Fox Chapel Area School District

KINDERGARTEN REGISTRATION INFORMATION

Fox Chapel Area School District utilizes an online registration system. Paper registration is not available. A valid email address and a computer with Internet access will be required to complete registration. You may also use a phone or tablet with a web browser. It is best to gather the required documents below **BEFORE** filling out the online application. Online registration must be completed before you visit the elementary school to complete the registration process. Your application is not complete until **ALL** documents have been submitted in person to the school. Computers will be made available to families requiring assistance on the days and times of your elementary school's registration found on the Important Dates document in this packet.

It would be helpful to have the following information available to complete the online Student Registration:

- 1 to 3 emergency contacts (not including yourselves)
- Early dismissal plan
- Physician's and Dentist's name and phone number
- Health insurance company name and policy number
- List of medications for each student (if applicable)

If you are unsure of which school your child will attend and would like to verify this information prior to completing the registration process, you may call any one of our schools. Assigned school is contingent on address verification by enrollment personnel.

Fairview Elementary	412-963-9315	Kerr Elementary	412-781-4105
Hartwood Elementary	412-767-5395	O'Hara Elementary	412-963-0333

To access the registration portal, go to **http://register.fcasd.edu** . You will need to create a new account to begin the registration process even if you have older children in the District. This account is separate from your PowerSchool account which is activated only after the registration process is completed.

If you encounter technical difficulties, support is available online at the PowerSchool Community Support Center as well as by phone at 1-866-752-6850, option #2.

Please turn over to see the documents you will need to complete the registration process.

Once your online registration is complete, you will need to bring the following documents to the school during one of the scheduled kindergarten registration days.

What You Need to Bring with You

All of these:

- ☐ Child's original **Birth Certificate** (with raised seal), passport, baptismal certificate, or official hospital documents for verification of birth date
- ☐ Child's up-to-date **Immunization Records** (Immunizations will not be complete until child is 5, nurse will review)
- ☐ **Parent/ Guardian Photo Identification**
- ☐ **Parental Registration Statement** (Will be available to sign at registration presence of school, no notary needed for kdg.)

Two of these:

Documents must have the name and current address of the student's parent/guardian.

- ☐ **A lease/rental agreement** *
  (*If the student's family is living with family members or friends, a notarized statement signed by the student's parent and an adult from the home where they are living may substitute for lease/ rental agreement. Use form 200-AR-4 "Sworn Statement by Resident".- The resident must also provide one document of residency. RESIDENT MUST APPEAR AT TIME OF REGISTRATION.)
- ☐ **Bill of sale for home/ mortgage arrangements**
- ☐ **Current utility bill -within 30 days (you may use 2 bills from separate utilities- gas, electric, telephone, water/sewer)**
- ☐ **Official pay stub with address (within 60 days)**
- ☐ **Verification of registration at the tax office**

If Applicable:

- ☐ **Court order for foster child or custody arrangements**
- ☐ **Special education records** (current IEP, current NOREP, current RR, initial ER).

Please note: Dental and Health Exams Forms are *not* required to register your child for kindergarten. Proof of their immunizations needs to be turned in prior to the first day of school. The dental and health exams need to be completed during their Kindergarten year and we cannot accept forms from exams that are older than one year prior to the entry of kindergarten. The health and dental exam can be provided by the school or your health providers. The forms are available online or from the school.

Fox Chapel Area School District

NOTICE OF PENNSYLVANIA SCHOOLS IMMUNIZATION REQUIREMENTS

Unless exempted for religious or medical reasons or permitted provisional attendance by the Superintendent or designee, all students in kindergarten through twelfth grade must provide proof of immunization.

The Pennsylvania immunizations and screenings required for school entry are:

Required Immunizations, Properly Spaced, for Grades K-12

- **4 doses of tetanus, diphtheria and acellular pertussis (1 dose on or after 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 and rubella, usually given as MMR**
- **3 doses of hepatitis B**
- **2 doses of varicella (chicken pox) or a written statement from physical/designee indicating month and year of disease or serologic proof of immunity**

Required Immunizations for Grades 7-12

- **1 dose of tetanus/diphtheria/pertussis (Tdap, given as Adacel or Boostrix)**
- **1 dose of meningitis vaccine (MCV4)**

Required Immunizations for Grades 12

- **2nd dose of meningitis vaccine (MCV4)**

Children 0-18 years can receive free immunizations from the Allegheny County Health Department if they are on Medicaid, if they have no health insurance, or if their health insurance does not cover vaccines, or if they are American Indian or Alaskan Native. Call 412-478-8060 for time and location. Any further questions may be addressed to the Certified School Nurse in the building to which your child is assigned.

Parents should notify the school nurse of any immunizations (booster shots) given to the student during the school years. Updated Tetanus information is extremely important if your child becomes injured.

These Immunization Requirements are current and are subject to change by the State of Pennsylvania.

Fox Chapel Area School District

NOTICE OF PENNSYLVANIA SCHOOLS PHYSICAL AND DENTAL EXAMINATION REQUIREMENTS

In an effort to provide some direction for promoting better health standards, a Health Code has been developed by the Pennsylvania Department of Health. Among the provisions included are sections relating to physical and dental examinations of students.

Physical examinations are required on entering school (kindergarten or first grade), in the sixth grade, and in the eleventh grade.

Dental examinations are required on entering school (kindergarten or first grade), in the third grade, and in the seventh grade.

If you prefer to have these examinations given by your personal physician or dentist, you may do so. However, forms for recording appropriate information, which are available from the school, must be completed by the examining physician and/or dentist and returned to the school nurse.

Records of examinations in the grades listed above are mandatory and must be included in the health folder and kept throughout the student's school career.

Thank you for your understanding. If you have any questions, please feel free to contact your child's building nurse.

Fox Chapel Area School District

PERMISSION FOR PHYSICAL / DENTAL EXAM

NAME OF CHILD _____

PARENT OR GUARDIAN _____

DATE _____ **GRADE** _____

The laws of the Commonwealth of Pennsylvania provide for a periodic health examination of all children who are attending school. Physical examinations are required on original entrance to school (Kindergarten or Grade 1), Grades 6 and 11. Dental examinations are required on original entrance (Kindergarten or Grade 1), Grades 3 and 7.

Please check the appropriate answer:

_____ **I wish to take my child to our own doctor for examination.** Please complete the enclosed form and return it to the school in the fall.

_____ **I wish to take my child to our own dentist for an examination.** Please complete the enclosed form and return it to the school in the fall.

_____ **I wish my child to be examined in school by the school physician.** If you require any special needs or arrangements for your child's school physical, please notify the school nurse.

_____ I wish to be present during the physical examination and understand I will be notified of the time and date.

_____ **I Do Not** wish to be present during the physical examination at school**.**

_____ I wish my child to be examined in school by the school dentist.

_____ I wish to be present during the dental examination and understand I will be notified of the time and date.

_____ **I Do Not** wish to be present during the dental examination at school.

Parent/Guardian Signature_____

MUST BE RETURNED TO THE SCHOOL NURSE

Fox Chapel Area School District

FAMILY DENTIST REPORT

Name of Student _____ Grade _____ Room _____

The above named student last visited my office on _____. At that time all necessary dental corrections were made.

YES _____ NO_____

If the answer is no, please fill in the following information:

Primary teeth _____ Fillings _____ Extractions _____

Permanent teeth _____ Fillings _____ Extractions _____

Diseases of the supporting tissues _____

Gross malocclusion, which is producing a facial deformity or is interfering with function _____

Cleft palate and/or cleft lip _____ Other congenital malformation _____

Prosthetic replacements for lost or missing teeth _____

The child is currently under treatment YES_____ NO _____

Signature _____ D. D. S.

Address _____

ACT OF GENERAL ASSEMBLY NO. 404

Section 1407. Examinations by Examiners of Own Choice. -In lieu of the medical or dental examinations prescribed by this article, any child of school age may furnish the local school officials with a medical or dental report of examination made at his own expense by his family physician or family dentist on a form approved by the Secretary of Health for this purpose. The in lieu examinations shall be made and the report shall be furnished prior to the date fixed for the regularly scheduled examination but no earlier than four months prior to the opening of the school term during which the regular examination is scheduled.

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_____

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 ☐**

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

IMMUNIZATION EXEMPTION(S):

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

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

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

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

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

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