UCF | Unionville-Chadds Ford School District

New Student Enrollment Checklist

Please bring the following to your appointment with our Registrar.

- ❏ Child's Proof of Age - one (1) of the following:
  - ❏ Birth certificate
  - ❏ Notarized copy of birth certificate
  - ❏ Baptismal certificate
  - ❏ Copy of the record of baptism, notarized or duly certified and showing date of birth
  - ❏ Notarized statement from the parents/guardians or relative indicating date of birth
  - ❏ Valid passport
  - ❏ Prior school record indicating date of birth
- ❏ Proof of Residency - one (1) of the following documents is required:
  - ❏ Property Deed
  - ❏ Mortgage Statement
  - ❏ Settlement Statement
  - ❏ Current Lease
  - ❏ Letter from employer evidencing employer provided housing

  AND one (1) of the following:
  - ❏ Driver's License
  - ❏ Government Issued ID
  - ❏ Vehicle Registration Card
  - ❏ Utility Activation or Current Billing Statement
  - ❏ Current Credit Card Statement
  - ❏ Property Tax Bill
- ❏ Immunization record
- ❏ Release of Records (attached)
- ❏ Health Services Form (attached)
- ❏ Physical Form (attached)
- ❏ Dental Form (attached)
- ❏ Home Language Survey (attached)
- ❏ Parental Registration Statement (attached)
- ❏ Custody Agreement, if applicable
- ❏ Special Education, Gifted or 504 Documents, if applicable
- ❏ Most recent report card, if applicable

In addition, please make sure you have submitted a **New Student Enrollment** form on our website, www.ucfsd.org.

District Office is located at the far right of the Unionville High School building when facing the High School. Proceed down the steps or ramp. Door is on the right side of the building.

Registrar Contact Information:
Noelle Nocera
Unionville-Chadds Ford School District
740 Unionville Road
Kennett Square, PA 19348
P: (610) 347-0970 x3300
enrollment@ucfsd.net

UCF | Unionville-Chadds Ford School District
740 Unionville Road • Kennett Square • Pennsylvania 19348 • (610) 347-0970 • www.ucfsd.org

AUTHORIZATION FOR RELEASE OF RECORDS

School student is transferring from:

School: _____

Street: _____

City: _____

State/Zip: _____

I hereby authorize you to furnish educational, medical, special education, or psychological information and any other records you may have pertaining to my child:

Child's Name: _____ **Birthdate:** _____

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

Records Requested

- Report Cards
- Official Transcript
- School Profile
- Standardized or State Testing Reports
- SAT/ACT Scores
- IEP/504/Gifted Documentation
- Health Records including Immunizations
- Attendance Records
- Discipline Records

Please send to:

Chadds Ford Elementary School
Attn: Student Records
3 Baltimore Pike
Chadds Ford, PA 19317
Fax: 610-388-8481
Phone: 610-388-1112

Pocopson Elementary School
Attn: Student Records
1105 Pocopson Road
West Chester, PA 19382
Fax: 610-793-7792
Phone: 610-793-9241

Charles F. Patton Middle School
Attn: Student Records
760 Unionville Road
Kennett Square, PA 19348
Fax: 610-347-0421
Phone: 610-347-2000

Hillendale Elementary School
Attn: Student Records
1850 Hillendale Road
Chadds Ford, PA 19317
Fax: 610-388-2266
Phone: 610-388-1439

Unionville Elementary School
Attn: Student Records
1775 West Doe Run Road
Kennett Square, PA 19348
Fax: 610-347-1443
Phone: 610-347-1700

Unionville High School
Attn: Student Records
750 Unionville Road
Kennett Square, PA 19348
Fax: 610-347-1677
Phone: 610-347-1600 x3073
Email: pdrumheller@ucfsd.net

UNIONVILLE-CHADDS FORD SCHOOL DISTRICT

HEALTH SERVICES

Child's Name:_____

Grade:_____

Birth Date:_____

1. **All students must present proof of immunizations at the time of enrollment.**

2. All **transfer students** must have a physical exam and a dental exam, unless these requirements are met by forms sent from a previously attended Pennsylvania school.

3. Pennsylvania School Health Law requires that all students have a physical on original entry to Pennsylvania schools. It is recommended that his exam be done by your family physician that can give follow-up care and needed immunizations.

   Physical exam form attached _____

   Our physician will complete the physical_____

   Please have the school physician examine my child_____

4. Pennsylvania School Health Law requires that all students have a dental examination on original entry to Pennsylvania schools. We encourage you to have this exam completed by your family Dentist.

   Dental exam form attached _____

   Our dentist will complete the dental exam_____

   Please have the school dentist examine my child_____

   Parent's Signature:_____

   Date:_____

(1/13)

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)

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19 ____

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

ADDRESS

No. and Street	City or Post Office	Borough or 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

HOME LANGUAGE SURVEY*

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: Unionville Chadds Ford School District **Date:**_____
School:_____

Student's 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.

(12/09)

PARENTAL REGISTRATION STATEMENT

Student's Name:_____

Date of Birth:_____ Grade:_____ Telephone:_____

Parent/Guardian Name(s):_____

Address:_____

_____

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 or is presently 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 by checking all that apply:

I hereby swear or affirm that my child:

☐ **IS NOT PRESENTLY SUSPENDED AND/OR EXPELLED**

☐ **WAS NOT PREVIOUSLY SUSPENDED AND/OR EXPELLED**

☐ **IS PRESENTLY SUSPENDED AND/OR EXPELLED**
(If checked, please complete the boxed area below)

☐ **WAS PREVIOUSLY SUSPENDED AND/OR EXPELLED**
(If checked, please complete the boxed area below)

From any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or 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.

If the student is presently or was suspended and/or expelled from another school, please complete:

Name of School from which student was suspended and/or expelled:_____

_____

Date(s) of suspension and/or expulsion:_____

Please provide additional school and dates of suspension and/or expulsion on the back of this sheet.

Reason for suspension and/or expulsion (optional):_____

_____

_____ Date_____

Parent Signature

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

(12/09)