WEST CHESTER AREA SCHOOL DISTRICT
ENTRY QUESTIONNAIRE

Date: ____________________

Child's Full Name: ______________________________ ☐ Male ☐ Female
Last *First* *Middle*

Birth Date: ______________ Child lives with: ______________________
mm/dd/yy

Mother's Name: ______________________ Maiden Name: ______________________

Father's Name: ______________________ Guardian Name: ______________________

Address: ____ Zip: __________

Home Phone #: __________ Work Phone #: __________ Fax/Beeper #: __________

Child's School History

Grade entering: __________ School: ______________________

Previous school attended: Name: ______________________ None: __________

School's Location: (city, state, zip) ______________________

Dates of attendance (month, year): From: __________ To: __________

Number of days per week: ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days

Child's Health History

Child's Birth Weight: ________ lbs ________ oz

Problems with pregnancy (optional): ☐ No ☐ Yes Explain: ______________________

Any Health Conditions/Problems? ☐ No ☐ Yes Describe: ______________________

On any medication? ☐ No ☐ Yes Explain: ______________________

Serious illness or accidents? ☐ No ☐ Yes Describe: ______________________

Has your child been hospitalized? ☐ No ☐ Yes If yes, at what age: ______ For how long? ______

Why? ______________________

Has your child had chicken pox disease? ☐ No ☐ Yes Date: ______________________

Date of most recent physical exam: ______________ Name of Doctor: ______________

Date of most recent dental exam: ______________ Name of Dentist: ______________

Does your child have any allergies? ☐ No ☐ Yes Food: __________ Medication: __________

Did your child ever sustain a traumatic brain injury/concussion? ☐ No ☐ Yes Explain: __________

Hearing

Was hearing ever tested? ☐ No ☐ Yes

Hearing difficulty? ☐ No ☐ Yes Describe: ______________________

Ear infections: ☐ No ☐ Infrequent (1-3 per year) ☐ Frequent (4+ per year) ☐ Prolonged (10-14 day +)

Vision

Has your child had an eye test? ☐ No ☐ Yes Results: ______________________

Any visual problems? ☐ No ☐ Yes Describe: ______________________

PLEASE COMPLETE BOTH SIDES

TUBERCULIN RISK EVALUATION

Please read the "High Tuberculosis risk" situations listed below. If your child has a high risk for tuberculosis, the school nurse will refer your child to your Health Care Provider for further testing.

- he/she is living with a person with infectious TB
- he/she has had extensive travel in high risk tuberculosis areas
- he/she has an HIV infection or another condition that is a high risk for TB disease
- you think your child might have TB disease
- your child is foreign born from a country where TB disease is very common (most countries in Latin America and the Caribbean, Africa, and Asia, except for Japan)
- he/she is living with an IV drug user
- he/she lives or has lived in a communal sitting where TB disease is common (most homeless shelters, migrant farm camps, orphanages)
- he/she is living with a person who recently has been in prison and/or jail, or a nursing home

Is your child at risk for Tuberculosis? ☐ No ☐ Yes **Explain:** ____________________

Your child is being referred to your Health Care Provider for further Tuberculin testing. ☐ No ☐ Yes

EXAMINATIONS AND TESTS – KINDERGARTEN THROUGH TWELFTH GRADE

I understand that state law requires physical examinations (grades K/1,6 and 11th) and dental examinations (grades K/1,3 and 7th). If these are not performed by the student's private physician or dentist, they may be received at school.

State law also requires school nurses to perform yearly screening tests for growth, body mass index, vision, color vision, hearing, and scoliosis. I understand that I will be informed of any abnormal results of health examinations and tests given to my child by the School Nurse.

STUDENT HEALTH RECORD

I understand that Student Health Records are kept confidential. The information in the Student Health Record is shared with school personnel only when that information is relevant to the education of the child. As with all student records, the Student Health Record is shared with persons outside of the school district only with the written consent of parents / guardians. The Student Health Record does follow the student as they transfer to other public and private schools.

IMMUNIZATION PERMISSION

The West Chester Area School District in coordination with the Chester County Health Department is establishing a means of tracking immunizations for children. By tracking the immunizations, any school district needing immunization information would be able to obtain this data immediately.

As parent and/or guardian of the minor child, ______________________________ I hereby authorize the release of the medical **immunization record only**, past, and present, of said minor for the purposes of inclusion in the Health Department immunization tracking system, provided that said information shall at all times be held in confidence, excepting the Health Department and the designated health care provider or insurer. If you have a questions please call Sandra Schwartz, MSN. R.N. at the Chester County Health Department (610) 344-5562 or 1-800-692-1100 ext. 5562.

____________________ ______________________________

DATE **SIGNATURE OF PARENT/GUARDIAN**

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