NORTHEAST BRADFORD SCHOOL DISTRICT
526 PANTHER LANE ROME, PA 18837
Phone: (570)744-2521 | Fax: (570)744-2933 | www.nebpanthers.com
NORTHEAST BRADFORD ELEMENTARY SCHOOL NORTHEAST BRADFORD JR-SR HIGH SCHOOL

INFORMATION NEEDED FOR KINDERGARTEN ENROLLMENT

Welcome to the Northeast Bradford School District.

Kindergarten enrollment will be held at Northeast Bradford Elementary School on March 13-14, 2024. Children who are 5 years old on or before September 1st are eligible to start kindergarten in the **2024-2025** school year. Please call as soon as possible to schedule an appointment.

Please complete all forms attached. Our school nurse has included a confidential health history form, a physician's form and a dentist's form. The health history form should be completed by you and brought to registration. Your family doctor should complete the physician's form at your child's next physical examination. Your dentist should complete the dental form. If the examinations are done before registration, please bring them with you. If this is not possible, the physician and dental form may be returned to the school during the summer.

When you come to registration, you will need to bring these forms as well as the following information:

- **Your child's original birth certificate**
  If you do not have a birth certificate for your child, you can contact the PA Department of Health for an application:

  Division of Vital Statistics
  PO Box 1528
  New Castle, PA 16103
  Phone: (724) 656-3100

- **Your child's immunization records**
  Commonwealth of Pennsylvania requires the following immunizations for new entries into kindergarten.

  - 4 doses of DTP or DTaP or if medically advisable, DT or Td (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 MMR
  - 3 doses of hepatitis B
  - 2 doses of varicella (chickenpox) vaccine or evidence of immunity

  Please call the school nurse with questions regarding immunizations at (570) 744-2521, ext. 2224.

- **Proof of residency in our district.**
  The state requires that parents provide the district with proof of residency. This can be any document that shows your name and street address to indicate you live in our district. Examples are driver's license, vehicle registration, lease, current tax bill, current utility bill, or current credit card statement.

We look forward to meeting you and your new student. If you have any questions, please call. We will be happy to help you.

2/2018
(Rev. 1/2024)

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STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child (ren). Thank you for your cooperation.

1. Student Name: _____ Birthdate: _____
2. Person completing form: _____ Relationship to child: _____
3. In what type of setting is the student living in now?

Check a 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. ___ Other places not designed for, or ordinarily used as a regular sleeping accommodation for human beings **CONTINUE** to Question 4 if you check any boxes in **SECTION A.**	___ None of the choices in Section A apply  **If you checked this section, you do NOT need to complete the remainder of this form.**

4. Contact number for person completing the form:_____
5. Address where student is now living: _____
6. The student lives with: (check all that apply)
   - ☐ Parent(s) or legal guardian
   - ☐ Relative, friend(s), or other adult(s)
   - ☐ Alone
   - ☐ Other: _____

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STUDENT ENROLLMENT FORM

Student Info I

Last Name:	First Name:	Middle Name:	Gender: □ Male □ Female
Birthdate:	Grade:	Is your child repeating this grade: No☐ Yes☐	Nickname:
Please provide Physical Address- no P.O. boxes please::			

Has your child ever been a student in the Northeast Bradford School District? No☐ Yes☐ **If yes, please give dates:**
Did your child attend nursery school or Head Start? No☐ Yes - nursery school☐ Head Start☐
Does student have an IEP? No ☐ Yes ☐ Does Student have a 504? No ☐ Yes ☐
With whom does student live?
Is there a court custody agreement? No ☐ Yes ☐ Shared Custody: No☐ Yes ☐
Legal document description: Custody Agreement☐ PFA☐ Guardianship Papers: Court Order☐ Affidavit☐
Legal document included: No ☐ Yes ☐
Custodial restrictions:
Is student in foster/court placement? No ☐ Yes ☐ **If yes, please attach copy of agency letter.**
Is student homeless or currently living with a resident family because of lack of housing? No ☐ Yes ☐
Did your child previously receive free or reduced meals in school? No ☐ Free ☐ Reduced ☐
Is student a single parent? No ☐ Yes ☐

Student Info II

Birth City:	Birth State:	Birth Country:
Previous City:	Previous State:	Previous Country:
Previous School:		
Previous School Address:		
Does student have siblings who attend this school already? No ☐ Yes☐		
If "YES" please provide names:		
If this student has siblings who attend NEB and will be using the same contact information, you do not need to fill out the following contact information.		

RACE & ETHNICITY DATA

Ethnicity: □ No, not Hispanic or Latino □ Yes, Hispanic or Latino
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ White □ Native Hawaiian or Other Pacific Islander □Multi-racial

Contact Info

If you have children who already attend Northeast Bradford and wish to use the same contact information for this student, please provide the name of the student who is already attending and **you will not need to fill out the information below**. Phone numbers in highlighted fields will be used in our emergency messaging system *OneCall Now*.

Name_____ Grade: _____

C1 Primary Household Contact
Name_____Relationship to Student_____

Address_____Send Mail_____

Primary phone_____ Secondary phone_____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Legal Guardian_____ Custody_____ Can Pick Up_____

C2 Secondary Household Contact
Name_____Relationship to Student_____

Address_____Send Mail_____

Primary phone_____ Secondary phone_____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Legal Guardian_____ Custody_____ Can Pick Up_____

C3 Other Parent, if divorced or separated
Name_____Relationship to Student_____

Address_____Send Mail_____

Primary phone_____ Secondary phone_____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Legal Guardian _____Custody_____ Can Pick Up_____

C4 Emergency Contact
Name_____Relationship to Student_____

Address_____

Primary phone _____ Secondary phone _____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Can Pick Up_____

C5 Emergency Contact
Name_____Relationship to Student_____

Address_____

Primary phone_____ Secondary phone_____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Can Pick Up_____

C6 Emergency Contact
Name_____Relationship to Student_____

Address_____

Primary phone_____ Secondary phone_____ Tertiary phone_____

Email address_____Employer_____

Send Email_____ Can Pick Up_____

I CERTIFY THAT ALL INFORMATION ABOVE IS TRUE AND CORRECT.	
Signature:	Date:

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HOME LANGUAGE SURVEY

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

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

Child's first name: _____

Child's family name: _____

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

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

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

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

NORTHEAST MIGRANT EDUCATION PROGRAM
FAMILY SURVEY

Date:
Family name: Address: Phone:
Names of anyone under the age of 21 living in your home:

Your children may qualify for a FREE educational program which includes year-round educational support. Someone will contact you if your children appear to be eligible for the program.

Have you and/or your children moved from one school district to another within the last 3 years?

☐ No ☐ Yes

What types of work have you done or looked for in the last 3 years? (Check all that apply)

	Dairy, horse, hog, veal or poultry farm
	Food processing plant (beef, pork, milk)
	Forestry: Timber cutting, thinning, transporting
	Fruit tree trimming
	Crop farming
	Milk truck driver
	Fruit or vegetable farm
	Christmas tree farm or nursery
	Mushroom plant

Please specify your current work:

Central Susquehanna Intermediate Unit
Northeast Migrant Education Program
PO Box 213, Lewisburg PA 17837

Call 570-523-1155, Extension 2331 for Migrant Education Information.

OFFICIAL USE – FAMILY CONTACT LOG

2/2018
(Rev. 1/2022)

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TRANSPORTATION ASSIGNMENT

Students needing transportation:

1. _____ Grade: _____
2. _____ Grade: _____
3. _____ Grade: _____
4. _____ Grade: _____
5. _____ Grade: _____
6. _____ Grade: _____

Address: _____

To assist us in properly assigning your students, include information about landmarks near home (e.g. next to fire station, color of house, third house from intersection of _____ and _____Roads. Also, if you know the number of the bus that picks up on your road or are aware of other NEB students living on your road, please list.)

Location: _____

_____

_____

_____

Home Phone Number: _____

Parent's Cell Phone Number: _____

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PHOTOGRAPHIC RELEASE FORM

Dear Parent or Guardian:

The Northeast Bradford School District requests your permission to use photographs or photographic images for educational purposes, including but not limited to: district websites, yearbook, publications and/or social media. Your consent is needed so that names, pictures and/or student creations may be published.

Please visit the district's website www.nebpanthers.com often to stay updated with your child's school and district activities.

Student Name:	School:
Student Name:	School:
Student Name:	School:
Student Name:	School:

Please check to give or deny consent:

□ Yes, my child(ren) may be photographed.

□ No, my child(ren) may not be photographed. (If no, please indicate exceptions, such as yearbook, group photo, photo only - no name, name only -no photo, etc., on the back of this form.)

By granting permission, I understand that my consent will remain in effect until I notify the District in writing.

Parent/guardian signature: _____

Date: _____

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STUDENT CONFIDENTIAL HEALTH RECORD

Student's Name First:	Middle:	Last:	
Date of Birth:	Grade:	Phone:	Sex: □ Male □ Female
Father's Name:		**Phone:**	
Mother's Name:		**Phone:**	
Person with whom child lives if other than parent:		**Phone:**	

COMMUNICABLE DISEASES/CONDITIONS – Has your child ever been diagnosed with any of the following diseases or conditions? Please check next to all that apply.		
□ Asthma □ Inhaler	□ Hepatitis B	□ Mumps
□ Whooping Cough	□ Measles	□ German Measles
□ Scarlet Fever	□ TB Tine test – Date:	□ Emotional Problems
□ Varicella - Chicken Pox – Date of disease or age child was when had disease:		
□ Varicella Vaccine – Date given:		
□ Varicella lab evidence – Date:		

Vision problems (please check) □ Glasses □ Difficulty seeing □ Frequent redness □ Frequent watering □ Crossed eyes □ "Lazy" Eye	Hearing problems (please check) □ Hearing aids □ Difficulty hearing □ Draining ears □ Frequent ear infections □ OPERATION(S) & DATE(S):

Is your child highly allergic to anything such as foods, plants, insects, medicine? □ No □ Yes If yes, explain:

Does your child need a special diet or have any food problems? □ No □ Yes If yes, explain:

Do you think your child is fit to participate in all school sports, athletics, playground activities and/or gym? □ No □ Yes If no, explain:

Is your child presently under medical treatment? □ No □ Yes **Explain:**

Serious injury or illness in the past year or any other health problems:

04/2016

MEDICAL / EMERGENCY CARE INFORMATION

Physician:	Phone:
Dentist:	Phone:
Daily Medication (see attached medication policy) Name of medication:	 Dosage: At home ☐ At school
Does the district have permission to share health problems/needs with the staff? ☐ No ☐ Yes	

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? GIVE DETAILS:

Chicken Pox:
Operations:
Recurring Illness:
Emotional Problems:
Serious Accidents:
Allergies:
List any illness or health problem you or your family physician feel should be known to school authorities:

By signing this document, I give permission for medical treatment to be given to my child in the event of an emergency, trauma, or condition requiring such treatment. I have reviewed and understand the above information to my satisfaction.
Parent signature: Date:

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

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

Signature of parent / guardian / emancipated student_____ Date_____

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

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

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

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

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

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ Phone_____

Signature of examiner_____ MD ☐ DO ☐ PAC ☐ CRNP ☐

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

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

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address