For Kindergarten children pre-registering for the upcoming school year, spring registration will occur at the student’s prospective home school. Children are eligible for admission to kindergarten if they have attained the age of five (5) years on or before September 1st. Appointments may be made by contacting your local school’s office. At the conclusion of spring registration, any additional kindergarten students will be registered at the District’s Central Registration office located in Thorndale.

School staff will be able to schedule appointments, answer your questions and provide information regarding necessary paperwork needed for the registration process. Please contact your child’s home school at the numbers below:

- Caln Elementary: 610-383-3760
- East Fallowfield Elementary: 610-383-3765
- Friendship Elementary: 610-383-3770
- Kings Highway Elementary: 610-383-3775
- Rainbow Elementary: 610-383-3780
- Reeceville Elementary: 610-383-3785

www.casdschools.org

Your registration is scheduled for:

DATE: ____________________________

TIME: ____________________________

WITH: ____________________________
REGISTRATION CHECKLIST

Please bring the following documents with you on your appointment day to Kindergarten Registration.

- **ALL** of the items listed below must be brought to the school where registering:

  1. Birth certificate
  2. Immunization Records
  3. Lease or Deed (or mortgage book) in Parent's (Guardian's) Name
  4. Early Intervention IEP (Individual Education Plan), Initial ER (Evaluation Report), RR (Reevaluation Report), Initial NOREP (Notice of Recommended Educational Placement/Prior Written Notice) and NOREP (Notice of Recommended Educational Placement)

- **Proof of Residency Checklist:**
  Any **TWO must be brought** to the appointment:

  1. Valid Driver's License with Current Address
  2. Valid Vehicle Owner's Card with Name and Address
  3. Utility Bill within 30 Days with Name and Address
  4. Current and Valid Assistance Paper or Medical Card
  5. Pay Check Stub within 30 Days with Name and Address
  6. Letter from Personnel Director Verifying Address on File
School Children Immunizations

*Pennsylvania School Immunization Requirements*

Authority: 28 Pa. Code § 23(C)

**All Students** need the following immunizations to attend school:

4 doses of tetanus* (1 dose on or after the 4th birthday)
4 doses of diphtheria* (1 dose on or after the 4th birthday)
3 doses of polio
2 doses of measles**
2 doses of mumps**
1 dose of rubella (German measles)**
3 doses of hepatitis B
2 doses of varicella (chickenpox) with first dose on or after the 1st birthday or history of the disease

*Usually given as DTP or DTaP or DT or TD
**Usually given as MMR with the first dose on or after the 1st birthday

**Students in 7th Grade** also need the following immunizations:

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

Proof of immunization means a written record showing the dates (month, day, year) your child was immunized.

The only exceptions to the school laws for immunization are medical reasons and religious beliefs. If your child is exempt from immunizations, your child may be removed from school during a disease outbreak.
COATESVILLE AREA SCHOOL DISTRICT
Central Registration Office
3030 C. G. Zinn Road, Thorndale, PA 19372

STUDENT REGISTRATION FORM

For Office Use Only:

Student #: PA State ID#: Registration Date:

Entry Code: District Enrollment Date: State Enrollment Date: US Enrollment Date:

START HERE -- PLEASE PRINT

Student's Legal Name:

(First) (Middle) (Last)

Home Address:

(House Number) (Street or Road Name) (Apartment or Unit Number)

City: State: PA Zip: Home Phone __________ Unlisted? __

Mailing address: (if different from above)

City: State: PA Zip:

Birth Date __ / __ / __ Gender: □ M □ F Student is: □ US Citizen □ Immigrant □ Migrant

Grade: (Circle one) K 01 02 03 04 05 06 07 08 09 10 11 12 Other: __________

Ethnicity: (check one) Hispanic/Latino □ Yes □ No

Race: (check one or more) White □ Black/African American □ Asian □ Am Indian/Alaskan Native □ Native Hawaiian/ Pacific Islander

Student Resides at the Address Above with: □ Both Parents □ Father Only □ Mother Only □ Step Father □ Step Mother

□ Guardian (relationship to student) □ Grandmother □ Grandfather □ Aunt □ Uncle □ Sister □ Brother □ Foster Parent

Father (Mr. Dr.) ________________________________________________________________________________

(Or Guardian (Dr. Mr.)

Home Phone: __________________________

Cell Phone: __________________________ Check if Primary # □

Employer: __________________________

Work Phone: __________________________

Address: __________________________ (only if different from student)

City: State: PA Zip: __________

Address above to also receive district mailings Yes No

E-Mail address: ____________________________________________________________________________

Type of Residency: (Check one) □ Resident □ Foster Child □ Guardianship □ Future Resident □ Non-Resident

□ Multi-Occupancy Resident □ Foreign Exchange Homeless: □ Yes □ No Residing in shelter: □ Yes □ No

(Prior Approval Required)

Placing Agency Name __________________________________________________________________________

Phone # __________________________ Contact: __________________________

Does the student have any health related problems that require attention? _____ Yes _____ No

If yes, what is the nature of the problem? __________________________________________________________________________

Has the student been identified for any of the following services? □ Special Ed □ ESL □ Gifted □ 504 □ Other __________

Language Spoken in the Home: ____________________________________________________________

Country of Origin: __________________________________________________________

Please continue to Side 2

Rev06/30/15
COATESVILLE AREA SCHOOL DISTRICT
STUDENT REGISTRATION FORM
Side 2 of 2

Emergency Contact Information: (Please list others who can be contacted by the school during the day)

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Birth Certificate #: __________ Birth City/State: __________________________ Birth Country: __________

FORMER SCHOOL INFORMATION:
Former School District: ______________________________________________________

Last School Attended: _______________________________________________________

Address: __________________________________________________________________

City: __________________ State: _______ Zip: __________ Phone: ________________

Last Grade: ______ Last Date Attended: ______________________

PLEASE LIST ANY BROTHERS OR SISTERS RESIDING AT THE SAME ADDRESS:

<table>
<thead>
<tr>
<th>Name (Last Name, First Name)</th>
<th>Date of Birth</th>
<th>Gender (Circle one)</th>
<th>Grade</th>
<th>School Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
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<td>Male or Female</td>
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</tbody>
</table>

Signature of Parent/Guardian: ____________________________________________ Date: __________

The Coatesville Area School District shall provide equal opportunities for education to all persons regardless of their race, religion, color, ancestry, national origin, sex, handicap or disability as provided by the Pennsylvania Fair Educational Opportunities Act, 24 P.S. §§5002 et seq., the Pennsylvania Human Relations Act, 42. For information regarding civil rights, grievance procedures, or services, activities and facilities that are accessible to and usable by handicapped persons, contact the Director of Pupil Services, 3030 C. G. Zinn Road, Thorndale, PA. 19372. Phone: 610 466-2400.

Office Use: Data Entry Date: __________________ Entered By: __________________

Send copy of Registration Form to: Home School, Transportation and Special Education (when applicable)
HOME LANGUAGE SURVEY

The Office of Civil Rights (OCR) requires that all Local Education Agencies (LEA’s) 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 initial step in the identification process.

School District: ____________________________ Date: __________
School: ___________________________________
Student’s Name: ____________________________ Grade: __________

1. What is/was the student’s first language? _____________________________________________

2. Does the student speak a language(s) other than English? □ 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. 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: _________________________________________________________

1 The local education agency (LEA) has the responsibility under the federal law to serve students who are limited English proficient and reed English Instructional services. Given this responsibility, the LEA 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 LEA 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 LEA in the future.

Revised July 2013
INFORMATION FOR MEDICAL EMERGENCIES

PARENT/GUARDIAN:

Mother Name _________________________________
Home Address __________________________________
Home Phone Number _____________________________
Work Place _____________________________________
Work Phone Number _____________________________

Father Name _________________________________
Home Address __________________________________
Home Phone Number _____________________________
Work Place _____________________________________
Work Phone Number _____________________________

Grandparent (or other relative name) ________________________________
Home Address __________________________________
Home Phone Number _____________________________
Work Place _____________________________________
Work Phone Number _____________________________

PERSON LOOKING AFTER CHILD AFTER SCHOOL:

Name _________________________________
Address __________________________________
Phone Number _____________________________

DOCTOR

Name ____________________________
Phone Number ______________________

DENTIST

Name ____________________________
Phone Number ______________________
SPECIAL HEALTH NEEDS (Circle Yes or No)

Has the pupil ever had any serious illness or operation? ............................................ YES NO

What? ____________________________ When? ________________________________

Is the pupil going to a hospital, clinic or doctor now for treatment of a condition? ............... YES NO

What for? ____________________________ When? ________________________________

Apart from vitamins, is the pupil taking any medication at this time? .............................. YES NO

Name of Medication ____________________________ When? ________________________________

What time during school hours? ______________________________________________________

What for? ____________________________

Is the pupil allergic to anything, such as foods, plants, insects, medication? ..................... YES NO

What? ____________________________

Has the pupil ever had any convulsions? ................................................................. YES NO

When? ____________________________ How frequently? ________________________________

Treatment ____________________________

Does the pupil need a special diet or have any food problems? ..................................... YES NO

Give details ____________________________

Does the pupil have any special health needs, restrictions or activities or problems
the school should know? ................................................................. YES NO

Has the pupil had any other illnesses, accidents, broken bones? ................................. YES NO

When? ____________________________ What was the problem? __________________________

Has the pupil ever been seen by a dentist? .............................................................. YES NO

When? ____________________________ Name of Dentist __________________________

__________________________________________________________________________________

Signature of Mother/Guardian ____________________________ Date ______________________

Signature of Father/Guardian ____________________________ Date ______________________
STUDENT NAME: ____________________________

STUDENT HEALTH HISTORY (ENTRY)

A. Pre-Natal History (circle Yes or No)
   1. Did the mother have any major illness during pregnancy? Yes No
   2. Did the mother take any medication or drugs (other than iron or vitamins during pregnancy? Yes No
   3. Did the baby come on time? Yes No

B. Developmental History
   1. What was the baby’s weight? ________________________________
   2. Did the baby have any trouble while in the hospital? Yes No
   3. Did the baby have any special problems in the first six months? Yes No
   4. At what age did the child sit alone without support? ________________________________
   5. At what age did the child walk alone without support? ________________________________
   6. At what age did the child begin to say two or three words together? ________________________________
   7. Can the child use the toilet without help? Yes No
   8. If the child wet the bed, at what age did they stop? ________________________________

C. Family Health History
   1. Circle any of the following diseases that this child’s parents, grandparents, aunts, uncles, brothers, or sisters have had: Allergy: food/medication/environment, asthma, cancer, drug or alcohol addiction, diabetes, heat disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision/hearing/learning problems, anemia, other inherited or family diseases.

2. Family Members (note any special relationship such as step-parent, adopted, foster child)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>Name</th>
<th>State of Health</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
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</tr>
<tr>
<td>Father</td>
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<tr>
<td>Brothers</td>
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</tr>
<tr>
<td>Sisters</td>
<td></td>
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</tbody>
</table>

3. Have any family members died? (not including miscarriages) Yes No
4. How many people live in the same house as the child? ________________________________
5. Are there any family problems such as housing, employment, food, etc. Yes No
D. CHILD’S HEALTH HISTORY

1. Check any of the following illnesses the child has had:
   __________ Read Measles
   __________ German or “3 Day” Measles
   __________ Whooping Cough
   __________ Chicken Pox
   __________ Rheumatic Fever
   __________ Pneumonia

2. Has the child had more than six colds or throat infections, with a fever, a year? …………………. Yes No
3. Has the child had any trouble with ears or hearing? ………………………………………………….. Yes No
4. Has the child had any trouble with eyes or seeing? …………………………………………………….. Yes No
5. Has the child had any trouble with teeth? ………………………………………………………………… Yes No
6. Has the child ever had a convulsion (fit or seizure)? ……………………………………………………… Yes No
7. Has the child ever had a fainting spell? …………………………………………………………………….. Yes No
8. Does the child complain of headaches? ……………………………………………………………………. Yes No
9. Has a doctor ever said the child had a heart murmur? …………………………………………………… Yes No
10. Does the child have trouble keeping up with other children? ………………………………………… Yes No
11. Do any foods disagree with the child? …………………………………………………………………….. Yes No
12. Does the child often have diarrhea? ………………………………………………………………………. Yes No
13. Has constipation ever been much of a problem for this child? …………………………………………. Yes No
14. Has the child ever had worms or parasites? ……………………………………………………………………… Yes No
15. Have you ever seen blood in the child’s stools (bowel movements)? ………………………………… Yes No
16. Has the child ever had yellow jaundice or trouble with the liver? ………………………………………… Yes No
17. Does the child complain of belly aches? …………………………………………………………………….. Yes No
18. Does the child have any problems with urination? …………………………………………………………. Yes No
19. Does the child have any skin problems? ……………………………………………………………………… Yes No
20. Has the child ever had eczema or allergy? ……………………………………………………………………… Yes No
21. Has the child ever had asthma or wheezing? ………………………………………………………………….. Yes No
22. Has the child ever had an allergy or reaction to any medication or injections? …………………………………… Yes No
      What medication or injection? ________________________________________________________________
23. Does the child seem to have trouble breathing through the nose? ……………………………………… Yes No
24. Does the child snore at night? …………………………………………………………………………………….. Yes No
25. Has the child ever complained of pain in the arms or legs? ……………………………………………… Yes No
26. Has the child ever had swelling of any joints or limping? ………………………………………………… Yes No
27. Has there ever been any trouble with the child’s blood? …………………………………………………… Yes No
28. Has the child ever eaten paint or plaster or anything else which is not food? …………………………. Yes No
29. Has the child ever been treated for lead poisoning? ………………………………………………………….. Yes No
30. Does the child have any trouble sleeping? …………………………………………………………………….. Yes No
31. How does the child go to sleep at night? (routine) ………………………………………………………….. 

Where the results normal? ……………………………………………………………………………………

32. Has the child ever had a skin test to TB? ……………………………………………………………………… Yes No

Health History obtained from: ___________________________ Signature of Parent/Guardian ______________ Date __________
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL ___________________________ DATE __________

NAME OF CHILD ___________________________ AGE ____________ SEX __________ GRADE __________ SECTION/ROOM __________

Last ______ First ______ Middle ______

ADDRESS

No. and Street ______ City or Post Office ______ Borough or Township ______ County ______ State ______ Zip ______

REPORT OF EXAMINATION

<table>
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<tr>
<th>TOOTH CHART</th>
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<td>____________</td>
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<tr>
<th>RIGHT</th>
<th>LEFT</th>
<th>TOOTH CHART</th>
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<th>UPPER</th>
<th>LOWER</th>
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</tbody>
</table>

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 __________
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE ___________ 20 ___________

NAME OF SCHOOL ___________________ GRADE _______ HOMEROOM _______

NAME OF CHILD ___________________ DATE OF BIRTH _______

SEX ____________________

M F

ADDRESS _______________________

No. and Street ___________________ City or Post Office _______ Borough or Township _______ County _______ State _______ Zip Code _______

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>Enter Month, Day, And Year Each Immunization Was Given</th>
<th>DOSES</th>
<th>BOOSTERS &amp; DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td</td>
<td>1 / / 2 / / 3 / / 4 / / 5 / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (Circle): OPV, IPV</td>
<td>1 / / 2 / / 3 / / 4 / / 5 /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>1 / / 2 / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1 / / 2 / / 3 / /</td>
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<tr>
<td>HIB</td>
<td>1 / / 2 / / 3 / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>1 / / 2 / / Varicella Disease or Lab Evidence Date:</td>
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</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health

☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

<table>
<thead>
<tr>
<th>Tuberculin Tests</th>
<th>Date Applied</th>
<th>Arm</th>
<th>Device</th>
<th>Antigen</th>
<th>Manufacturer</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Read</td>
<td>Results (mm)</td>
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</tr>
</tbody>
</table>

Follow-Up of significant tubercu in tests:
Parent/Guardian notified of significant findings on. ______________ Date ______________

Result of Diagnostic Studies: ________________________________ Date ______________

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ ☐ ☐ Date

(Continued on Back)
### Significant Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Cardiac</td>
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<tr>
<td>Chemical Dependency</td>
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<td></td>
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<tr>
<td>Drugs</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Diabetes Mellitus</td>
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<tr>
<td>Gastrointestinal Disorder</td>
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<tr>
<td>Hearing Disorder</td>
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<tr>
<td>Hypertension</td>
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<td></td>
</tr>
<tr>
<td>Neuromuscular Disorder</td>
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<tr>
<td>Orthopedic Condition</td>
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<tr>
<td>Respiratory Illness</td>
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<tr>
<td>Seizure Disorder</td>
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<tr>
<td>Skin Disorder</td>
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<td></td>
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<tr>
<td>Vision Disorder</td>
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<tr>
<td>Other (Specify)</td>
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</tr>
</tbody>
</table>

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify ________________________________

### Report of Physical Examination

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Not Examined</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (inches)</td>
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<tr>
<td>Weight (pounds)</td>
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<tr>
<td>BMI</td>
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<tr>
<td>Pulse ( )</td>
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<tr>
<td>Blood Pressure /</td>
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<tr>
<td>Hair/Scalp</td>
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<tr>
<td>Skin</td>
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<td>Spine (Presence of Scoliosis)</td>
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Date of Examination ________________________________

Signature of Examiner ________________________________

Print Name of Examiner ________________________________

Address ________________________________

Telephone Number ________________________________