



# MIDLAND BOROUGH SCHOOL DISTRICT

173 7TH STREET

MIDLAND, PA 15059

PHONE: 724-643-8650

FAX: 724-643-4887

*A 2007 National Blue Ribbon School of Excellence*

MR. SEAN TANNER, SUPERINTENDENT      MS. SARAH SAUT, DIRECTOR OF CURRICULUM & COMPLIANCE

Dear Parents and Guardians of New Students:

Welcome to the Midland Borough School District. We will need the following items to be included with the completed District forms in order to process your child's registration:

- Copy of lease/rental agreement, mortgage agreement, utility bill, or property tax bill with parent/guardian name & Midland address (Proof of residency)
- Copy of parent/guardian current valid PA Driver's license or State ID with your Midland address (Proof of residency)
- Copy of your child's birth certificate or passport
- Copy of your child's current immunization record
- Proof of Guardianship/Custody documents (*if applicable*)
- Request of Student Records form (*if your child(ren) is a transfer student*)

If your child will be entering our Kindergarten programs for the 2026-2027 school year, please keep in mind to enroll in K4 the student will need to be 4-years old on or before September 1, 2026. To enroll in the K5 program the student will need to be 5 years old on or before September 1, 2026.

Please do not hesitate to contact the Administration Office at 724-643-8650 if you have any questions or concerns. You may want to visit our website at [www.midlandpa.org](http://www.midlandpa.org) and our Midland Borough School District Facebook page for more information and the latest news about our District.

Thank you for entrusting your child with us and we look forward to your family becoming a part of our Midland Leopard family!

Very truly yours,

Kelley A. Schulte  
Assistant to the Superintendent

Enclosures

**MIDLAND ELEMENTARY MIDDLE SCHOOL  
EMERGENCY CARE CARD**

Student \_\_\_\_\_ Circle M or F Grade \_\_\_\_\_ Homeroom \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_

Circle Ethnic Code: African-American American Indian Asian Hispanic Multi-Racial White Birth Date \_\_\_\_\_

Circle who your child lives with. Mother Father Stepmother Stepfather Grandparents  
Other \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Father's Name \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Father's Employer \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Names and grades of brothers and sisters \_\_\_\_\_

The MBSD has partnered Intouch Notification System to provide mass communication to parents for general information, weather, and emergencies. Please complete how you wish to receive emergency information

Cell/Home Phone \_\_\_\_\_ Can you receive a text from this number? Yes or No

Email 1 \_\_\_\_\_

Please list only **Parent Substitutes** who school officials can contact regarding your child's care in the event a parent cannot be located if there is an illness or emergency & photo ID is required. *PLEASE NOTE: If your child has a dismissal or transportation change you will need to send a separate note with them to school. We will not accept phone calls for dismissal changes even if you use a parent substitute listed below. The emergency card parent substitute does not constitute authorization for transportation or dismissal changes.*

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

List below anyone who is **NOT PERMITTED** to visit/pick up your child from school:

Name \_\_\_\_\_ Name \_\_\_\_\_

## HEALTH INFORMATION

List any **health conditions** that your child has: \_\_\_\_\_

List any **medications** that your child takes:

At home \_\_\_\_\_

At School \_\_\_\_\_

List any **allergies** that your child has and what treatment is needed for reactions.

Environmental allergies \_\_\_\_\_

Food Allergies \_\_\_\_\_

Insect/Bee Allergies \_\_\_\_\_

\_\_\_\_\_ YES. \_\_\_\_\_ NO Has your child had the chicken pox disease? If yes, at what age? \_\_\_\_\_

Do you give permission for your child to receive these *Over the Counter* medications? MBSD has "standing orders" for these medications. Generic forms may be used. Circle YES or NO for each item.

Advil/Ibuprophen	YES or NO	Benadryl (for allergic symptoms)	YES or NO	Cough Drops	YES or NO
Anbesol/Orael	YES or NO	Tylenol/acetaminophen	YES or NO	TUMS	YES or NO
Antibiotic Ointment	YES or NO	Insect sting/burn gel	YES or NO		

Any student receiving Advil and/or Tylenol via standing order for **3 consecutive days or 10 doses in a school year will automatically have the standing order discontinued.** To continue Acetaminophen and/or Ibuprofen therapy a prescription must be received from the student's family physician requesting the medication be continued and for what length of time.

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Office Address \_\_\_\_\_

\_\_\_\_\_ YES. \_\_\_\_\_ NO Does your child have medical health insurance? If not, information will be sent home concerning the CHIPS program.

\_\_\_\_\_ YES. \_\_\_\_\_ NO In the event of a radioactive emergency, do you want your child to receive **potassium iodide** if instructed by public health officials?

\_\_\_\_\_ YES. \_\_\_\_\_ NO **Do you give your permission for your child to be photographed or video graphed for school publications and school publicity purposes?**

The following **screenings** are mandated by Pennsylvania School Code. Please notify the school nurse in writing if you do not wish to have the screenings done at school.

Vision: All grades Hearing: Kdg through grade 3 plus grades 7 and 11 and all special ed students

Height and Weight: All grades Scoliosis: Grades 6 & 7

IF SCHOOL REPRESENTATIVES ARE UNABLE TO CONTACT PARENTS IN THE EVENT OF AN EMERGENCY, THE SCHOOL WILL HAVE YOUR STUDENT TRANSPORTED BY AMBULANCE SERVICE

\_\_\_\_\_ YES. \_\_\_\_\_ NO I give permission for my child's health information to be shared with school staff and emergency care personnel on a need to know basis.

\_\_\_\_\_ YES \_\_\_\_\_ NO I give my permission for the school nurse to communicate with the physician listed above regarding any pertinent medical issues relating to my child.

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

Date \_\_\_\_\_



# 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

**MIDLAND BOROUGH SCHOOL DISTRICT**

173 SEVENTH ST  
MIDLAND, PA 15059  
724-643-8650

**PARENT REGISTRATION STATEMENT**

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

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

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

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:

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.

<p>If this student has been or is presently suspended or expelled from another school, please complete:</p> <p>Name of the school from which the student was suspended or expelled:</p> <p>_____</p> <p>Dates of suspension or expulsion: _____</p> <p>Reason for suspension/expulsion _____</p> <p>(Please provide additional schools &amp; dates of expulsion or suspension on back of this sheet)</p>
--

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

\_\_\_\_\_  
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

Additional information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date



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MS. SARAH SAUT, DIRECTOR OF CURRICULUM & COMPLIANCE

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

Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

School District of Residence \_\_\_\_\_

Pennsylvania School Code §11.11. Entitlement of resident children to attend public school in part:

*A school age child is entitled to attend the public schools of the child's district of residence. A child's district of residences is that in which the parents or guardian resides. When the parents reside in different school districts due to separation, divorce or other reason, the child may attend school in the district of residence of the parent with whom the child lives for a majority of the time, unless a court order or court approved custody agreement specifies otherwise. If the parents have joint custody and time is evenly divided, the parents may choose which of the two school districts the child will enroll for the school year. If the child is an emancipated minor, the resident school district is the one in which the child is then living.*

*A nonresident child is entitled to attend the district's public schools if that child is fully maintained and supported in the home of a district resident as if the child were the resident's own child and if the resident receives no personal compensation for maintaining the student in the district. Before accepting the child as a student, the board of school directors of the district shall require the resident to file with the secretary of the board of school directors either appropriate legal documentation to show dependency or guardianship or a sworn statement that the child is a resident of the district, the child is supported fully without personal compensation or gain, and that the resident will assume all personal obligations for the child relative to school requirements and intends to so keep and fully support the child continuously and not merely through the school term.*

After reviewing this document, please sign and date that you understand the residency requirements of the Pennsylvania School Code and the Midland Borough School District:

I hereby swear and affirm that I and my student(s) are residents of Pennsylvania in the Midland Borough School District. I understand that to be considered a resident of Pennsylvania in the Midland Borough School District, the student(s) and parent/guardian must live in the District full-time. The student(s) and parent must reside full-time at the address listed on the proof of residency documents provided to the Midland Borough School District. I understand students cannot reside only Monday thru Friday for the school year and go home to another location for weekends, holidays, summer months, etc. during the school term in order to circumvent residency and tuition laws. I affirm that I do not reside on a part-time basis within the Midland Borough School District in order to circumvent residency laws. I also understand that merely renting or owning property in the District does not constitute residency and should my residence change, I will notify the Midland Borough School District immediately and complete all the necessary paperwork needed to maintain enrollment in the Midland Borough School District.

I make this statement subject to the penalties of 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.

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

Address \_\_\_\_\_

**MIDLAND BOROUGH SCHOOL DISTRICT**

173 SEVENTH ST  
MIDLAND, PA 15059  
724-643-8650

**SPECIAL EDUCATION SERVICES INFORMATION**

Welcome to the Midland Borough School District

We are requesting the following information from you in order to best meet the needs of your child:

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

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

\_\_\_\_\_ No, my child has not received any special services at their former school.

\_\_\_\_\_ Yes, my child has received special services at their former school.  
Former school district \_\_\_\_\_

\_\_\_\_\_ My child is currently in the process of being evaluated for Special Education Services at their former school. Former school district \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING SERVICES RECEIVED:**

- \_\_\_\_\_ Early Childhood Classroom
- \_\_\_\_\_ Inclusion with Accommodations
- \_\_\_\_\_ Resource (Separate Special Education Class)
- \_\_\_\_\_ Speech and Language
- \_\_\_\_\_ Related Services (i.e., Occupational Therapy, Physical Therapy)
- \_\_\_\_\_ Positive Behavior Support Plan

**SECTION 504**

\_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

**GIFTED AND TALENTED**

\_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

**OTHER**

- \_\_\_\_\_ Title I
- \_\_\_\_\_ ESL (English as a Second Language) Bilingual
- \_\_\_\_\_ Alternative Placement Outside of Home District \_\_\_\_\_

***If you checked any of the above services, a member of the school staff will contact you to initiate services in the Midland Borough School District.***

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Number

MIDLAND BOROUGH SCHOOL DISTRICT  
STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,



Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

2. In what type of setting is the student living now?

Check one box below –

SECTION A	SECTION B
<p><input type="checkbox"/> In an emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p>CONTINUE to Question 3  if you checked any box in SECTION A</p>	<p><input type="checkbox"/> None of the choices in Section A apply.</p> <div data-bbox="1047 892 1226 1060"></div> <p>If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.</p>

3. Contact number for person completing the form: \_\_\_\_\_

Address where student is now living: \_\_\_\_\_

4. The student lives with:

Check all that apply

Parent(s) or legal guardian

Relative, friend(s), or other adult(s)

Alone

Other: \_\_\_\_\_

5. School student attended last : \_\_\_\_\_

Address of school: \_\_\_\_\_

\_\_\_\_\_

Telephone number of school: \_\_\_\_\_

Contact person at school (if known): \_\_\_\_\_

6. Does the student have an IEP or a Chapter 15/504 agreement?

NO

YES. Please explain: \_\_\_\_\_

Signature of Parent/Legal Guardian:

\_\_\_\_\_

Date: \_\_\_\_\_

# MIDLAND BOROUGH SCHOOL DISTRICT

## REQUEST FOR STUDENT RECORDS

Date \_\_\_\_\_

\_\_\_\_\_, date of birth \_\_\_\_\_, grade \_\_\_\_\_, has enrolled in the Midland Borough School District. Please send a copy of the academic and health records for this student. It is emphasized that this request is for ALL records relating to the named student so that a proper placement and appropriate educational programs can be provided. If you prefer, you can fax the records to 724-643-4887 or email them to [kelly.schulte@midlandpa.org](mailto:kelly.schulte@midlandpa.org).

### ***Former School Information:***

Name of School: \_\_\_\_\_

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

School Telephone Number: \_\_\_\_\_ School Fax Number: \_\_\_\_\_

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

If you have any questions or concerns regarding this request, please feel free to contact the administrative office at 724-643-8650. Thank you for your assistance and attention to this request.

Student Assigned PA Secure ID Number \_\_\_\_\_

*Please include the PA State assigned PA Secure Student Identification Number*

Please send records to:

Midland Borough School District  
173 Seventh St  
Midland, PA 15059

Or via fax at 724-643-4887 or email at [kelly.schulte@midlandpa.org](mailto:kelly.schulte@midlandpa.org)

Sincerely yours,

School Official

Parental permission is no longer required when records are requested by Authorized School Personnel. (Family Educational Rights and Privacy Act, Final Rule on Education Records, Federal Register, June 17, 1979, Vol. 41, No. 118, Page 24674.)

173 Seventh Street, Midland, PA 15059  
Telephone 724-643-8650 Fax 724-643-4887  
[www.midlandpa.org](http://www.midlandpa.org)  
"Home of the Leopards"

MIDLAND BOROUGH SCHOOL DISTRICT

Health Services

Health History & Student Information

HOME & FAMILY:

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender: M F Place of Birth (City/State) \_\_\_\_\_

Father's Name \_\_\_\_\_ (Place of Employment) \_\_\_\_\_ Phone Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ (Place of Employment) \_\_\_\_\_ Phone Number \_\_\_\_\_

Please list a Substitute Parent – This is a person that the School could contact in case of illness or an emergency and the parent(s) cannot be reached.

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Child \_\_\_\_\_

With whom does the child live? \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepmother \_\_\_\_\_ Stepfather \_\_\_\_\_ Other

List Name(s) \_\_\_\_\_

How many children are in the family? \_\_\_\_\_ List names \_\_\_\_\_

What place does he/she have in the birth order of children? Oldest \_\_\_\_\_ Middle \_\_\_\_\_ Youngest \_\_\_\_\_

Medical History

Complete health and emotional history enables us to understand your child better and helps him/her to make a better adjustment to school:

- Asthma, Bleeding Disorder, Bone Disease, Chicken Pox, Convulsions/High Fever, Coordination Problems, Diabetes, Heart Condition, Pneumonia, Poor Appetite, Rheumatic Fever, Scarlet Fever, Seizures/Fainting Spells, Speech Difficulty, Tires Easily, Frequent Colds, Frequent Earaches, Frequent Headaches, Frequent Nosebleeds, Frequent Sore Throats, Frequent Urination, Allergies List

Was your child full term? Yes \_\_\_\_\_ No \_\_\_\_\_ Birth Weight \_\_\_\_\_

Was there a health problem or handicap present at birth? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain and list Doctors and Hospitals that made the diagnosis \_\_\_\_\_

Is your child presently under care of a physician? Yes \_\_\_\_\_ No \_\_\_\_\_

**Medical History (continued)**

List any injuries, operations or hospitalizations and dates \_\_\_\_\_  
\_\_\_\_\_

If physical activity is to be limited, please explain \_\_\_\_\_  
\_\_\_\_\_

Is your child on any Medication? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Medication \_\_\_\_\_  
\_\_\_\_\_

Is Medication to be given at School? Yes \_\_\_\_\_ No \_\_\_\_\_ List Medication(s) \_\_\_\_\_  
\_\_\_\_\_

**Vision and Hearing:**

Does your child wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_ Does your child wear hearing aids? Yes \_\_\_\_\_ No \_\_\_\_\_  
Does your child wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have any of the following?

**Eyes**

Squinting Yes \_\_\_\_\_ No \_\_\_\_\_  
Cross Eyes Yes \_\_\_\_\_ No \_\_\_\_\_  
Difficulty Seeing Yes \_\_\_\_\_ No \_\_\_\_\_

**Ears**

Difficulty Hearing Yes \_\_\_\_\_ No \_\_\_\_\_  
Frequent Ear Infections Yes \_\_\_\_\_ No \_\_\_\_\_  
Draining Ears Yes \_\_\_\_\_ No \_\_\_\_\_

**Developmental History:**

Does your child dress him/herself Completely \_\_\_\_\_ Partially \_\_\_\_\_ Not at all \_\_\_\_\_

Can he/she use the toilet by him/herself? Yes \_\_\_\_\_ No \_\_\_\_\_ Is your child potty trained? Yes \_\_\_\_\_ No \_\_\_\_\_

**Education:**

Was your child enrolled in Head Start, Nursery School or Kindergarten before entering Midland Borough School District?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Name of School \_\_\_\_\_

Has your child attended any other school? Yes \_\_\_\_\_ No \_\_\_\_\_

List the school(s) and how long he/she attended \_\_\_\_\_  
\_\_\_\_\_

**Immunizations:**

*A record of immunizations must be present at the time of registration.*

Immunizations Complete \_\_\_\_\_ Immunizations Incomplete \_\_\_\_\_

**Home Language Information:**

What is the child's first language? \_\_\_\_\_ What language(s) is spoken in the home? \_\_\_\_\_

Does the child speak a language other than English? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify language \_\_\_\_\_

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

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
Reviewed by school personnel

*Check* \_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date* Kas 05/2026

# MIDLAND BOROUGH SCHOOL DISTRICT

## HEALTH CONSENT FORM

### HEALTH SCREENINGS FOR STUDENTS IN ALL GRADES

- Height and weight screening each year. School code also requires that the results of these screenings (along with BMI calculations) be sent annually to parents.
- Vision screening each year. A representative from the Blind Association of Beaver County may assist with vision screening.
- Hearing screening is required yearly for K4 through Grade 3 plus Grades 7 and 11. Screenings are also required for all special education students. Students in other grades may be screened if symptoms suggest a hearing problem
- Scoliosis is required for students in grades 6 and 7. The school nurse will conduct each screening individually with another faculty member or student nurse present.

\_\_\_\_\_ I give permission for the above screenings to be done at school

\_\_\_\_\_ I will have the screening done by my family physician. I will return all results to the school within 90 days of the start of the school year

### SCHOOL PHYSICAL CONSENT FOR STUDENTS IN KINDERGARTEN, GRADE 6 & GRADE 11

Pennsylvania School Code requires school physicals for students entering school (Kindergarten – Age 5), Grade 6 and Grade 11. The school physical exam consists of a check of eyes, ear, nose and throat; a check of heart rate and lung sounds; and palpitation of abdomen to check for enlarged liver and/or spleen. Students remain dressed during the exam.

\_\_\_\_\_ I give permission for the school physical to do the physical exam for my child

\_\_\_\_\_ I will have the physical exam done by my family doctor and return results to the school by the date of the school physicals (April of each year).

### SCHOOL DENTAL CONSENT FOR STUDENTS IN KINDERGARTEN, GRADE 3 AND GRADE 7

Pennsylvania School Code requires school dental exams for students entering school (Kindergarten – Age 5), Grade 3 and Grade 7. This is a visual exam of the teeth for screening purposes only. Students with any dental problems will be referred to their family dentist if needed.

\_\_\_\_\_ I give permission for the school dentist to do the dental screening for my child

\_\_\_\_\_ I will have physical exam done by my family dentist and return results to the school by the date of the school dentals (November of each year).

STUDENT NAME \_\_\_\_\_

GRADE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

# MIDLAND BOROUGH SCHOOL DISTRICT

173 7<sup>TH</sup> STREET  
MIDLAND, PA 15059  
724-643-8650 • FAX NO. 724-643-4887

Dear Parents & Guardians:

The Commonwealth of Pennsylvania has made potassium iodide (KI) pills available free of charge to people who live, work or attend school within a ten-mile radius of a nuclear facility. KI (“kay-eye”) is approved by the U.S. Food and Drug Administration for use in providing an extra layer of protection against thyroid disease, including thyroid cancer, in the event of a release of radioactive iodine. Taken at the time of or within the first few hours following a radiological release, KI will protect the thyroid gland, which is located in the front of the neck.

**PLEASE NOTE: The best protective action in a radiation emergency is evacuation.**

Should an emergency occur, the media would broadcast official recommendations to the public for protective actions including the possible use of KI. Most importantly, KI tablets will be available at school should a recommendation to take KI occur while school is in session. Distribution through the school system is being given high priority for the reason that children are much more sensitive to the ill effects of radioactive iodide than are adults.

KI should NOT be taken by anyone who is allergic to iodide.

If you have any questions or need more information regarding the school’s participation in the program or the consent form, please call Mrs. Beth Calahan at 724-643-8650 Ext. 215.

-----  
**Please place a check mark next to your preference and sign below:**

I **DO** want my child to be given potassium iodide, when instructed by the public health officials, in the event of a radioactive emergency during school hours.

I **DO NOT** want my child to be given potassium iodide, when instructed by the public health officials, in the event of a radioactive emergency during school hours.

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

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

DATE: \_\_\_\_\_

**Return to the School Nurse at Midland Elementary-Middle School**



# MIDLAND BOROUGH SCHOOL DISTRICT

173 7TH STREET

MIDLAND, PA 15059

PHONE: 724-643-8650

FAX: 724-643-4887

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MR. SEAN TANNER, SUPERINTENDENT

MS. SARAH SAUT, DIRECTOR OF CURRICULUM & COMPLIANCE

7/31/25

Dear Parents & Guardians:

Welcome to Midland Borough School! Pennsylvania school law requires school physicals for students entering school K4, K5 (Kindergarten), Grade Six and Eleven and any new child entering a school district.

We should also have a dental exam on file to ensure that your child has had a dental check-up to ensure they have good oral hygiene which also promotes a successful school year.

Please make an appointment with your child's PCP and dentist and use the enclosed forms when you go for your appointment. Your PCP will give any of the required vaccines at the appointment and give you an updated shot record to turn in with your physical form.

Please have your Dentist complete the private dental exam form when you go for their dental checkup.

Once all forms are complete and you have the copy of the updated shot record you can turn them in with your enrollment packet.

Please contact me with any questions or concerns.

Sincerely,

*Beth A. Calahan RN, BSN, CSN*

Beth A. Calahan RN, BSN, CSN

School Nurse



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 <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?		
EARS/NOSE	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 JOINTS <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. FEMALES ONLY: 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 HISTORY	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 \_\_\_\_\_

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	COMMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT					
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td					
Polio Type: OPV or IPV					
Hepatitis B (HepB)					
Measles/Mumps/Rubella (MMR)					
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>					
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella					
Meningococcal Conjugate Vaccine (MCV4)					
Human Papilloma Virus (HPV) Type: HPV2 or HPV4					
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)					
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13					
Hepatitis A (HepA)					
Rotavirus					
<b>Other Vaccines: (Type and Date)</b>					

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

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

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

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street      City or Post Office      Borough/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
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	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