PLEASE COMPLETE FORMS AND RETURN THE FOLLOWING WITH YOUR FORMS IN THE ENVELOPE YOU RECEIVED WITH THE FORMS.

KINDERGARTEN:

1. Two different forms of proof of residency (i.e, tax bill, mail, driver's license, etc.)
2. Birth Certificate
3. Copy of immunizations

PRE-K:

1. Two different forms of proof of residency (i.e., tax bill, mail, driver's license, etc.)
2. Birth Certificate
3. Copy of immunizations
4. Proof of income (2020 federal tax return, 2020 W-2s or 3 current consecutive paystubs)

Should you have any questions, please feel free to contact the elementary office at 570-547-1608, ext. 1127 or by email at jkulka@montasd.org.

MONTGOMERY AREA SCHOOL DISTRICT
KINDERGARTEN REGISTRATION

CHILD'S NAME _____ SEX: F or M SS#: _____
Last First Middle (circle one)

GUARDIAN'S ADDRESS _____
Street Address Town State Zip Boro/Township

DOB_____ STATE OF BIRTH _____ **If other than PA, date entered PA** _____

CITY OF BIRTH _____ COUNTRY OF BIRTH _____ **If other than US, date entered US** _____

FATHER'S NAME _____ HOME # _____ CELL # _____

EMAIL ADDRESS _____ EMPLOYER AND # OF EMPLOYER _____

MOTHER'S NAME _____ HOME # _____ CELL # _____

EMAIL ADDRESS _____ EMPLOYER AND # OF EMPLOYER _____

STUDENT LIVES WITH (CIRCLE) - MOTHER - FATHER - STEPFATHER - STEPMOTHER OTHER _____

IS THERE A CUSTODAY AGREEMENT? YES NO NOT APPLICABLE
(PLEASE CIRCLE ONE)

If so, a copy must be on file in the office. If you do not have a copy with you today, please submit one to the elementary office ASAP.

NON-CUSTODIAL PARENT'S ADDRESS (If applicable) _____

LIST PRIORITY PHONE NUMBERS FOR FATHER AND MOTHER THAT WILL BE USED IN THE DISTRICT'S AUTOMATED CALLING SYSTEM

FATHER 1) _____ 2) _____ 3) _____

MOTHER 1) _____ 2) _____ 3) _____

WHO SHOULD BE SET AS THE PRIORITY CONTACT FOR THE AUTOMATICE SYSTEM? (CIRCLE ONE) MOTHER FATHER

IF YOU SHOULD NEED TO CHANGE ANY OF THESE PHONE NUMBERS OR YOUR ADDRESS, YOU WILL NEED TO CONTACT THE OFFICE DIRECTLY. UPDATES OF ADDRESSES AND PHONE NUMBERS WILL ***NOT BE TAKEN OFF OF THE EMERGENCY CARD AT THE BEGINNING OF EACH YEAR. ***ALL CHANGES*** MUST BE DONE BY DIRECT CONTACT WITH THE OFFICE.***

NAMES OF OTHER ADULTS RESIDING IN THE CHILD'S HOUSEHOLD, ALONG WITH RELATIONSHIP AND PHONE NUMBER IF NOT LISTED ABOVE

_____

_____

NAMES AND AGES OF OTHER CHILDREN IN HOUSEHOLD _____

MEDICAL OR EDUCATIONAL NEEDS WHICH WE SHOULD BE AWARE? ____ YES ____ NO If so, please explain _____

_____

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan)? ____ YES ____ NO If so, please explain _____

_____

ETHNIC IDENTITY: (check 1) _____ Hispanic or Latino _____ Not Hispanic or Latino
(optional)

RACE: (you may check 1-2 that apply) ____ White ____ Black/African American ____ Asian ____ American Indian or Alaska Native
(optional) ____ Native Hawaiian or Other Pacific Islander
What is the primary household language _____

BY SIGNING BELOW I SWEAR THAT I AM A RESIDENT OF MONTGOMERY AREA SCHOOL DISTRICT AND ALL INFORMATION IS TRUE AND CORRECT.

_____ _____
PARENT/GUARDIAN'S SIGNATURE DATE

MONTGOMERY AREA SCHOOL DISTRICT
120 PENN STREET
MONTGOMERY, PA 17752

PROGRAMS FOR LIMITED ENGLISH PROFICIENCY STUDENTS

(Student Home Language Survey)

Student's Name _____
First Name Middle Name Last Name

School: Montgomery Elementary Montgomery Jr./Sr. High School
(Circle One)

Person Completing Survey (for the student named above):
_____ Mother _____ Father _____ Guardian
_____ Other (specify): _____

Circle the best answer to each question and provide additional information (for the student named above):

1. Was the first language you learned English? No Yes
2. Can you speak a language other than English? No Yes
3. Is any language other than English used at home? No Yes
4. Which language do you use most often with friends? English Other: _____
5. Which language do you use most often at home? English Other: _____
6. Which language do you use most often with other relatives? English Other: _____
7. Have you attended school in a country other than the United States? No Yes (How long and what grades)
   _____
8. Have you attended another school in the United States No Yes (Where and how long)
   _____
9. Please provide any other related information that would help the school (for example, referral to gifted or special education programs in prior schools, etc.): _____
   _____
   _____
   _____

RETURN THIS PAGE

Montgomery Area School District Health History

Students Name_____ Parents_____

Address_____ Phone Number_____

Grade_____ Is Student transferring from another school?_____ State transferring from_____

The information on this form will help the school nurse in determining the health status of your child and will assist him/her to receive the maximum benefits from his educational experience.

Has your child had any of the following? If so please describe.

Whooping Cough_____

German Measles_____

Mumps_____

Bee Sting Allergy_____

Other Allergy_____

Asthma_____

Heart Disease_____

Diabetes_____

Ear Disease_____

Vision Problems_____

Serious Accidents_____

Operations_____

Scarlet Fever_____

Measles_____

Polio_____

Bowel Disease_____

Stomach Problems_____

Skin Disease_____

Chicken Pox_____

Recurring Illness_____

Hearing Problems_____

Urinary Tract Disease_____

Emotional Problems_____

Other Issues_____

Please list any illness or health problem which you or your family doctor feels should be known by school personnel. _____

Family Doctor_____ Phone Number_____

Please feel free to contact the school nurse at 570-547-1608 ext 125 to discuss any confidential information you wish to share

RETURN THIS PAGE.
Please fill out in addition to attaching immunization record.

MONTGOMERY AREA SCHOOL DISTRICT

Child's Name _____ (Last) (First) (Middle)

Birth Date _____ Sex _____

Father's Name _____ (Last) (First) (Middle)

Mother's Name _____ (Last) (First) (Maiden)

Child Lives With _____

Address _____ Telephone _____

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter Month, Day, And Year Each Immunization Was Given DOSES				
Diptheria and Tetanus (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	
Hepatitis B	1 / /	2 / /	3 / /		
Measles - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology: Date		Titer
Varicella (Vaccine or Disease)	1 / /	2 / /	Rubella Serology: Date		Titer
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Doses required by law for new school enterers (K or 1st Grade) are shaded in green.
Age appropriate dose(s) of varicella vaccine or history of disease and 3 doses Hepatitis B vaccine required for entry into 7th grade.
To the best of my knowledge, this child has received the minimum required immunizations. Source ☐ Written ☐ Verbal ☐ Both

Signed _____ DO NOT SIGN UNLESS MINIMUM REQUIRED DOSES ARE COMPLETE Date _____
(PHYSICIAN, PUBLIC HEALTH OFFICIAL, SCHOOL NURSE, OR THEIR DESIGNEE)

H502.320 Rev. 2/01

I certify that the information provided is correct _____
Parent or Guardian

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

MEDICAL EXEMPTION

The physical condition of the above named child is such that immunization would endanger life or health.

Signed _____ Date _____
(PHYSICIAN)

RELIGIOUS EXEMPTION

(Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption _____

Signed _____ Date _____
(PARENT OR GUARDIAN)

THIS FORM MUST ACCOMPANY YOUR CHILD TO THE FREE VISION SCREENING

RETURN

NORTH CENTRAL SIGHT SERVICES INC.

Member of Pennsylvania Association for the Blind

ROBERT B. GARRETT PRESIDENT/C.E.O.

W AA A H NA O UK

DATE: MAY 14 & 15, 2015

SITE: MONTGOMERY AREA PRESCHOOL REG.

SCR: _____ REFERRED: ☐

FREE VISION SCREENING!

Our organization is scheduled to perform **FREE Vision Screenings** at your child's preschool. Young children don't always know they are having trouble seeing because they often don't know how they should see the world around them. Most eye problems do not go away as a child grows! Early detection and treatment yields the best results. Parents should also be alert for signs of vision problems that include: frequent rubbing of the eyes, holding books and papers close to the face, squinting, excessive blinking, or tilting of the head from one side to the other. Covering one eye to favor the other, frequent sties or redness, and even watery eyes can also be signs of a vision problem.

The screening will be conducted by our highly trained staff using the latest technology--the Welch Allyn SPOT Screener, a camera like device that scans the eye for **SIX** different vision problems in a matter of seconds. Please fill out the consent form below and return to your child's preschool as soon as possible. *Only children with signed consent forms will be able to participate.*

VISION SCREENING CONSENT & REGISTRATION FORM | COMPLETE IN FULL (PLEASE PRINT)

Please mark one: ☐ I DO want my child screened. ☐ I DO NOT want my child screened.

Child's Name: _____ **Age:** _____ **Date of Birth:** _____ **Gender:** M F

Parent/Guardian Name: _____ **Phone:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email (optional): _____ **County of Residence:** _____ **School Dist:** _____

Known Vision Issues/Concerns: _____

Date of child's last eye exam: _____ **(Circle One): Pediatrician or Optometrist/Opthalmologist**

As the undersigning parent/guardian, I hereby grant permission to North Central Sight Services, Inc. to screen the vision of the above named child. If a professional eye exam is recommended, I give my consent to permit North Central Sight Services, Inc to obtain information from the examining eye specialist regarding my child's eye examination and recommended treatment and to furnish such information, as needed, to the appropriate school/agency. I also understand that follow-up is required and that I may be contacted by the agency for further information. In addition, I understand that this procedure is a limited vision screening, designed only to detect certain symptoms of potential vision problems in children. It is not an eye exam and is not intended to take the place of a professional eye exam performed by an optometrist or opthalmologist.

Parent/Guardian Signature: _____ **DATE:** _____

Occasionally, North Central Sight Services will use pictures taken during screenings and events for marketing purposes. If you wish for your child's picture not to be used in our non-profit marketing material, please initial here. _____

Office Use Only

OD		OS	
SE	_____	SE	_____
OS	_____	DS	_____
OC	_____	OC	_____

North Central Sight Services, Inc.

2121 Reach Road PO Box 3292 Williamsport, PA 17701-0292

Phone (570) 323-9401 Toll Free 1-866-320-2580 Fax (570) 323-8194

Our Prevention of Blindness and Social Services Programs are funded in part through grants from the PA Dept. of Labor and Industry, Bureau of Blindness & Visual Services, Office of Vocational Rehabilitation, and the United Way.

FILL OUT AND RETURN

Attachment N

Dear Parents:

The School Health Law requires **medical examinations** for children in Grades Pre-K, K, 6, and 11 and **dental examinations** for those in Grades Pre-K, 1, 3 and 7. These grades were selected because they represent critical periods of growth and development in a child's life.

You are receiving this letter because your child will require this exam **next** school year. **(2021-2022).**

We are recommending that these examinations be done by your family physician or dentist. They can best evaluate your child's health and assist you in obtaining necessary treatment and corrections. An exam dated no earlier August 27, 2020 will be accepted for the 2021-2022 school year. Sports physicals done during the school year will also be accepted.
After this mandated exam, **please provide a copy to the school nurse** or your doctor can fax it directly. The nurse's office fax is 570-515-0093.

Sincerely,

Mrs. Walton, RN, MSN, CSN
School Nurse

Name of Child _____ Grade (next year) _____

_____ Yes, I want the exam done at school.

_____ No, I will have a private exam for my child.
_____ - Date exam is scheduled.

_____ _____
Parent Signature Date

YOU KEEP

Attention Parents/Guardians

DON'T WAIT – VACCINATE NOW

FOR ATTENDANCE IN ALL GRADES children need the following:

- 4 doses of tetanus*
  (1 dose on or after the 4th birthday)
- 4 doses of diphtheria*
  (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) vaccine or history of disease

*Usually given as DTP or DTaP or DT or Td
**Usually given as MMR

Children ATTENDING 7th grade need the following:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (MCV)

These requirements allow for the following exemptions:
Medical reason
Religious belief
Philosophical/strong moral or ethical conviction
If your child is exempt from immunizations,
he/she may be removed from school during an outbreak.

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

pennsylvania
DEPARTMENT OF HEALTH

Dear Parents/Guardian: CONFIRM WITH DOCTOR THAT YOUR CHILD HAS ALL.

Your child may not be up to date with the Pa State Immunizations required for school for the 2021-2022 school year. It is possible that the school does not have the most up to date immunization record for your child. Please contact your doctor and either set up an appointment for the needed doses or get an updated copy and provide it to the school nurse. **They will be placed on provisional enrollment for 2021-2022 (this applies to all students, hybrid and remote) without these immunizations and a copy given to the nurse. They will not be allowed to attend after the fifth day of school next year without these.**

You may contact your doctor or local Department of Health at 570-327-3440 to obtain these vaccinations if you do not have health insurance.

Please make sure the updated copy is then giving to the school nurse.
They can be faxed to me at 570-515-0093. Please call to confirm they have been received to prevent exclusion

The immunizations needed are listed below:

_____ DTP #1 #2 #3 #4 (After 4th birthday)

_____ Hepatitis #1 #2 #3

_____ Polio #1 #2 #3 #4 (after 4th birthday)

_____ MMR #1 #2

_____ Varicella #1 #2

7th grade:

_____ Tdap

_____ MCV (Meningococcal)

12th grade:

_____ MCV (Meningococcal)

Thank you for your prompt attention to this matter

Sincerely,

Mrs. Walton RN, MSN, CSN

FOR YOUR DOCTOR TO FILL OUT AND RETURN

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
▪ Height (inches)				
▪ Weight (pounds) BMI				
▪ Pulse ( )				
▪ Blood Pressure				
▪ Hair/Scalp				
▪ Skin				
▪ Eyes/Vision				
▪ Ears/Hearing				
▪ Nose and Throat				
▪ Teeth and Gingiva				
▪ Lymph Glands				
▪ Heart – Murmur, etc				
▪ Lung – Adventitious Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
PRINT Name of Examiner

_____
Address

_____
Telephone Number