

# Muhlenberg School District - New Student Registration Requirements

To enroll a new student at the Muhlenberg School District, **please call and schedule an appointment with the Registrar.** Registrations are by appointment only. \*\*\*Kindergarten students must be five (5) years old, on or before August 31<sup>st</sup>, to be admitted in the fall.

**Central Registrar** - Blue Center  
Located by the tennis courts and  
C.E. Cole gym.

**Grades Kindergarten – 6th**  
Nytza Santiago  
610-921-8000 ext: 5510  
santiagon@muhlsdk12.net

**Grades 7th - 12th**  
Elizabeth Lanning  
610-921-8000 ext: 5536  
Lanninge@muhlsdk12.net

**\*\*Please bring the following documents to your Registration Appointment\*\***

## Two (2) Proofs of Residency

### If you Own:

- ✓ Mortgage Statement, Tax Bill or Deed **AND one of the following items:**
- ✓ Utility Bill (gas, electric, water, trash) or
- ✓ Current vehicle registration or
- ✓ Voter registration card or
- ✓ Current payroll stub/statement from wages, public assistance or Social Security

### If you Rent:

- ✓ Lease or Rental Agreement which *list all student's names* on the lease.
- AND one of the following items:**
- ✓ Utility Bill (gas, electric, water, trash) or
  - ✓ Current vehicle registration or
  - ✓ Voter registration card or
  - ✓ Current payroll stub/statement from wages, public assistance or Social Security

**OR**

**If living with a resident of the Muhlenberg School District, please bring the following documents to your Registration Appointment.**

### If Primary Resident Owns:

- Primary Resident completes our Certificate of Residency form which must be **signed in front of a Notary.**
- ✓ Mortgage Statement, Tax Bill or Deed AND one of the following items:
  - ✓ Utility Bill (gas, electric, water, trash) or
  - ✓ Current vehicle registration or
  - ✓ Voter registration card or
  - ✓ Current payroll stub/statement from wages, public assistance or Social Security

### If Primary Resident Rents:

- A Lease agreement which includes the names of the students & parents living with the primary resident.
- A letter or an Addendum from Landlord confirming and listing the names of students & parents living with primary resident.

→ **The individuals sharing a home with the Muhlenberg Resident must provide TWO of the following proofs:**

- Voter registration card
- Current vehicle registration
- A utility bill in the owner's name
- Current payroll stub/statement from wages, public assistance or social security

**AND**

Photo ID of the parent or guardian - (Not a requirement for registration but encouraged)

✓  
**Birth Certificate**

✓  
**Immunization Records**

✓  
**IEP**  
Individual Education Plan  
\*If applicable

**A parent/guardian must be present in order for a student to enroll.**

**Appointment Date / Time:** \_\_\_\_\_

**MUHLENBERG SCHOOL DISTRICT  
STUDENT REGISTRATION FORM**

Today's Date: \_\_\_\_\_

Page 1 of 2

Check school below that student is entering:

- ☐ Elementary Center (K-3)      ☐ C.E. Cole Intermediate School (4-6)      ☐ JH School (7-9)      ☐ High School (10-12)
- ☐ Virtual School (K-12)

**PLEASE COMPLETE THE FOLLOWING VITAL INFORMATION**

Student Last Name	First Name	Middle Name	Mother's Maiden Name	Entering Grade	Sex
Social Security No. *	Birthdate	Birth City/State/Country		Home Phone (     ) <input type="checkbox"/> Check if Unlisted	
Student's Address  Street Address  City/State/Zip		Is the student of Hispanic or Latino ethnicity?  <input type="checkbox"/> Yes  <input type="checkbox"/> No		Race Category (Check all that apply) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Multi-Racial	
Date your student first attended a school in the USA (Month/Year)			Date your student first attended a PA public school <b>or</b> the date your student returned to a PA public school (Month/Year)		

**PRIMARY HOUSEHOLD INFORMATION: Use page 2 to supply information concerning other parent(s) and/or guardian(s).**

**Name(s) of person WITH WHOM STUDENT IS LIVING: (Check one)**

- ☐ Both Parents      ☐ Mother Only      ☐ Father Only      ☐ Self      ☐ Foster Parents  
☐ Guardian      ☐ Mother/Stepfather      ☐ Father/Stepmother      ☐ Other(Specify) \_\_\_\_\_

Last Name	First Name	Employer Name and Address	Work Phone: (     ) Ext. Cell/Pager: (     )
Last Name	First Name	Employer Name and Address	Work Phone: (     ) Ext. Cell/Pager: (     )

**Parent/Guardian E-mail Address:** \_\_\_\_\_

Parent/Guardian Address of Primary Residence	City/State/Zip
Parent/Guardian Mailing Address (if different than above)	City/State/Zip

**EMERGENCY INFORMATION:** List two (2) local persons (**other than yourself**) usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. **We attempt to contact parents first.**

Name	Relationship to Student	Address	Daytime Phone: (     ) Ext.
Name	Relationship to Student	Address	Daytime Phone: (     ) Ext.

Enter the name of your family physician who may be contacted by school staff when a parent cannot be reached and medical assistance is necessary. Please note that when Fire Department Medical Unit responds, they will contact an available emergency room physician who may in turn contact your family physician. If you have no family doctor, you can state any local physician.

Family Doctor Name and Phone Number	Family Dentist Name and Phone Number
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**If legal custody of a child is split between two parents, you must attach a certified copy of the court order identifying each parent's respective award of physical custody. You are responsible to inform the school of any changes to the court order.**

\* Disclosure of a student's social security number is voluntary.

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**Muhlenberg School District Student Registration Form – Page 2****Student Name:** \_\_\_\_\_

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**PREVIOUS SCHOOL INFORMATION:**

Last School Attended	Grade	Address of Former School, City, State, Zip
Was your child ever retained? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which grade:	Has your child ever attended Muhlenberg School District? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child ever been enrolled in a special program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:		

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**Student's siblings names/birthdates/and grade level if they attend Muhlenberg School District:**

Name:	Name:	Name:
Birthdate:                      Grade:	Birthdate:                      Grade:	Birthdate:                      Grade:
Name:	Name:	Name:
Birthdate:                      Grade:	Birthdate:                      Grade:	Birthdate:                      Grade:

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**SECOND HOUSEHOLD INFORMATION:**

Name of Parent(s) and/or Guardian(s) OTHER than those listed under Primary Household Information.

Last Name	First Name	Relationship to Student	Employer Name/Address
Cell Phone: (     )			Work Phone: (     )                      Ext.
Home Phone: (     )		Parent/Guardian E-mail Address	Can this parent/guardian pick student up at school? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Check if Unlisted</b>			
Last Name	First Name	Relationship to Student	Employer Name/Address
Cell Phone: (     )			Work Phone: (     )                      Ext.
Should school mailings be sent to this household also? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can this parent/guardian pick student up at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Address of Residence			City/State/Zip
Parent/Guardian Mailing Address (if different than above)			City/State/Zip

Additional comments that will assist us in caring for your student (daycare, etc.):

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**I verify that the above information is true and correct to the best of my knowledge, information and belief. Falsification of any information or document required for student enrollment may result in a revocation of student enrollment, being held liable to reimburse the district for expenses incurred to educate this student, and/or civil and criminal action.**

\_\_\_\_\_  
**Signature of Parent/Guardian**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Signature of Parent/Guardian**\_\_\_\_\_  
**Date**

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**MUHLENBERG SCHOOL DISTRICT  
STUDENT RESIDENCY QUESTIONNAIRE**

Dear Parent or Guardian:

Your responses to these questions will help staff determine what residency documents are necessary to enroll your child.  
Thank you for your cooperation.

1. Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Person completing form: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_

2. In what type of setting is the child living now? Check one box below:

Section A	Section B
<div style="margin-bottom: 10px;"><input type="checkbox"/> In an emergency or transitional shelter</div> <div style="margin-bottom: 10px;"><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</div> <div style="margin-bottom: 10px;"><input type="checkbox"/> In a motel, hotel, campsite, or car due to lack of alternative, adequate accommodations</div> <div style="margin-bottom: 10px;"><input type="checkbox"/> In a car, park, public space, abandoned building, substandard housing, bus or train stations, or similar settings</div> <div style="margin-bottom: 10px;"><input type="checkbox"/> Other places not designed for, or ordinarily used as, regular sleeping accommodations for human beings</div> <p><b>CONTINUE TO THE QUESTIONS BELOW IF YOU CHECKED A BOX IN SECTION A</b></p>	<div style="margin-bottom: 20px;"><input type="checkbox"/> None of the choices in SECTION A apply</div> <div style="text-align: center; margin-bottom: 20px;"></div> <p>If you checked this section, you do not need to complete questions 3 through 6. Please sign, date the form, and return it with your registration packet.</p>

3. Contact number for person completing this form: \_\_\_\_\_  
Address where child is now living: \_\_\_\_\_  
\_\_\_\_\_

4. The child lives with (Check all that apply):  
☐ Parent or legal guardian  
☐ Relative, friend or other adult  
☐ Alone  
☐ Other: \_\_\_\_\_

5. Name, address and phone number of the school the child last attended: \_\_\_\_\_  
\_\_\_\_\_

6. Does the child have an IEP or Chapter 15/504 Agreement?  
☐ No  
☐ Yes. Please explain: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

Parent(s)/Guardian(s) Names: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

I confirm that I have listed below all tenants **(including all adults and children)** residing in the leased property. I am also providing below the name, address and phone number for the owner/landlord of said leased property. I understand that by signing below, I hereby authorize the owner/landlord of the leased property to release to Muhlenberg School District and its representatives any and all information requested pertaining to my lease/rental agreement, term of lease, tenants living in the property, and any other information in order to verify that I reside in the property and am living within the boundaries of the Muhlenberg School District.

**Tenants Names (First and Last): (include all adults and children)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Owner/Landlord Contact Information:**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Printed Name: _____	_____	_____
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Signature

Date

Printed Name: _____	_____	_____
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Signature

Date

**MUHLENBERG SCHOOL DISTRICT  
RESIDENCY VERIFICATION**

**School Year: 20\_\_ - 20\_\_**

School: \_\_\_\_\_

**I. Identifying Information – please print**

This form is to be completed by the student's parent or legal guardian and signed/witnessed by a school district employee. You must submit a separate Residency Affidavit for each child enrolled in the district. You may photocopy this form.

**A. Student Information:**

Student's Name \_\_\_\_\_  
First Name/Middle Name/Last Name

Address \_\_\_\_\_  
Street Address/City/State/Zip

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**B. Student lives with:** Print name(s) and relationship to student:

Parent or Guardian's Full Name: \_\_\_\_\_

Relationship to the Student: \_\_\_\_\_

Parent or Guardian's Full Name: \_\_\_\_\_

Relationship to the Student: \_\_\_\_\_

**C. Address: PLEASE NOTE THAT POST OFFICE IS NOT ACCEPTABLE AS A RESIDENCE ADDRESS.**

Address \_\_\_\_\_  
Street Address/City/State/Zip

Phone Number \_\_\_\_\_  
Home/Work/Cell

**I declare under the penalty of perjury that this student resides at the above address. I also agree to notify the school within two (2) weeks when residency has been changed. I understand that a new affidavit and a new proof of residency must be submitted. If I move outside the district, appropriate forms will be required. I understand that an inter district transfer may not be accepted by the district.**

**Falsification of any information or document required for residency verification or the use of the address of another person without actually residing there will result in; a) revocation of student enrollment; b) being held liable to reimburse the district for expenses incurred to educate this student; and/or c) civil and/or criminal action resulting from fraud, negligent misrepresentation and negligence.**

\_\_\_\_\_  
Signature of Parent/Guardian/Caregiver

\_\_\_\_\_  
Date

**Subscribed and sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.**

\_\_\_\_\_  
**OFFICIAL SCHOOL DISTRICT SIGNATURE**

## II. Residency

### A. Verification of Joint Residency

The person with whom the student lives and who claims custody of the student must attach proof of residency, dated within the last 30 days and must show parent, guardian or caregiver's legal name and street address.

**PRINT FIRST AND LAST NAMES OF PERSON(S) providing proof of residency, I declare under penalty of perjury, that the above named student lives at this address with me. I also agree to notify the school within two (2) weeks when residency has changed.**

First Name

Last Name

Signature (s) of Person(s)

_____	_____	_____
_____	_____	_____

### B. Proof of Residency (all proofs of residency must be originals):

If you **own/rent** property in the school district, please attach :

1. A current year's Property Tax Bill, most recent month's Mortgage Statement or original Recorded Deed in your name showing residence property or the original signed lease/rental agreement identifying the student(s) as a tenant; and
2. **One** of the following items listed below:
  - a. Proof of residency from the County Registrar of Voters; or
  - b. Current vehicle registration showing residence property address; or
  - c. Utility bill in your name for the current month showing residence property address (cell phone bill is not a utility); or
  - d. Check stubs/statement from wages, public assistance, or Social Security showing residence property address.

If you are sharing a home with another individual or family in the school district, please attach:

1. The Certificate of Residency signed by the primary resident of the home and subscribed and sworn before a Notary Public; and
2. **Two** of the items listed below within 30 days :
  - a. Proof of residency from the County Registrar of Voters; or
  - b. Current vehicle registration showing residence property address; or
  - c. Utility bill in your name for the current month showing residence property address (cell phone bill is not a utility); or
  - d. Check stubs/statement from wages, public assistance, or Social Security showing residence property address.

### NOTE:

When parents reside in different school districts, the child shall attend school in the district of the parent with whom the child lives for the majority of the time, unless a court order or court-approved custody agreement specifies otherwise. If the parent is relying on a court order or custody agreement as the basis for enrolling the child, the parent must provide a copy of the order or agreement. Parents are responsible to immediately notify the school of any changes to the court order.

A custody or dependency order is also required when a resident is seeking to enroll the child under 24 P.S. §13-1302 (a) (1) which requires "appropriate legal documentation to show dependency or guardianship."

# Muhlenberg School District

## Parental Registration Statement

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

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 action of offense involving a weapon, 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:

I hereby swear or affirm that my child was \_\_\_\_\_ was not \_\_\_\_\_ previously suspended or expelled , or is \_\_\_\_\_ is not \_\_\_\_\_ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or 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. 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 this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

\_\_\_\_\_

Dates of suspension or expulsion:

\_\_\_\_\_

(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) \_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

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.





# 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

**138-A English as a Second Language (ESL) Core Program****ATTACHMENT A: MUHLENBERG SCHOOL DISTRICT  
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:** Muhlenberg School District**Date:** \_\_\_\_\_

**School:** ☐ Muhlenberg Elementary Center  
☐ Muhlenberg Junior High School

☐ C.E. Cole Intermediate  
☐ Muhlenberg High 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? ☐ Yes ☐ No  
 (Do not include languages learned in school)  
 If yes, specify the language(s): \_\_\_\_\_
3. What language(s) is/are spoken in your home? \_\_\_\_\_
4. What is the primary spoken language in your home? \_\_\_\_\_
5. What is the primary written language in your home? \_\_\_\_\_
6. 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:** \_\_\_\_\_

**Muhlenberg School District  
Student Registration Assistance Form**

Student Name: \_\_\_\_\_

**Did your child receive special assistance, instruction or services in his/her previous school? *Please check all that apply.***

**Regular Education Support Services**

- ☐ English as a Second Language Services
- ☐ Remedial Reading Services (Title One, etc.)
- ☐ Remedial Math Services
- ☐ Guidance Counselor support
- ☐ Social Worker support
- ☐ Alternative Education
- ☐ Other: \_\_\_\_\_

**Special Education Services**

- ☐ Learning Support (please specify) \_\_\_\_\_
- ☐ Lifeskills Support (please specify) \_\_\_\_\_
- ☐ Emotional Support (please specify) \_\_\_\_\_
- ☐ Physical Support (please specify) \_\_\_\_\_
- ☐ Deaf and Hearing Support (please specify) \_\_\_\_\_
- ☐ Speech and Language Support (please specify) \_\_\_\_\_
- ☐ Gifted Support (please specify) \_\_\_\_\_
- ☐ Multiple Disabilities Support (please specify) \_\_\_\_\_
- ☐ Blind and Vision Support (please specify) \_\_\_\_\_
- ☐ Autistic Support (please specify) \_\_\_\_\_

**Other Services**

- ☐ Occupational Therapy (please specify) \_\_\_\_\_
- ☐ Physical Therapy (please specify) \_\_\_\_\_
- ☐ Behavior Intervention Plan (please specify) \_\_\_\_\_
- ☐ Nursing Services (please specify) \_\_\_\_\_
- ☐ My child has missed an extended amount of school due to illness or other reasons (please specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

## Muhlenberg School District Student Alternate Dismissal Form

The school district recognizes that there may be times during the school year when the student may need to be dismissed early from school because of illness, family emergency, doctor appointment, etc. It also recognizes that sometimes the parent or guardian may not be available to pickup the student from school. Please fill in below the names and phone numbers of individuals who are authorized to pick up your child from school. A note stating the name of the person who will pick up the student is required for all early dismissals. Verification will be required from the parent or guardian in order for the student to be dismissed to any individual not on this list. Parents of driving age students are reminded that students will not be released from school to drive home without a note from the parent or guardian.

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to student: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Daytime Phone # \_\_\_\_\_

Daytime Phone # \_\_\_\_\_

# REQUEST FOR STUDENT RECORDS

ENROLLMENT DATE: \_\_\_\_\_ START DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

GRADE: \_\_\_\_\_ STUDENT NAME: \_\_\_\_\_

I, the parent/guardian of the student listed above, give permission for the following records to be released (check one):

<input type="checkbox"/> <b>MUHLENBERG HIGH SCHOOL</b> Guidance Office – Grade 10 <sup>th</sup> – 12 <sup>th</sup> 400 Sharp Avenue Reading, PA 19605  Please send records to kneppj@muhlsdk12.net Jessica Knepp 610-921-8078 ext. 4108	<input type="checkbox"/> <b>MUHLENBERG JUNIOR HIGH SCHOOL</b> Guidance Office – Grade 7 <sup>th</sup> – 9 <sup>th</sup> 801 Bellevue Avenue Reading, PA 19605  Please send records to jaquezd@muhlsdk12.net Denisse Jaquez 610-921-8034 ext. 3510
<input type="checkbox"/> <b>C.E. COLE INTERMEDIATE SCHOOL</b> Grade 4 <sup>th</sup> – 6 <sup>th</sup> 3630 Kutztown Road Reading, PA 19605  Please send records to cecoffice@muhlsdk12.net Front Office 610-921-8212	<input type="checkbox"/> <b>MUHLENBERG ELEMENTARY CENTER</b> Grade K -3rd 610 Sharp Avenue Reading, PA 19605  Please send records to brookinss@muhlsdk12.net Stacey Brookins 610-921-8028 ext. 6117

Please forward any and/or all of the latest report cards/grade reports, testing information, medical records (**immunization records are mandatory for enrollment**), psychological evaluations, special education records, discipline records for the present and/or previous school year, any other information deemed important to the student's successful transfer to Muhlenberg School District.

\*\*\*\*Parental permission is no longer required when records are requested by authorized school personnel (Family Educational Rights and Privacy Act, Final Rule on education Record, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 24673).\*\*\*\*

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY/STATE/ZIP CODE



\*\*\*Please complete form even if the answer is "NO". Thank you

# Children of Military Survey

Dear Parents/Guardians:

Muhlenberg School District is required by ESSA (Every Student Succeeds Act) to collect and report the information below on all military children. This information is PRIVATE and CONFIDENTIAL and will only be used to report to Pennsylvania Department of Education. Filling out this information will not impact benefits you receive in ANY way. You only need to do ONE form per household. Send the form back to school with ONE of your children. Please note: it is VERY important that this form is returned, and filled out completely. Thank you for your assistance.

## PART ONE: Fill in your information.

Parent/Guardian Name:		
Address:		Apt. #:
City:	State:	Zip Code:

## PART TWO: Fill in for all children living in your household in grades K - 12

Student First and Last Name	Date of Birth	School	Grade

## PART THREE: Is the student's parent and/or guardian an active duty member of a branch of the armed forces (Army, Navy, Air Force, Marine Corp, Coast Guard) including fulltime Reserve or National Guard duty?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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\*If a parent and/or guardian has enlisted after you have completed this form, please notify the child's school to complete a new form.

Exciting and important news :)



## Our class is using ClassDojo!

Hi parents,

This year I'm using ClassDojo to encourage important skills, like working hard and participating. I'll also use it to communicate with you: we can instantly share messages, updates and photos from class. It's the easiest way for you to see how your child is doing at school and to get in touch with me.

I'd like all families to join me and sign up for ClassDojo! You can use it on any device: it is a **simple, free mobile app** for iOS and Android, and can also be used from a computer at: [www.classdojo.com](http://www.classdojo.com).

I will need your cell number or email to invite you to ClassDojo. Our class goal is for every family to **fill out and return the slip below by tomorrow!** Feel free to ask me any questions.

Thank you so much!

### Learn more about ClassDojo!

Used by teachers in 1 in every 2 schools, ClassDojo is the most popular classroom management app in the U.S. Find out more about why we're excited to use ClassDojo, and how it is safe and simple for everyone:

[www.classdojo.com/LearnMore](http://www.classdojo.com/LearnMore)

[www.classdojo.com/PrivacyCenter](http://www.classdojo.com/PrivacyCenter)



## Please send me my invitation to ClassDojo

Student name: \_\_\_\_\_

Your name: \_\_\_\_\_

Your cell number  
**OR** email: \_\_\_\_\_

To the Parent/Guardian: Correct or Add Information and return to your child's Homeroom Teacher

Bus #: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_  
Last First Middle

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/guardian Name (primary contact): \_\_\_\_\_ Relationship \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Other phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/guardian Name (second contact): \_\_\_\_\_ Relationship \_\_\_\_\_

Address(if different): \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Other phone: \_\_\_\_\_ Email: \_\_\_\_\_

If parents are divorced or separated, who has legal physical custody? Parents should notify the district immediately if there is a change.

Joint \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian \_\_\_\_\_

In case of illness, emergency or accident and parent/guardian cannot be reached; the following adults are authorized to act on behalf of the parent/guardian:

- |                |                    |             |
|----------------|--------------------|-------------|
| 1. Name: _____ | Relationship _____ | Phone _____ |
| 2. Name: _____ | Relationship _____ | Phone _____ |
| 3. Name: _____ | Relationship _____ | Phone _____ |
| 4. Name: _____ | Relationship _____ | Phone _____ |

\*Date of your child's most recent physical examination \_\_\_\_/\_\_\_\_/\_\_\_\_ location of exam \_\_\_\_\_

\*Date of your child's most recent dental examination \_\_\_\_/\_\_\_\_/\_\_\_\_ location of exam \_\_\_\_\_

\* I give my permission to share necessary medical information with appropriate staff who work directly with my child in the interest of their health, safety, and welfare.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*I give permission for the Muhlenberg School District Health Services licensed school nursing staff to administer over-the-counter medications (such as medication for pain, fever, stomach upset, coughing or allergic reaction) and/or emergency medications as needed according to the Muhlenberg School District's standing physician orders.

Medication Allergies (list the reaction): \_\_\_\_\_

\*\*Parent/Guardian signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*\*\*\*COMPLETE the BACK of this PAGE\*\*\*\*\*

v.8.18.2021



YES	Past History	NO	Health Condition (diagnosed by medical provider)	If yes, please list explanation and the medication and/or treatment below:
			ADD/ADHD	Medicine?
			Asthma***	Inhaler?
			Diabetes***, Type:	Explain:
			Migraines***	Explain:
			Food Allergy***	List the food and the reaction:
			Drug Allergy	List the medicine & the reaction:
			Life Threatening Bee Allergy Requiring Epi-Pen**	List the reaction:
			G6PD***	List triggers:
			Seizure/Epilepsy Disorder***	Last seizure:
			Vision Issue	Has glasses or contacts(circle which one)?
			Hearing Issue	Hearing aid?
			Emotional or Behavioral Issues	Explain:
			Cardiac (heart) Issue	Explain:
			Head Injury/Concussion	Explain:
			Serious or Chronic Illness	Explain:
			Serious Operation(s)	Explain:
			Other	Explain:

\*\*\*Emergency/Action Plan for care during school needs to be completed by child's Medical Provider.

These forms are available through the Health Services website or the school nurse.

List any medications your child is presently taking <u>if not listed above</u>			
Name of Medication:	Dosage	How Often	Reason for taking medicine

MSD Students that live in the same household:	Building	Grade	Relationship

**Muhlenberg School District  
Health Services Department**

**Students name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**NATURE AND PURPOSE OF STUDENT HEALTH RECORD**

- I understand that sometimes medical information given to the school nurse is important to share with the professional education staff in order for them to understand how certain medical issues may affect my child's school work, activity and/or health at school.
- I understand that all medical information will be kept confidential by the MSD Health Services Staff and will be shared with other educational professionals on an as needed basis only in order to support my child's health and education.
- I understand that my written permission is required to share my child's health record with any other institution or agency with the exception of immunization records.

**Parent/Guardian signature:** \_\_\_\_\_

**HEALTH SCREENINGS, PHYSICAL AND DENTAL EXAMINATIONS**

Pennsylvania School law mandates that all students in grades Kindergarten thru 12<sup>th</sup> grade be given health specific screenings yearly. I understand that Pennsylvania State law requires:

- Height, weight and vision screening ( annually grades K-12)
- Hearing screening (grades K-3<sup>rd</sup>, 7<sup>th</sup> 11<sup>th</sup>)
- Scoliosis Screening (grades 6<sup>th</sup> and 7<sup>th</sup>)
- Physical Exam (grades K or 1, 6<sup>th</sup>, 11<sup>th</sup>)
- Dental Exam (grades K-1, 3<sup>rd</sup>, 7<sup>th</sup>)

Parents/guardians should **choose family or school** in the following statement:

**Date of most recent Physical Exam:** \_\_\_\_\_ **Date of most recent Dental Exam:** \_\_\_\_\_

**PLEASE CIRCLE ONE CHOICE**

- I wish to have my child's **physical exam** examination done by **FAMILY** **SCHOOL** doctor.
- I wish to have my child's **dental exam** done by **FAMILY** **SCHOOL** dentist.

**Parent/ Guardian signature:** \_\_\_\_\_

## **IMMUNIZATION RECORDS**

Children at any grade, kindergarten through 12th, including all public, private, parochial or nonpublic school, vocational schools, intermediate units, special education and home education programs, cyber and charter schools in this state, ***must show proof of immunization before they can attend school in the Commonwealth of Pennsylvania.*** ( 28 Pa. Code Chapter 23, subchapter C)

**The following immunizations are required as a condition of attendance in ALL GRADES:**

\* 4 doses of tetanus and diphtheria usually given as DTP, DtaP, DT or Td

**(One dose needs to be given on or after the 4<sup>th</sup> birthday)**

\* 3 doses of polio

\* 2 doses of measles, mumps and rubella (MMR)

**(First dose must be given on or after 1<sup>st</sup> birthday)**

\* 3 doses of hepatitis B

\* 2 doses of varicella (chickenpox) vaccine

**(First dose must be given on or after 1<sup>st</sup> birthday) OR**

\* History of chicken pox disease

**Students ENTERING the 7th grade need the following:**

\*1 dose of tetanus, diphtheria, acellular pertussis (Tdap, Dtap, Td) if 5 years has elapsed since last tetanus immunization.

\*1 dose of meningococcal conjugate vaccine (MCV)

Immunization complete as of \_\_\_\_\_

Immunization **NOT** complete as of \_\_\_\_\_

**I understand that my child needs the following shots:** \_\_\_\_\_

***I understand that registration of this student is NOT COMPLETE until all immunization requirements listed above are complete.*** I further understand that admission of this child to Muhlenberg School District may be denied unless proof of completed immunizations, medical contraindication or written statement of religious objection to these immunizations is provided.

**Parent/guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **OTC MEDICATION DURING SCHOOL HOURS**

**\*I give permission for the Muhlenberg School District Health Services licensed school nursing staff to administer over-the-counter(OTC) medications(such as medication for pain, fever, stomach upset, coughing or allergic reaction) and/or emergency medications as needed according to the Muhlenberg School District's standing physician orders.**

**Medication Allergies:** \_\_\_\_\_

**Parent/Guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTHPRIVATE DENTIST REPORT OF  
DENTAL EXAMINATION OF A PUPIL OF  
SCHOOL AGE

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_

NAME OF CHILD			AGE	SEX		GRACE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M	<input type="checkbox"/> 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	5	6	7	8	9	10	11	12	13	14	15	16	Upper
					A	B	C	D	E	F	G	H	I	J				
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
					T	S	R	Q	P	O	N	M	L	K				
	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

**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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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.

**SEND COPY OF IMMUNIZATION RECORD TO SCHOOL NURSE**

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

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	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 <input type="checkbox"/>				
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 ☐

SEND COPY OF IMMUNIZATION RECORD TO SCHOOL NURSE

# **\* Free Childhood Immunization Clinic\***

\*Available to uninsured or underinsured children age 18 and under.

## **DEPARTMENT OF HEALTH**

Reading State Office Building

625 Cherry Street, Room 401

Reading, PA 19602

**(610) 378-4377**

**\*You must call to schedule an appointment at this Clinic.**

### **\*Local Pediatric Health Care Providers \***

#### **Berks Community Health Center**

1110 Rockland St.

Reading, PA 19604

610-988-4838

#### **Berks Pediatrics**

555 Raymond St

Reading, PA 19605

610-921-1111

Fax- 610-921-2419

#### **Children's Clinic of Wyomissing**

2240 Ridgewood Rd

Wyomissing, PA 19610

610-376-8691 Fax-610-376-8745

#### **Exeter Pediatrics**

6 Hearthstone Ct., Suite 201

Reading, PA 19606

610-779-9550 Fax-610-779-6433

#### **Laureldale Family Practice- Tower Health**

3212 Kutztown Rd.

Reading, PA 19605

610-816-2060 Fax-610-685-9290

#### **Patient First Medical Center**

2600 Papermill Rd.

Wyomissing, PA 19610

484-220-0051

Open 8AM-10PM -365 days/year

\*Perform routine physical exams, sports exams and  
childhood immunizations

#### **Pediatrics Tower Health Medical Group**

2101 State Hill Rd, Suite 6

Wyomissing, PA 19610

484-628-7540 Fax- 610-478-1170

#### **Penn State Health All About Children**

655 Walnut St.

West Reading, PA 19611

610-372-9222 Fax-610-372-0232

#### **Penn State Health St. Joseph Downtown Family Practice**

145 N. 6th St, 2nd floor

Reading, PA 19603

610-208-4559 Fax-610-208-4675

#### **Reading Hospital Children's Health Center**

206 S. 6<sup>th</sup> Ave.

Reading, PA 19611

610-988-5437

#### **Reading Pediatrics (3 locations)**

**1)**40 Berkshire Ct.

Reading, PA 19610

610-374-7400 Fax- 610-374-4252

**2)**25 Lorane Rd.

Reading, PA 19606

610-374-7400 Fax-610-779-1413

**3)**5101 Allentown Pike, Temple, PA 19560

610-374-7400 Fax 610-374-4252