WELCOME TO APOLLO-RIDGE

Requirements for Enrollment (Grade K)

In order to enroll a child in the Apollo-Ridge School District, you need to provide the school with the following information/documentation.

1. Completed Enrollment Forms (attached)

2. Proof of Residence – Must be in the parent/guardian's name at the student's residence within district boundaries.

   We require three (3) proof of residency forms showing that the parent/guardian and student lives in the district.

   Examples are:

   - lease
   - mortgage information
   - driver's license
   - automobile registration
   - auto insurance card
   - current utility bill(s)
   - tax statements
   - public assistance documents

3. Parent/Guardian Photo ID

4. Immunization Record

5. Birth Certificate of Student

6. PLEASE BRING YOUR CHILD (INCOMNG KINDERGARTEN STUDENT) FOR SCREENING.

SPECIAL CIRCUMSTANCES

Sometimes special circumstances exist when a person just moves into the District, or for other reasons. We will look at these situations on an individual basis, but can grant extra time to obtain documentation under many of these circumstances.

Once you have all paperwork completed and obtained, please contact Kimberlie Akins, Guidance Secretary, Elementary, at 724-478-6000 Ext. 5001 for an appointment to enroll your child(ren).

APOLLO-RIDGE SCHOOL DISTRICT STUDENT ENROLLMENT FORM

____ Elementary School ____ Middle School ____ High School

(Please complete forms in blue or black ink, or pencil only) START DATE: _____

Parent/Guardian MUST present photo identification at time of registration

*At least three (3) of the following proofs of residency MUST be present at time of registration:

____ Deed of Ownership ____ Notarized Lease Agreement ____ Tax Statements ____ Current Utility Bill
____ Public Assistance Documents ____ Current Driver's License ____ Automobile Registration ____ Auto Insurance Card

*Immunizations needed prior to registering:

____ Diptheria/Tetanus ____ Polio ____ Hepatitis B ____ Measles, Mumps, Rubella ____ Varicella

*Birth or Baptismal Certificate of student MUST be presented at time of registration:

____ Received Birth Certificate Number _____ / ____ Not Received _____ Reason

Student Name: _____ ____ Male ____ Female
Last Name, First Name, Middle Name

Date of Birth: ____/____/____ ____ Place of Birth _____
Month Day Year Age City/State

Home Address: _____
911 Street Address, P.O. Box, City, State, Zip Code

Phone Numbers: _____ _____ _____
Home Phone Dad Cell Phone Mom Cell Phone

Ethnic Origin: ___ White (Not Hispanic) ___ Black (Not Hispanic) ___ Hispanic (Any Race) ___ Multi-Racial (Not Hispanic)
___ American Indian/Alaskan Native (Not Hispanic) ___ Asian (Not Hispanic) ___ Native Hawaiian/Other Pacific Islander (Not Hispanic)

Father's Name: _____ Living With Child? Y or N
Last Name, First Name, Middle Name Responsible for Child? Y or N

Occupation Employer Work Phone/Email Address

Mother's Name: _____ Living With Child? Y or N
Last Name, First Name, Middle Name Responsible for Child? Y or N

Occupation Employer Work Phone/Email Address

Guardian's Name _____ Living With Child? Y or N
(if applicable) Last Name, First Name, Middle Name Responsible for Child? Y or N

Occupation Employer Work Phone/Email Address

Brother/Sister Name(s): _____ Grade: _____
_____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

For Office Use Only Grade _____ Teacher _____ PA Secure ID # _____ ID # _____

Bus# AM _____ Bus Stop AM _____ Bus # PM _____ Bus Stop PM _____

Entry Code/Date _____ Cumulative Folder _____ Study Island Set-Up _____

Course Set Up Date _____ Permanent Record _____ Computer Entry Date _____

Complete this section if there are any custody issues the school needs to be made aware of:
Custody/guardianship papers must be presented at time of registration.

Is there a **court order** dictating rights? _____ Yes _____ No
If yes, a copy of the court order must be on file in the Guidance Office and questions below need to be completed.

Who has physical custody? ____ Both Parents ____ Father Only ____ Mother Only
____ Other (indicate name and relationship) _____

Who has educational rights? ____ Both Parents ____ Father Only ____ Mother Only
____ Other (indicate name and relationship) _____

Who has visitation rights? ____ Both Parents ____ Father Only ____ Mother Only
____ Other (indicate name and relationship) _____

Second Parent Information: Name (Last, First, Middle) _____

911 Street Address, PO Box, City, State, Zip Code) _____

Home Phone/Cell Phone _____

HAS YOUR CHILD EVER ATTENDED THE APOLLO-RIDGE SCHOOL DISTRICT? _____ Yes _____ No

Name of Prior School District: _____
Name of School: _____ County of Prior School: _____
State of Prior School: _____ Dates Attended: _____
Prior School Address/Phone: _____

Last Grade Attended: _____ Any Retentions? _____ Yes _____ No If yes, what grade? _____
List ALL prior schools and dates attended:

_____

_____

Date student entered 9th Grade for the first time _____

State Entry Date: (if other than birth date) _____

INDIVIDUALIZED EDUCATION PLAN (I.E.P)

Does your child currently have an I.E.P.? _____ Yes _____ No

Check below for services included in your child's I.E.P.

_____ Learning Support
_____ Speech/Language Support
_____ Physical Therapy
_____ IST Support
_____ Other Services _____
_____ Hearing Impairment Support
_____ Visual Impairment Support
_____ Occupational Therapy
_____ Life Skills Support
_____ Emotional Support
_____ Gifted Support

APOLLO-RIDGE SCHOOL DISTRICT

P.O. BOX 219 •SPRING CHURCH, PENNSYLVANIA 15686 • (724) 478-6000 •FAX (724) 478-1149
High School, 1825 State Route 56, Spring Church, PA 15686 (ext 1020 – Fax: 724-478-9775)
Middle School, 1829 State Route 56, Spring Church, PA 15686 (ext 2000 – Fax: 724-478-3730)
Elementary School, 1831 State Route 56, PO Box 157, Spring Church, PA 15686 (ext 5001 – Fax: 724-478-2967)

Transportation Record

☐ New Student Effective Date: _____

Building: ☐ Elementary ☐ Middle School ☐ High School

Student Name: _____

Grade: _____ Student ID # _____

Teacher/Mentor: _____

Parent/Guardian Name: _____

Address: _____

_____

Primary Emergency Phone Number: _____

Email Address: _____

Directions for Reaching Home: *(Please give route numbers, approximate mileage, etc.)*

_____

_____

_____

_____

_____

****Office Use Only****

AM Bus Number _____ *PM Bus Number* _____

AM Bus Time _____ *PM Bus Time* _____

Bus Stop Name: _____

Apollo-Ridge School District

Home Language Survey*

Please complete the Home Language Survey for each of your children.

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.

School District: *Apollo-Ridge School District* **Date:** _____

School: _____

Student Name: _____ **Grade:** _____

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

2. **Does the student speak a language(s) other than English?**
(Do not include languages learned in school.)

   □ **Yes** □ **No**

   If yes, specify the language(s): _____

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

4. **Has the student attended any United States school in any 3 years during his/her lifetime?**

   □ **Yes** □ **No**

   If yes, complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 the school district/charter school/full day AVTS in the future.

APOLLO-RIDGE SCHOOL DISTRICT

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COMPUTER ACCESS CONSENT FORM

I understand the access and usage of the internet system is designed for educational purposes only and Apollo-Ridge School District has taken available precautions to eliminate controversial material. I also recognize it is impossible for Apollo-Ridge School District to restrict complete access to **all** controversial materials and I will not hold Apollo-Ridge School District responsible for materials acquired on the network/internet. I accept full responsibility for supervision, if and when, my child's use is not in a school setting.

As the Parent/Guardian of *(student name)* _____, I have read and understand the Terms and Conditions of Internet and Computer Technology access per the District Policy #132 of the Apollo-Ridge School District. I understand that any violation of the regulations are unethical and may constitute a criminal offense. Should any violation be committed, access privileges may be revoked, school disciplinary and/or appropriate legal action may be taken.

Please refer to the Parent/Student Handbook for disciplinary procedures.

By signing this contract states that I have read, understand, and discussed with my student the Apollo-Ridge School District Terms and Conditions of the internet, computer technology usage, and disciplinary actions. Therefore, I give Apollo-Ridge School District permission to issue access for my child and certify that the information contained on this form is correct.

This form will remain in the student's cumulative folder for the remainder of active enrollment in this district. Parents/Guardians may elect to change the status of this consent form at their discretion by notifying the student's current year Guidance Office.

Student Name: _____

Student Signature *(if in secondary level):* _____

Date: _____ Grade: _____

Parent/Guardian Name (Printed): _____

Do you have a home computer? ☐ Yes ☐ No

Do you have access to the internet? ☐ Yes ☐ No

Do you have an Email address? ☐ Yes ☐ No If so, please provide: _____

Parent Guardian Signature: _____

Date: _____ Phone Number: _____

APOLLO-RIDGE SCHOOL DISTRICT

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PARENTAL REGISTRATION STATEMENT

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

Telephone Number _____

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 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."

Please complete the following:

I hereby swear or affirm that my child was _____ was not _____ previously 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 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.

_____
(Signature of Parent or Guardian)

_____
(Date)

*Name of the school from which student was suspended or expelled; reason for suspension/expulsion; and dates of suspension or expulsion (optional) _____

_____

Any willful false statement made above shall be misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

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 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 unemployment compensation payments made by any governmental agency, and any wages or compensation paid by the United State for active service in the forces of the United States including bonuses or additional compensation for such service. In addition, net profits of corporation 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 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 INCOMETAX 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 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 is 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 a $500.00 per offense, plus the cost of prosecution; in default of payment of said fine costs, the taxpayer may be imprisoned for a period not exceeding thirty (3) 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.

Earned Income Tax Information for
Residents of the Apollo-Ridge 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 'Act511'. The Earned Income Tax or 'Wage Tax' is usually a tax on one percent (1%) on gross wages and/or net profits from a business or profession.

Berkheimer Associations is the appointed earned income tax officer for the Apollo-Ridge School District. As the appointed earned income tax collector, Berkheimer Associates is charged with the duty of administering the school district'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 tax payer.

Below is an Earned Income Tax Registration Form. A completed Registration Form will fulfill your registration requirement under the Earned Income tax rules and regulations adopted by the Apollo-Ridge School District. More importantly, this information will ensure that your tax dollars are sent to our 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 cooperation 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, you may contact Berkheimer Associates at 7-800-242-1222.

APOLLO-RIDGE SCHOOL DISTRICT
EARNED INCOME TAX REGISTRATION FORM

Your Name _____ Your Social Security No. _____

Spouse's Name _____ Spouses' Social Security No. _____

Address _____

City _____ State _____ Zip

Resident Municipality (Township or Borough in which you reside) – Circle one

Apollo Borough Kiski Township Black Lick Township North Apollo Borough Young Township

Date you moved to above address _____

Did you move here from another Pennsylvania location? Yes _____ No _____

Your Employer _____ Spouse's Employer _____

Working Jurisdiction (Twp/Boro/City) _____ Working Jurisdiction (Twp/Boro/City) _____

Is the earned Income Tax withheld from your pay? _____ From Spouse's Pay? _____

Are you Self-employed? _____ Spouse? _____

If you have no earned income, please record the reason why: retired/homemaker/temporarily unemployed/disabled/student/minor (please state age)/other (please specify)

Print your Name _____ Spouse Name _____

Your Signature _____ Date _____

APOLLO-RIDGE SCHOOL DISTRICT
Student Residency Questionnaire

The McKinney-Vento, as amended by the No child Left behind Act of 2001, defines homelessness and outlines the rights homeless students. Your responses to these questions will help staff determine what residency documents are necessary for enrollment of you child(ren). Thank you for your cooperation.

1. Student name: _____ Birth Date: _____

2. Person Completing form: _____

   Relationship to child: _____

3. In what type of setting is the student living now? Please check one box below:

Section A	Section B
____ In an emergency or transitional shelter ____ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ____ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations ____ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings ____ Other places not designed for, or ordinarily used as a regular sleeping accommodations for human beings CONTINUE to question 4 if you checked any box in SECTION A	____ None of the choices in Section A apply to my family.  If you checked this section, you do not need to complete the remainder of this form. Submit this form to school personnel. Thank you

4. Contact number for person completing the form: _____

5. Address where the student is now living: _____

   _____

6. The student lives with: Check all that apply

   ____ Parent (s) or legal guardian ____ Relative, friend(s), or other adults(s)

   _____ Alone ____ Other: _____

7. School student attended last: _____
Address of school: _____
_____
Telephone number of school: _____
Contact person at school (if known): _____

8. Does the student have an IEP or a Chapter 15/504 agreement?
____ NO
____ YES, please explain _____

The staff person who is helping you register will contact the Homeless Liaison/Homeless Coordinator to review the information provided. If homelessness is verifies, additional information will follow to assist your child(ren). You will be contacted by the Homeless Liaison or Homeless Coordinator for additional information.

Signature of Parent/Legal Guardian:

_____

Date: _____

NOTE TO STAFF: All forms with a checked box in Section A are to be faxed or given ***immediately*** to the Homeless Liaison to eliminate any delay.

Carol Gourley, Apollo-Ridge Homeless Liaison

Phone: 724-478-6000 ext. 1030

Fax: 724-478-9775

Apollo-Ridge School District Emergency Contact/Health Record Form

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

*Date of Birth: _____ Gender: _____ Locker #: (N/A Elm.) _____

Ethnicity (check one below)
☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander
☐ Black (Non-Hispanic) ☐ Hispanic
☐ White (Non-Hispanic) ☐ Multi-Racial/Ethnic

School: _____ Teacher: _____
Grade: _____
*Main Phone Number: _____
(check one) ☐ Home ☐ Dad Cell ☐ Mom Cell

Resident Address _____

Mailing Address _____
☐ same as Resident Address

Does the student reside with a Parent/Guardian who is an active member of the military? Yes ☐ No ☐

Biological Father/Guardian Name: _____
First Name Last Name

Lives with Student? Yes ☐ No ☐
Responsible for Student? Yes ☐ No ☐
Email: _____
Home Phone #: _____
Cell Phone #: _____
Work Phone #: _____
Name of Employer: _____

Biological Mother/Guardian Name: _____
First Name Last Name

Lives with Student? Yes ☐ No ☐
Responsible for Student? Yes ☐ No ☐
Email: _____
Home Phone #: _____
Cell Phone #: _____
Work Phone #: _____
Name of Employer: _____

Custody papers are very important to our school. Have you provided the school with a copy of any court ordered custody paperwork pertaining to your child? Yes ☐ No ☐ N/A ☐

****Emergency Contacts**
(Parents will be the first person called – list all other parties to be called in case of an emergency or educational issues)**

1. _____ _____ _____
Name Relationship Phone #
2. _____ _____ _____
Name Relationship Phone #
3. _____ _____ _____
Name Relationship Phone #

PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION

Physician _____ Phone _____ Dentist _____ Phone _____
HOSPITAL PREFERRED IN THE EVENT OF AN EMERGENCY: _____
Health Problems or allergies (including bee stings): _____
Prescribed Medications: _____

Physicals and Dental exams are required by state law to be completed periodically. If your child becomes out of compliance, do you give permission to have your child examined by our School Physician and School Dentist?	☐ **Yes**	☐ **No**

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

APOLLO-RIDGE SCHOOL DISTRICT

Entering Student's Health History

The purpose of this information is to help us know your child better and be aware of any special needs he/she may have.

Child's Name _____ Birthday _____ Sex _____
Last, First, Middle

Address _____ Phone _____

Father's Name _____

Mother's Name _____

If child is living with other than parents, give name and relationship _____

_____

****

Birth and Early Childhood Development – *Optional Information for Developmental Education Profile*

Was your pregnancy normal? _____

Was labor or delivery difficult? _____

Any problems at birth? _____

During the first six months, would you describe your baby as quiet or active? _____

Were there any concerns about growth and development during early childhood? _____

_____

Easy or difficult to care for? _____

Can your child use the toilet without help now? _____

****

MEDICAL HISTORY

Does your child have a history of any of the following medical conditions? (please check):

_____ AIDS	_____ diabetes	_____ hyperactivity
_____ asthma	_____ eye problems	_____ HIV infection
_____ attention deficit	_____ fainting spells	_____ kidney problem
_____ bladder problem	_____ family history of tuberculosis	_____ rheumatic fever
_____ bronchitis	_____ frequent ear infections	_____ scarlet fever
_____ chicken pox	_____ hearing impairment	_____ skin problems
_____ constipation	_____ heart murmur	_____ strep throat
_____ convulsions or seizures	_____ hernia	_____ tuberculosis

If checked, please explain _____

_____

Is your child allergic to anything? _____ If so, what? _____

_____

Are there any foods your child cannot eat? _____ If so, please list them _____

_____

Physician or usual source of medical care _____
Phone _____

List any serious illnesses, injuries, operations _____

_____

Note any medical condition or health problem that should be known by school personnel:

_____

_____

Is your child taking any medication now? _____ If so, please list _____

_____

Circle any of the following that are of concern to you:

Appetite or eating habits bedwetting Easily upset Overactive

Shyness Sleep habits Stubbornness

Stuttering Temper tantrums Thumb sucking Unusual fears

DENTAL HISTORY

Has your child been to the dentist? _____ Dentist's Name _____

Any dental problems? _____

Does your child take fluorides or vitamins with fluorides? _____

FAMILY HISTORY

Names of Children	Birthdate	School Attending
_____	_____	_____
_____	_____	_____
_____	_____	_____

Information given by _____
Relationship to child _____

Signature _____ Date _____

APOLLO-RIDGE MEDICATION POLICY

Dear Parents:

Please review the following guidelines of our DISTRICT'S MEDICATION POLICY and retain this notice for future reference.

1. All medication (both prescription and non-prescription) must be brought to school by a parent, guardian or other responsible adult. No student will be permitted to carry medication on his or her person or on the school bus. The only exception to this rule is emergency medications, such as inhalers for asthma, emergency allergies and emergency diabetic medications.

2. All medication must be presented to the school nurse. The medication must be properly labeled (see below) and must be accompanied by a **Medication Use Form.** Up to four (4) weeks supply can be accepted for those students on long-term therapy.

   - **Prescription medication must be in a pharmacy labeled container and must be accompanied by a written physicians order.**

   - **Non-prescription medication must be in the original container, labeled with the student's name and must be accompanied by a signed Parent Permission - Medication Use Form.** All non-prescription medication will be considered very short term unless prescribed by a physician.

   - **Cough drops are provided by the school nurse. Please do not send or bring cough drops to the school for your child.**

3. Only the school nurse will administer medications. However, other school personnel may assist a student in taking medication after the nurse has determined that the student can properly self-administer the medication.

4. Medication such as antibiotics that are to be taken three times a day will not be given at school. Any exception to this rule will require a physician's written statement, for the exception to be considered.

5. Students are permitted to take medication during school hours only when failure to do so would jeopardize health and/or he or she would be unable to attend school if the medicine was not available during school hours.

These guidelines were developed after substantial research and consideration. We feel they will meet the needs of our students and provide for a safe school environment. We appreciate your cooperation in this effort.

Respectfully,

Mona Mion – Elementary School Nurse
Carol Gourley – Secondary School Nurse

PARENT PERMISSION - MEDICATION USE FORM

Student's Name _____ Grade _____ Homeroom _____

MEDICATION TO BE GIVEN AT SCHOOL

Name of medication _____ Dosage _____ Time _____

Frequency _____ Prescription _____ Non-Prescription _____

Prescribing Physician _____ Phone Number _____

Purpose of the medication _____

Possible side effects of medication _____

The following non-prescription medicines are available in the nurse's office and will be dispensed in age appropriate doses. Please circle the medicines that your child is permitted to take while at school. Parents will be contacted prior to students receiving any of these medicines with the exception of cough drops.

Benadryl *Cough Drops* *Tylenol* *Ibuprofen*

LIST OTHER MEDICATIONS BEING TAKEN AT HOME AND/OR SCHOOL

_____ _____ _____

_____ _____ _____

Parent's Statement Requesting and Authorizing the Administration of Medication or Assistance in Taking Medication

As described elsewhere in this "Medication Use Form" it is necessary that my child receive medication while in school. I understand that the medication may be administered only by the school nurse, but that others such as my child's teacher, a school secretary or principal may assist my child in taking the medication. Further, I understand that others, as stated above are neither nurses, nor physicians, nor have they received any training in the administration of medication.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

APOLLO-RIDGE SCHOOL DISTRICT

Authorization Form and Procedures for Treatment of **Bee Stings**

The following is the standard procedure of treatment for anyone stung by a bee or insect.

1. Scrape off stinger if visible
2. Apply sting kill
3. Apply ice pack
4. Observe the student closely for 10-15 minutes. Monitor for an additional 10-15 minutes in the classroom.

PARENTS: Please make sure your child is aware of his/her bee sting allergy and of the need to inform someone of having been stung by a bee/insect.

Please check the status of your child's reaction to bee stings or insect bites and return this information to your child's school immediately:

_____ My child has a localized reaction (swelling or redness at the site of sting)

_____ My child has had a severe reaction (difficulty breathing, generalized swelling, redness, numbness, hives or itching). Describe your child's reaction.

_____

_____

If your child has had a severe reaction has he/she:

_____ Begun desensitization treatment (allergy shots)

_____ Begun maintenance dose of desensitization treatment

_____ My child has not been desensitized

If your child has had a reaction to bee stings or insect bites, please check the procedures to follow:

_____ Follow routine procedure for bee stings.

_____ Notify parent at once.

_____ Give medication as prescribed by my child's physician (parent must provide written order from Physician).

_____ Transport my child to the closest medical facility if necessary.

_____ My child's physician has ordered an anaphylactic kit to be administered by the school nurse, if she is available (parent will provide kit).

Name of Child _____ Home Room Teacher _____

Signature of Parent/Guardian _____ Phone _____

APOLLO-RIDGE SCHOOL DISTRICT

Medical/Dental Examination Form

Pennsylvania School Health Law requires a physical and dental examination upon original entry into school. We are recommending that your family physician and dentist do these examinations as they can best evaluate your child's health. However, the school's doctors can also do examinations. Please complete the sections below. The school physician and dentist will give medical and dental exams in the fall. Attached are the proper forms if you plan to have your physician or dentist examine your child. Please return these forms to the elementary office after your child has their examinations and prior to the first day of school.

Please note, private examinations are at the parent's expense.

MEDICAL EXAMINATION

_____

Child's Name

Please check preference:

_____ Please have the school physician examine my child.

_____ I will take my child to Dr. _____ for his/her physical examination. I will have my child's examination prior to the start of school and return the physical exam form to the school office.

_____

Parent/Guardian Signature

DENTAL EXAMINATION

_____

Child's Name

Please check preference:

_____ Please have the school dentist examine my child.

_____ I will take my child to Dr. _____ for his/her dental examination. I will have my child's examination prior to the start of school and return the dental exam form to the school office.

_____

Parent/Guardian Signature

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 t 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	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?		
HEADACHES / PAIN / NEUROLOGICAL	**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 / CHEST / VASCULAR	**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?		
BONES / MUSCLES / JOINTS / INJURIES	**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	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY (Male Students)	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 / MENTAL HEALTH	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS / 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 ☐ 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 ☐**

HEALTHCARE PROVIDERS: Recommended Immunizations for Children 0 - 6 Years of Age

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	DOSE NUMBER (1) Type of Vaccine (2) Date Completed (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)

H514.027 (08/2011)

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

APOLLO-RIDGE SCHOOL DISTRICT

Spring Church, PA 15686

High School- Grades 9 – 12:	1825 State Rt 56	* 724-478-6000 Ext. 1020	Fax **724-478-9775**
Middle School- Grades 6 – 8:	1829 State Rt 56	* 724-478-6000 Ext. 2000	Fax **724-478-3730**
Elementary School- Grades K – 5:	1831 State Rt 56, PO Box 157	* 724-478-6000 Ext. 5001	Fax **724-478-2967**

RELEASE OF RECORDS

Student Name _____ Grade _____ Date of Birth _____

Start Date at Apollo-Ridge: _____

PRIOR SCHOOL(S) INFORMATION:

School Name _____ School Name _____

Address _____ Address _____

_____ _____

Phone # _____ Phone # _____

Year(s) Attended _____ Year(s) Attended _____

I authorize _____ *to release all school records on my child to the Apollo-Ridge School District. I certify that the information is true and correct. I understand that providing false information will result in the exclusion of my child from the Apollo-Ridge School District.*

Parent/Guardian Signature _____ *Date* _____

PLEASE FORWARD THE FOLLOWING RECORDS:

Cumulative Records
Behavioral Records
Medical Records
All Special Education Records (IEP, ER, RR, Norep, Permission, Invitation)
All Psychological/Psychiatric Records
All Disciplinary Records
Other (Please Specify) _____
_____

RECORDS ARE TO BE RELEASED TO:

____ Apollo-Ridge **High School**
Attention: Michele Brown, Guidance Office
1825 State Rt 56, Spring Church, PA 15686

____ Apollo-Ridge **Middle School**
Attention: Barb Crewe, Guidance Office
1829 State Rt 56, Spring Church, PA 15686

____ Apollo-Ridge **Elementary School**
Attention: Kimberlie Akins, Guidance Office
PO Box 157, Spring Church, PA 15686

For Office Use Only

Request	Mail/Fax	Date Sent	School Name & Address	Date Received	Received By
1					
2					
3					

Comments:

"Inspire Growth and Prepare Futures".