Creative City
public charter school

April 24, 2018

Dear Parent/Guardian,

Welcome to Creative City Public Charter School! Included in this letter is a list of documents Creative City needs to have your child registered here. Please fill out the forms with all of the documentation and return them to our office by May 22nd.

If you have decided that your child will not be attending Creative City, please notify us immediately so that we may offer that seat to the next child on our waiting list.

A complete registration packet will include:

1. 2 Proofs of address
2. Copy of parent or guardian photo ID
3. Student Registration Form (there is an extra booklet for kindergarten)
4. Copy of birth certificate
5. Up to Date Immunization Record
6. Lead Certificate for K thru 1st grade
7. School Heath Assessment Forms Part 1 and 2 (Parent Completes Part One and Doctor Completes Part Two)
8. Exit Papers from previous school (if child has previously been in a Baltimore City Public School)
9. Individualized Education Program (IEP) (if applicable)

- ***If your child is new to the school system and has never been enrolled in school before please bring all the information above.***

- ***If your child has been enrolled in city schools, please be certain to get exit papers from the previous school at the end of the school year which should have the majority of the information listed above.***

If you have any questions please direct them to me at ahoard@bcps.k12.md.us or Ms. Worrell at (443) 642-3600.

Sincerely,

Ashley Hoard

Ashley Hoard
Enrollment Coordinator

2810 Shirley Avenue, Baltimore, MD 21215
Phone 443-642-3600 | Fax 410-466-6207
www.CreativeCitySchool.org

Baltimore City Public School System

Creative City Public Charter School

2810 Shirley Avenue
Baltimore, Maryland 21215

ELEMENTARY STUDENT REGISTRATION FORM
PLEASE COMPLETE THE FOLLOWING INFORMATION

Today's Date: _____ **Time:** _____

Student Last Name: _____ **First Name:** _____ **Middle Name**_____

Present Grade: _____ **Sex:** _____ **Social Security Number**_____-___-_____

Birthdate: ____/____/____ **Birthplace:**_____ **Home telephone:** _____-_____-_____

Ethnic Category :(check one) __American Indian ___African American __Asian ___White __Hispanic ___Other

Home Language: _____

Date your child first attended a school in the USA (Month/Year) _____/_____

PRIMARY HOUSEHOLD INFORMATION: Name(s) of person(s) with whom student is residing with.

Living with: (check one) __Both Parents __Mother only __Father only __Guardian ___Other

Last Name: _____ **First Name:** _____ **Work Place**_____

Business Phone _____-_____-_____ **Home Number:** _____-_____-_____ **Mobile Number:** _____-_____-_____

Parent/Guardian Mailing Address: _____

City/State/Zip Code: _____

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

1. **Name:**_____ **Relationship to child:**_____

   Address: _____ **Telephone Number:** _____

2. **Name:**_____ **Relationship to child:**_____

   Address: _____ **Telephone Number:** _____

PREVIOUS SCHOOL INFORMATION

Last school attended: _____ **Grade**_____ **Address of former school**_____

Has your child ever been enrolled in a special program? Yes☐ No☐ If yes, specify: _____

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

Baltimore City Public School System

PLEASE CHECK THE FOLLOWING IF THEY PERTAIN TO YOUR CHILD

CHECK HERE IF THERE ARE NO KNOWN HEALTH PROBLEMS ☐

EYES

Wears glasses ☐

To be worn at all times ☐

EARS

Has a hearing problem ☐

Uses hearing aid ☐

BROTHERS AND SISTERS:

	NAME	SCHOOL ATTENDING	GRADE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

GENERAL HEALTH:

CHECK HERE IF THERE ARE NO KNOWN HEALTH PROBLEMS ☐

Has the following condition(s) ☐ Epilepsy ☐ Hyperactive (ADHD) ☐ Asthma ☐ Diabetes
☐ Migraines ☐ Fainting Spells ☐ Heart Condition

Is any of the above life threatening? Yes☐ No☐

Please Explain:

_____

_____

_____

Allergies: _____

Allergic reaction to bee stings: _____

Other: _____

List medication(s) prescribed: _____

Does the medication need to be taken during school hours? Yes ☐ No ☐

Does your child have a physical condition which limits participation in: Classroom Activities ☐ Physical Education ☐

Please Explain:

_____

_____

FAMILY DOCTOR _____ TELEPHONE NUMBER_____-_____-_____

FAMILY DENTIST_____ TELEPHONE NUMBER_____-_____-_____

HOME LANGUAGE SURVEY

In accordance with federal and state requirements, the Baltimore City Public School System conduct the Home Language Survey (HLS) of all students to assist in identifying language minority students. The HLS provides a broad indicator of which students may require further assessment to determine eligibility for English to Speakers of Other Languages (ESOL) Services.

1. Give parents or guardians of ALL new students this form to complete at registration
2. Enter the language(s) reported on the SMS registration screen for primary and home languages, including ENGLISH.
3. File the original completed form in each student's cumulative record.

Student name: (Last or Family Name, First)	Date of Birth	Student Identification Number

Country of birth: _____

1. What was the language your child learned when he or she first learned to speak?

☐ Arabic ☐ Bosnian ☐ English ☐ Hindi ☐ Urdu
☐ Bengali ☐ Chinese ☐ French ☐ Spanish ☐ Yoruba

2. What language is used most often in your home?

☐ Arabic ☐ Bosnian ☐ English ☐ Hindi ☐ Urdu
☐ Bengali ☐ Chinese ☐ French ☐ Spanish ☐ Yoruba

SPANISH

1. ¿Cúal fue el primer idioma que su hijo(a) aprendió por su hijo o hija cuando empezóa hablar?

☐ inglés ☐ español ☐ otro _____

2. ¿Cúal idioma se usa con más frecuencia en su hogar?

☐ inglés ☐ español ☐ otro _____ Pais de nacimiento _____

FRENCH

1. Quelle a été la première langue que son fils (a) a appris par son fils ou fille quand empezóa à parler ?

☐ anglais ☐ français ☐ autre _____

2. Quelle langue est-ce que vous parlez le plus souvent chez vois?

☐ anglais ☐ français ☐ autre _____ Pays de naissance _____

ARABIC

[كل] [فو] [ال] تفجير كبسولة [ايديوما] [سو] [قو] [هيجو] ([!]) [أبرندي] [بور] [سو] [هيجو] [و] [هيجا] [كندو] [امبزا] [هبلر]?
([اينغلس] ([اسبول] ([أترو] _____ ؟ [كل] يفحص [ايديوما] [س] [أوسا] [مس] [فركنسا] [إن]
[سو] [هوغر]? ([اينغلس] ([اسبول] ([أترو] _____ [بيس] [د] [نسمينتو]

CHINSE

的第一种语言是哪些他/她的儿子(a)由他的儿子或女孩学会，当以讲话？ (英语 (法语 (其他_

您一般讲话在看见的哪种语言？ (英语 (法语 (其他出生国

STUDENT REGISTRATION FORM – Kindergarten Only

SCHOOL USE ONLY School Year _____ School Name _____ Grade_____

Local Student # _____ Person ID # _____ Today's Date _____
MONTH/DAY/YEAR

Enrollment Start Date_____ Enrollment Start Status _____ Immunizations Received: ❒ Yes ❒ No

Student Information

Legal Student Name _____
LAST FIRST MIDDLE SUFFIX

Preferred Name *(if applicable)*_____ Gender ❒ Male ❒ Female Date of Birth_____
MONTH/DAY/YEAR

Where was the student born? _____ When did the student first go to school in the U.S.?_____
MONTH/DAY/YEAR

What school did the student last attend? _____ Is the student Hispanic/Latino? ❒ Yes ❒ No

What is the student's race or ethnicity? Check all that apply.

❒ American Indian/Alaska Native ❒ Asian ❒ Black/African American ❒ Native Hawaiian/Other Pacific Islander ❒ White

Is the student temporarily living with others due to lack of permanent housing, living in a shelter, living in a motel/hotel, or otherwise homeless? ❒ Yes ❒ No

Does the student have a parent or guardian in the Active Duty, National Guard, or Reserve component of the United States military services? ❒ Yes ❒ No

Does the student have an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), 504 Plan, or receive other special programming? ❒ IEP ❒ IFSP ❒ 504 ❒ Other

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Medical Information

Please check with the school principal and nurse regarding treatment plans during school hours.

Does the student have any serious medical conditions?

❒ Diabetes ❒ Asthma ❒ Epilepsy ❒ Heart Disease ❒ ADD/ADHD ❒ Major Surgery ❒ Vision/Hearing Difficulties ❒ Other

Does the student have any allergies (food, insect, medication, environmental)? ❒ Yes ❒ No
If yes, please list: _____

Does the student take any medication (including inhalers)? ❒ Yes ❒ No
If yes, please list: _____

Maryland Home Language Survey

In accordance with federal and state requirements, the Home Language Survey will be administered to all students and used only for determining whether a student needs English language support services and will not be used for immigration matters or reported to immigration authorities.

If a language other than English is indicated on two or more of the three questions below, the student will be assessed for English language support services. Additional criteria for testing may be considered.

1. **What language(s) did the student first learn to speak?**_____
2. **What language does the student use most often to communicate?** _____
3. **What language(s) are spoken in your home?** _____

STUDENT REGISTRATION FORM – *Continued* Kindergarten Only

PRIMARY HOUSEHOLD – *This is the address where the student lives most of the time. If the student lives at two addresses, please fill out the "Secondary Household" section as well.*

Street Address _____

Mailing Address *(if different)* _____

Household Phone Number _____

Parent/Guardian 1

Legal Parent/Guardian Name _____
LAST FIRST MIDDLE SUFFIX

Gender ☐ Male ☐ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ☐ Parent ☐ Legal guardian ☐ Foster parent ☐ Step parent ☐ Other: _____

Email Address _____ **Cell Number** _____ **Work Number** _____

Lives with student ☐ Yes ☐ No **Has legal custody of student** ☐ Yes ☐ No

Has permission to pick up student ☐ Yes ☐ No **Gets mailings for student** ☐ Yes ☐ No

Should have access to Campus Portal *(online access to grades and attendance information; visit www.baltimorecityschools.org/campus)* ☐ Yes ☐ No

Parent/Guardian 2

Legal Parent/Guardian Name _____
LAST FIRST MIDDLE SUFFIX

Gender ☐ Male ☐ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ☐ Parent ☐ Legal guardian ☐ Foster parent ☐ Step parent ☐ Other: _____

Email Address _____ **Cell Number** _____ **Work Number** _____

Lives with student ☐ Yes ☐ No **Has legal custody of student** ☐ Yes ☐ No

Has permission to pick up student ☐ Yes ☐ No **Gets mailings for student** ☐ Yes ☐ No

Should have access to Campus Portal *(online access to grades and attendance information; visit www.baltimorecityschools.org/campus)* ☐ Yes ☐ No

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SECONDARY HOUSEHOLD – *Please fill out only if applicable (e.g., legal shared custody).*

Street Address _____

Mailing Address *(if different)* _____

Household Phone Number _____

Parent/Guardian 1

Legal Parent/Guardian Name _____
LAST FIRST MIDDLE SUFFIX

Gender ☐ Male ☐ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ☐ Parent ☐ Legal guardian ☐ Foster parent ☐ Step parent ☐ Other: _____

Email Address _____ **Cell Number** _____ **Work Number** _____

Lives with student ☐ Yes ☐ No **Has legal custody of student** ☐ Yes ☐ No

Has permission to pick up student ☐ Yes ☐ No **Gets mailings for student** ☐ Yes ☐ No

Should have access to Campus Portal *(online access to grades and attendance information; visit www.baltimorecityschools.org/campus)* ☐ Yes ☐ No

Parent/Guardian 2

Legal Parent/Guardian Name _____
LAST FIRST MIDDLE SUFFIX

Gender ☐ Male ☐ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ☐ Parent ☐ Legal guardian ☐ Foster parent ☐ Step parent ☐ Other: _____

Email Address _____ **Cell Number** _____ **Work Number** _____

Lives with student ☐ Yes ☐ No **Has legal custody of student** ☐ Yes ☐ No

Has permission to pick up student ☐ Yes ☐ No **Gets mailings for student** ☐ Yes ☐ No

Should have access to Campus Portal *(online access to grades and attendance information; visit www.baltimorecityschools.org/campus)* ☐ Yes ☐ No

STUDENT REGISTRATION FORM – *Continued* Kindergarten Only

OTHER HOUSEHOLD MEMBERS – *Please list any other individuals, including children, who live with the student (e.g., siblings, grandparents, etc.). Please list additional household members on a separate sheet of paper.*

Household Member 1

Legal Name _____
LAST FIRST MIDDLE SUFFIX

Gender ❒ Male ❒ Female **Date of Birth** _____ **Relationship to Student** _____
MONTH/DAY/YEAR

Is this person a current City Schools' student? ❒ Yes ❒ No **Does this person live in the primary or secondary household?** ❒ Primary ❒ Secondary

Household Member 2

Legal Name _____
LAST FIRST MIDDLE SUFFIX

Gender ❒ Male ❒ Female **Date of Birth** _____ **Relationship to Student** _____
MONTH/DAY/YEAR

Is this person a current City Schools' student? ❒ Yes ❒ No **Does this person live in the primary or secondary household?** ❒ Primary ❒ Secondary

EMERGENCY CONTACTS

Emergency Contact 1

Legal Name _____
LAST FIRST MIDDLE SUFFIX

Gender ❒ Male ❒ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ❒ Parent ❒ Legal guardian ❒ Foster parent ❒ Step parent ❒ Other: _____

Cell Number _____ **Home Number** _____ **Work Number** _____

Emergency Contact 2

Legal Name _____
LAST FIRST MIDDLE SUFFIX

Gender ❒ Male ❒ Female **Date of Birth** _____ **Preferred Language** _____
MONTH/DAY/YEAR

Relationship to Student ❒ Parent ❒ Legal guardian ❒ Foster parent ❒ Step parent ❒ Other: _____

Cell Number _____ **Home Number** _____ **Work Number** _____

I agree that the information provided is complete and accurate. I understand that this information is being used by the school district for the purposes of registering my student. I understand that incomplete or inaccurate information may delay, prevent, or invalidate my student's registration in school. I agree to promptly inform the school district of any changes in this information, including changes in the residency of my student.

Parent/Guardian Printed Name _____

Signature _____ **Date** _____
MONTH/DAY/YEAR

STUDENT REGISTRATION FORM – Pre-k/Kindergarten Addendum Kindergarten Only

If you are enrolling your child in pre-k or kindergarten, please fill out this section as well.

Number of primary household members_____

Total monthly household income _____

Is the student fluent in English? ❒ Yes ❒ No

Where did the student spend the most time in the last 12 months?

❒ Head Start

❒ Pre-k in a non-City Schools program

❒ Kindergarten

❒ Non-public nursery school

❒ State-licensed childcare center

❒ Family childcare (paid childcare provided at someone's home that's regulated by the state)

❒ Home care (childcare provided in a home by a relative or non-relative)

❒ Other_____

The Enoch Pratt Free Library would like to give your child his or her very own **First Card,** a free library card for young children that has no late fees. The First Card can be used at any Enoch Pratt Free Library in the city to borrow children's materials. Your child will receive his or her First Card during the first few weeks of school. To learn more about the First Card, please visit *www.prattlibrary.org.*

❒ **YES, please give my child a First Card.** I understand that this means my name, email address, phone number and my child's name, home address, birthday, and school will be shared with the Enoch Pratt Free Library system.

Please check all items below that apply to the student (please note that this information will help the school prepare needed supports):

❒ Child is not fully toilet trained

❒ Parent/guardian has a chronic illness or is disabled

❒ Child experienced death of a parent(s)

❒ Child had a birth weight of six pounds or less

❒ Child is/was in foster care

❒ Child has/had delayed speech/language

❒ Child has a sibling with learning difficulties

❒ Child had exposure to lead

❒ Child has/had a serious injury or trauma exposure

❒ Parent or sibling is receiving special education services

❒ Child has asthma

❒ Child has long-term use of medication

❒ Child has hearing problems

❒ Parent has concerns about child's development

❒ Child has vision problems

❒ Child has/is receiving speech/language therapy

❒ Child has/is receiving occupational therapy

I agree that the information provided is complete and accurate. I understand that this information is being used by the school district for the purposes of registering my student. I understand that incomplete or inaccurate information may delay, prevent, or invalidate my student's registration in school. I agree to promptly inform the school district of any changes in this information, including changes in the residency of my student.

Parent/Guardian Printed Name_____

Signature _____ **Date** _____
MONTH/DAY/YEAR

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
ADDRESS CITY STATE ZIP

SEX: ☐ MALE ☐ FEMALE BIRTHDATE _____ / _____ / _____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN _____ / _____ / _____ / _____
LAST FIRST MIDDLE PHONE

_____ / _____ / _____ / _____
ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003, the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

RECORD OF BLOOD LEAD TESTING

Test #1. _____ Date Test # 2. _____ Date Comments: _____

Signature _____ / _____
Health Care Provider or Designee OR School Health Professional or Designee Date

RECORD OF BLOOD LEAD TESTING EXEMPTION

I, _____ certify that my child does not AND has never resided in an at-risk area.
Parent or Guardian (Print)

Signature _____ / _____
Parent or Guardian Date

COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed _____ / _____
Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed _____ / _____
Health Care Provider Date

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?

No Yes Name(s) of Medications: _____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No Yes Treatment _____

Does your child require any special procedures? (catheterization, etc.)

No Yes

Parent/Guardian Signature _____ Date: _____

PART II - SCHOOL HEALTH ASSESSMENT

To be completed ONLY by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes _____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No Yes _____
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes _____

7. Screenings Tuberculin Test	Results	Date Taken
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed ONLY by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has:

• • no evident problem that may affect learning or full school participation • • problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date