

# Lower Merion School District

65 Rock Hill Road

Bala Cynwyd, PA 19004

Phone: 610-658-3996 ♦ Fax: 610-785-1837 ♦ www.lmsd.org

Office of Central Registration

## WELCOME TO THE LOWER MERION SCHOOL DISTRICT

**Before your child can be scheduled for classes, the information requested in the following paragraphs must be provided.** If you need help in determining which school your child will attend, call 610-658-3996.

**According to 28 PA CODE CH 23.81 (School Immunization) and 28 PA CODE CH 23.2 (Medical Examination), the following information must be provided:**

1. **Evidence of Immunization:** The Pennsylvania Department of Health regulations require the exclusion from Pennsylvania Schools of any students who do not meet the following minimum immunization requirements:

- a. **Four doses of tetanus (1 dose on or after the 4<sup>th</sup> birthday)**, usually given as DTP, DTaP, DT or Td
- b. **Four doses diphtheria (1 dose on or after the 4<sup>th</sup> birthday)**, usually given as DTP, DTaP, DT or Td
- c. **Three doses of polio vaccine**
- d. **Two doses of measles, mumps and rubella (MMR) vaccine**, one after 12 months of age and second doses of measles, mumps vaccine (**preferably given as MMR**)
- e. **Three doses of hepatitis B vaccine**, the first two doses given one month apart and the third dose six months after the first dose
- f. **Evidence of varicella (Chicken pox) immunity:**
  1. Date of varicella disease
  2. Varicella vaccine per the Pennsylvania Department of Health- one dose of varicella vaccine administered at 12 months of age through 12 years of age; or two doses of varicella vaccine administered at age 13 years or after

**\*For ALL students in all grades in School Year 2010/2011: (in addition to immunizations above)**

- Second dose of varicella vaccine or history of disease

**\*For students entering Grade 7 in 2010/2011:**

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (MVV)

2. **Physical Examination:** The School Health Law requires medical examinations for children on entrance to school (Kindergarten or grade 1) and in grades 6 and 11. These grades were selected because they represent critical periods of growth and development in a child's life. It is important that the school have a record of the child's health status. The exam must be done within the school year for which it is required. This knowledge enables the school staff to help children achieve the maximum benefit of their educational opportunities.

It is recommended that these examinations be done by your family physician since they can best evaluate your child's health and assist you in obtaining necessary treatments and corrections, if needed. However, you may submit a written request at the time of registration to have your child receive an abbreviated physical exam by the school district Physician. Please return the completed form as soon as possible to the School Nurse.

3. **Dental Examination:** The dental form must be completed and signed by the family dentist for students upon entrance to school (Kindergarten or grade 1), grades 3 and 7. It is strongly recommended that your family dentist perform the exam as he/she is the most familiar with your child's dental needs and will be able to provide follow up treatments, cleanings etc. A written request must be submitted to have your child receive an abbreviated visual exam by the School District consulting dentist.
4. **Tuberculin Testing:** Routine tuberculin testing is not required for enrollment to school. Tuberculin testing may be required if a student is in a high risk group (as defined by the Centers of Disease Control) for contracting tuberculosis. The School Nurse will contact you if tuberculin testing is required.
5. **TWO (2) Proofs of Residency:** LMSD must be certain that the parent/guardian's residence, with whom the child lives, is located in Lower Merion Township or the Borough of Narberth. Any of the following documents will verify your LMSD residency:
  - a. A signed lease
  - b. A copy of the Deed, Real Estate Tax Bill or Sewer Rental Bill
  - c. Utility bill (gas, electric, oil, water, phone or cable)
6. **Proof of Age:** (one of the following must be presented)
  - d. Birth Certificate, Baptismal Certificate, or Passport
7. **Completion of Pupil Registration Form:**
  - e. At time of registration, please sign your name to the form requesting school records from the school your child previously attended
  - f. If you are the custodial parent, guardian, or foster parent, please present documentation of custody, court, or placing agency verification

If you believe your school-aged child seems to be developing differently than other children, and you desire information concerning possible Special Education services, please call 610-645-1800 (also indicate on the Registration Form that your child may need Special Education).

***The District reserves the right to verify the information on the registration form for accuracy.  
If you have any questions about registration, please call 610-658-3996.***

LOWER MERION SCHOOL DISTRICT  
PUPIL REGISTRATION

I certify the following information is correct and realize tuition is required if the residency information is not correct. If the District determines that (a) you have supplied false information to the District and/or (b) the information that you provided ceases to be true and you have failed to inform the District of the change in circumstances prior to or at the time the change occurred, then in addition to or in lieu of civil proceedings for collection of nonresident tuition and/or exclusion proceedings, the District may refer the matter to appropriate law enforcement officials and/or initiate a private criminal complaint against you for unsworn falsification to authorities, theft of services and/or any other applicable criminal offense.

1. Last Name \_\_\_\_\_ 2. First Name \_\_\_\_\_ 3. Middle Name \_\_\_\_\_

4. Nickname \_\_\_\_\_ 5. Date of Birth \_\_\_\_\_ 6. Home Phone \_\_\_\_\_

6. Ethnicity\*(optional)  American Indian  Asian/Pacific Islander  Caucasian  African-American  Hispanic  Multi-Racial

7. Child resides with: \_\_\_\_\_ Relationship: \_\_\_\_\_

8. Parent 1/Guardian Name \_\_\_\_\_

9. Parent 1/Guardian Email \_\_\_\_\_

10. Parent 1/Guardian Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

11. Parent 1/Guardian Address \_\_\_\_\_

12. Parent 2/Guardian Name \_\_\_\_\_

13. Parent 2/Guardian Email \_\_\_\_\_

13. Parent 2/Guardian Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

11. Parent 2/Guardian Address \_\_\_\_\_

12. Application is made for admittance to \_\_\_\_\_ Grade \_\_\_\_\_ To Begin \_\_\_\_\_

13. School District/School Previously Attended \_\_\_\_\_ School Phone # \_\_\_\_\_

14. Address \_\_\_\_\_ Grade and Date Last Attended \_\_\_\_\_

15. The most recent date the student entered PA or the most recent date enrolled in a school in PA \_\_\_\_\_

15. Has your child ever been in a Special Education Program?  Yes  No Date \_\_\_\_\_

16. Other Children in House	Name	Date of Birth	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

\*These classifications provide a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal, State, and Local reporting purposes and are not modifiable. Provision of this data is optional and will not be used as determinants of eligibility for participation in any Federal, State or Local programs.

**TO BE COMPLETED BY SCHOOL PERSONNEL:**

17.  New  Re-Entry If Re-Entry: \_\_\_\_\_ Date Last Attended \_\_\_\_\_  
*(Name of Lower Merion School Last Attended)*

18. Student # \_\_\_\_\_ 19. Grade \_\_\_\_\_ 20. School \_\_\_\_\_

19. Signature of Registrar \_\_\_\_\_ Date \_\_\_\_\_

**LOWER MERION SCHOOL DISTRICT**  
**PUPIL EMERGENCY INFORMATION**  
Use this form for initial registrations

Name \_\_\_\_\_ GR/HR \_\_\_\_\_

Student's # \_\_\_\_\_ School \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

circle one:  
parent1/parent2

Address 2 \_\_\_\_\_

circle one:  
parent1/parent2

**Contact Information**

Home Phone \_\_\_\_\_

Parent1/Guardian Name  Miss  Ms.  
 Mrs.  Mr.  Dr. \_\_\_\_\_

Parent1/Guardian Phone 1 \_\_\_\_\_

Parent1/Guardian Phone 2 \_\_\_\_\_

Parent1 Email \_\_\_\_\_

Parent2/Guardian Name  Miss  Ms.  
 Mrs.  Mr.  Dr. \_\_\_\_\_

Parent2/Guardian Phone 1 \_\_\_\_\_

Parent2/Guardian Phone 2 \_\_\_\_\_

Parent2 Email \_\_\_\_\_

Please list 2 adults likely to be available to assist in the event of an emergency, if parent/guardian cannot be reached:

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

The district has an automated dialing system. Please list 6 numbers that you would like entered into the system. The amount of numbers called will increase based on urgency of the situation.

1 _____	3 _____	5 _____
2 _____	4 _____	6 _____

**Medical Information** Your Child Will Be Taken To The Nearest Hospital If Emergency Treatment Is Necessary

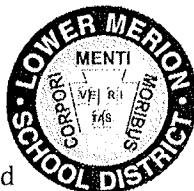
Physician \_\_\_\_\_ Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Health Issue  
past or current \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_



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Office of Central Registration

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

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

Student's Name: \_\_\_\_\_

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

1. What is/was the student's first language? \_\_\_\_\_

2. Does the student speak a language(s) other than English?  
*(Do not include languages learned in school.)*

Yes  No

If yes, specify the language(s): \_\_\_\_\_

3. What language(s) is/are spoken in your home? \_\_\_\_\_

4. Has the student attended any United States school in any 3 years during his/her lifetime?  Yes  No

If yes, complete the following:

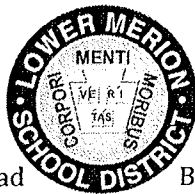
Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Was the student born outside of the United States?  
 Yes  No If Yes, what date did student enter the US? \_\_\_\_\_

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

Person completing this form (if other than parent/guardian): \_\_\_\_\_

\*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.



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## Family Dentist Report

### **Entrance to school (K or 1), grade 3, 7**

THE PENNSYLVANIA SCHOOL HEALTH LAW REQUIRES dental examinations upon entrance to school (**kindergarten or grade one**), **third and seventh grades**. It is strongly recommended that your family dentist perform the exam as he/she is the most familiar with your child's dental needs and will be able to provide follow up treatments, cleanings etc. Examination forms completed by the family dentist should be returned to your child's school.

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

\_\_\_\_\_  
(Home address)

The above named student last visited my office on \_\_\_\_\_  
(date)

At that time (Please check below):

No dental corrections were necessary \_\_\_\_\_

All necessary corrections were made \_\_\_\_\_

Appointment for corrections scheduled \_\_\_\_\_

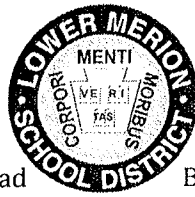
Topical Fluoride was applied \_\_\_\_\_ Fluoride tablets were prescribed \_\_\_\_\_

Please note any specific problems \_\_\_\_\_  
\_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_



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## Custodial Parent Information

“A child of separated or divorced parents, one of whom lives outside of the District, may attend District schools without payment of tuition if the child lives within the District at least one-half of the time during the school term. Otherwise, such children shall only be permitted to attend District schools to the extent required by law” (Administrative Regulation No. 202, Non-Resident Pupils).

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

### CUSTODIAL PARENT 1

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

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

Telephone#: \_\_\_\_\_

### CUSTODIAL PARENT 2

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

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

Telephone#: \_\_\_\_\_

With whom does the child(ren) physically reside for at least one-half of the time during the school term ? (print name)

\_\_\_\_\_

Is there a court order or consent agreement regarding custody? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has a copy of the court order or consent agreement regarding custody been given to the District?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, to whom was the court order or consent agreement given? \_\_\_\_\_

**VERIFICATION STATEMENT**

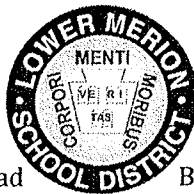
I understand that should my child(ren) reside outside of Lower Merion School District for more than 50% of the year (January – December) with the other parent, my child(ren) will no longer be eligible to attend the District’s public schools.

It is understood that should a change in physical custody resulting in a residence out of the District not be disclosed, the District reserves the right to pursue nonresident tuition, attorney’s fees and other costs associated with any legal proceedings which may result.

The Lower Merion School District will allow divorced/separated parents equal access to their child(ren) unless a court order or consent agreement regarding custody is provided to the school which restricts this. If such a document is provided, the school will follow the terms of the decree specifically.

Custodial Parent1 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Custodial Parent2 Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## 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:

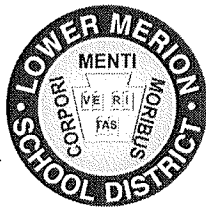
\_\_\_\_\_

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.



# Lower Merion School District

## Request for Release of Information To the District

I (we) \_\_\_\_\_ authorize and request

\_\_\_\_\_  
(name of sending school/agency)

\_\_\_\_\_  
(address of sending school/agency)

\_\_\_\_\_  
(city, state, zip of sending school/agency)

to release information regarding:

\_\_\_\_\_  
(name of student)

\_\_\_\_\_  
(birthdate)

### Send to:

**Name of Building:**

**Address of Building:**

Please release the following information:

- Educational Information (school records)
- Registration
- Immunization
- Medical Information
- ER
- IEP/NOREP
- Psychological Evaluation
- Psychiatric Evaluation
- Neurological Evaluation
- Other (please specify)

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

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

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

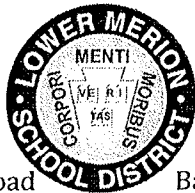
Date: \_\_\_\_\_

Student Signature: (for all records if student is 18 years or older)

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

This permission will expire on: \_\_\_\_\_

(Date)



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School \_\_\_\_\_

## REPORT OF PHYSICAL EXAMINATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_

*Last First*

Home Address \_\_\_\_\_ Home Tel# \_\_\_\_\_

*# and Street City Zip*

Vaccine	Doses				
	Please give exact dates				
DtaP DPT Td	1	2	3	4	5
	6	7			
Tdap* (Adacel)	1	2			
Polio (OPV, IPV)	1	2	3	4	5
Hepatitis B	1	2	3		
MMR	1	2			
Varivax #1			Varivax #2		Varicella(disease)
Meningococcal*MCV					Other
PPD		MM results	INH Therapy		Other

### Medical History:

Allergy \_\_\_\_\_ Epi-pen \_\_\_ Yes \_\_\_ No

Medical History \_\_\_\_\_

Surgical History \_\_\_\_\_

### Examination:

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI for Age Percentile \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

General Nutrition _____	<input type="checkbox"/>	Normal	Neuro Muscular _____	<input type="checkbox"/>	Normal
Skin _____	<input type="checkbox"/>		Skeletal _____	<input type="checkbox"/>	
Ears _____	<input type="checkbox"/>		Emotional Status _____	<input type="checkbox"/>	
Nose & Throat _____	<input type="checkbox"/>		Hearing _____	<input type="checkbox"/>	
Glands _____	<input type="checkbox"/>		Scoliosis (Bending Pos) _____	<input type="checkbox"/>	
Heart _____	<input type="checkbox"/>		Speech _____	<input type="checkbox"/>	
Lungs _____	<input type="checkbox"/>		Vision R: 20/ L: 20/		
Abdomen _____	<input type="checkbox"/>		Wears Corrective Lens Yes <input type="checkbox"/> No <input type="checkbox"/>		

Is this student currently under treatment? No  Yes  \_\_\_\_\_

Please list any current or long-term medications (reason for administration): \_\_\_\_\_

Should this student have any physical restrictions? \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Phone \_\_\_\_\_

Printed name \_\_\_\_\_ Office Stamp \_\_\_\_\_

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