _____		
ADD/ADHD _____	Latex allergy _____	Whooping Cough _____
Asthma _____	Dental Problems _____	Chickenpox _____
Epilepsy _____	Scarlet fever _____	Operations:
High fever _____	Seizures _____	Appendix removed _____
Enuresis (bed wetting) _____	T. B. _____	Tonsils/Adenoids removed _____
Encopresis (unable to control bowel movements) _____	Tonsillitis _____	Hernia _____
		Cleft palate/lip _____

Hospitalizations _____

Family History: (Please circle)

T.B.	Kidney Conditions	Asthma	Blindness	Emotional issues
Cancer	Heart Disease	Epilepsy	Deafness	Eye Glasses Worn
HIV/Aids	Diabetes	Allergies		

Please list other childhood diseases, accidents, or problems: _____

1. Is your child on any medication now or previously: Yes - No
Name of Medication _____

2. Did you provide immunization records today when registering? Yes - No

3. Is your child allergic to bee stings? _____ Does child need: Benadryl _____ Epi-pen _____

4. Does your child have other allergies? _____ What? _____

5. Has your child ever had a seizure? _____ Date _____ Reason _____

6. Any other medical problems that the school should be aware of? _____

7. Does your child need any modifications (health related) to perform successfully in the school environment?
Ex. assistance with locomotion, wheelchair, catheterization, special diet, etc. _____

8. Last school your child attended _____

Address/Telephone Number _____

PLEASE LIST OTHER CHILDREN LIVING IN HOUSEHOLD -- Name and Birth date



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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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 PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	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 <input type="checkbox"/>				
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

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__

<u>NAME OF STUDENT</u>			<u>AGE</u>	<u>SEX</u>	<u>GRADE</u>	<u>SECTION/ROOM</u>
<u>Last</u>	<u>First</u>	<u>Middle</u>		<u>M</u> <u>F</u>		

ADDRESS

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

REPORT OF EXAMINATION

		<u>TOOTH CHART</u>																
		<u>RIGHT</u>							<u>LEFT</u>									
<u>UPPER</u>		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u> <u>A</u>	<u>5</u> <u>B</u>	<u>6C</u>	<u>7</u> <u>D</u>	<u>8</u> <u>E</u>	<u>9</u> <u>F</u>	<u>10</u> <u>G</u>	<u>11</u> <u>H</u>	<u>12</u> <u>I</u>	<u>13J</u>	<u>14</u>	<u>15</u>	<u>16</u>	<u>Upper</u>
<u>LOWER</u>		<u>32</u>	<u>31</u>	<u>30</u>	<u>29</u> <u>T</u>	<u>28</u> <u>S</u>	<u>27</u> <u>R</u>	<u>26</u> <u>Q</u>	<u>25</u> <u>P</u>	<u>24</u> <u>O</u>	<u>23</u> <u>N</u>	<u>22</u> <u>M</u>	<u>21</u> <u>L</u>	<u>20</u> <u>K</u>	<u>19</u>	<u>18</u>	<u>17</u>	<u>Lower</u>
<u>EXAM</u>	<u>UPPER</u>																	<u>Upper</u>
	<u>LOWER</u>																	<u>Lower</u>

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

Pennsylvania Migrant Education Program

Family Survey



Versión en español al otro lado de la hoja

The Migrant Education Program (MEP) is authorized by Title 1, Part C of the Elementary and Secondary Education Act (ESEA). The Pennsylvania MEP (717-783-6466) provides a variety of educational services to families who work in agriculture, regardless of their nationality. This program is free of charge to all eligible families and may include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed. A program employee may contact you for further information if needed. All responses are confidential and will be used for educational purposes only.

Child's Name: _____

Birthdate: _____ Grade: _____ School: _____

1. In the past three years, has your family lived in another Pennsylvania school district, another state, and/or another country?

Yes _____ (continue to #2)

No _____ (stop here)

2. In the past three years, has anyone in your household had a job working with any of these products (not including your own property) on a farm, in a field, in a greenhouse, in a nursery, or in a factory? Please circle all that apply.



Livestock
(cattle, pigs, sheep, dairy, etc.)



Eggs



Chickens



Crops
wheat, corn, soybeans, etc.



Vegetables



Dairy



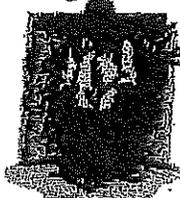
Nursery, Sod, Greenhouse



Fruits



Hay



Trees, Timbers, Plants, Flowers



Soil Preparation



Processing
(meat, fruit, vegetables, trees, etc.)

3. Parents' Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Please list all children in the household younger than 22 years of age:

Name	Date of Birth	Grade	School

El Programa de Educación de Migrante de Pennsylvania

Encuesta de Padres

English version on other side



El Programa de Educación de Migrante está autorizado por el Título 1 de la Parte C de la Ley de Educación Primaria y Secundaria (ESEA). La oficina Regional de Pennsylvania (717-783-6466) se proporciona una variedad de servicios educativos a las familias que trabajan en la agricultura, **sin importar su nacionalidad**. Este programa **es gratis** para todas las familias elegibles y **puede incluir** tutoría, elegibilidad de almuerzo gratis, viajes educativos, programas del verano, actividades para padres, referencias para emergencias y otros servicios como sea necesario. Un empleado del programa se contactará con usted si necesita más información. Todas las respuestas son **confidenciales** y solo se usarán para propósitos educativos.

Nombre del niño: _____

Fecha de cumpleaños: _____ Nivel: _____ Escuela: _____

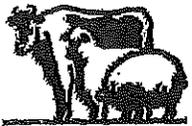
1. ¿En los últimos tres años, ha vivido su familia en otro distrito escolar en Pennsylvania, en otro estado, o en otro país?

Sí _____ (siga al #2)

No _____ (pare aquí)

2. ¿En los últimos tres años, ha trabajado alguien en su familia en cualquiera de los trabajos abajo (sin incluir su propia propiedad), en una granja, en el campo, en un invernadero, en un vivero, o en una fábrica?

Por favor ponga círculos alrededor de todos que se aplican:



Ganados, Ovejas, Cerdos, Vaquería



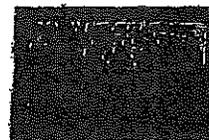
Huevos



Gallinas



Trigo, Maíz, Frijoles



Verduras



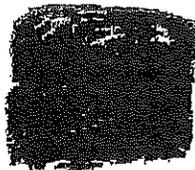
Lechera



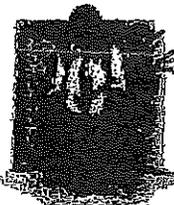
Semillero, Césped, Invernadero,



Frutas



Pasto Seco



Árboles, Madera, Plantas, Flores



Preparación de Suelo



Procesando (pollo, carne, cerdo, frutas, verduras, árboles)

3. Nombre de los padres: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código postal: _____ Teléfono: _____

Por favor anota a todos los niños menos de 22 años de edad en la casa:

Nombre	Fecha de nacimiento	Nivel	Escuela

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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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)	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)					

