RIDGWAY AREA SCHOOL DISTRICT
Student Registration Form

Date: ____________ Grade: ____________ Starting Date: ______________ Circle One: Male Female

Student's Name: ____ Birthdate: ________________
Last First Middle MM/DD/YYYY

Address: ____ Birth Place: ______________________________
City State

____ Country of Origin: __________________________

Home Phone #: ____ Date of State Entry: ________________________

Access Card #: ____ Date in Initial US Entry: ______________________

Has the student previously been enrolled in the Ridgway School District? :____________Date:______________
Previous School(s)/Address(es): 1. ____
(Begin with most recent and list year(s) of attendance)
2. ____
3. ____

Number of Years in US Schools: _____________ Date of Grade 9 Entry (High School Only)________________

Are the student's parents and or guardians an active duty member of a branch of the armed forces (Army, Navy, Air Force, Marine Corp, Coast Guard) including fulltime National Guard duty? ____________________________

Parent / Guardian Information	Birthdate	Occupation/Employed By	Business Telephone
Mother's Name w/ Maiden Name (if applicable) Address: Cell Phone: E-Mail:			
Father's Name Address: Cell Phone: E-Mail:			

Student is living with (Check all that apply)

- ☐ Biological Parents
- ☐ Father
- ☐ Stepfather
- ☐ Guardian (male)
- ☐ Foster Father
- ☐ Grandfather
- ☐ ______________
- ☐ Grandparents
- ☐ Mother
- ☐ Stepmother
- ☐ Guardian (female)
- ☐ Foster Mother
- ☐ Grandmother
- ☐ ______________

Ethnicity (choose one):
☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (choose one or more, regardless of ethnicity):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Other Children in Family

____
Last First Middle Birthdate

____
Last First Middle Birthdate

____
Last First Middle Birthdate

Use back of form if additional space is needed.

Health Information (Check)

- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Bee sting sensitivity
- ☐ Hearing problem
- ☐ Wears glasses
- ☐ Takes medicine regularly (list): ________________
____
- ☐ Mental Health Diagnosis: ________________
____
- ☐ Other health or personal problems: ____________
____

PLEASE TURN PAGE OVER AND CONTINUE ON OTHER SIDE

Support Services/Special Education Services/Related Services

☐ Child Study/RTI	☐ Deaf or Hearing Support	☐ Gifted Support
☐ Family Based Services	☐ Vision Support	☐ Multiple Disabilities Support
☐ Student Assistance Program (SAP)	☐ Physical Support	☐ Emotional Support
☐ Title I Reading	☐ Life Skills Support	☐ Behavior Support
☐ Title I Math	☐ Learning Support	☐ Occupational Therapy
☐ Adapted Physical Education	☐ Autistic Support	☐ Physical Therapy
☐ Mobile Therapy/Therapeutic Support	☐ Speech and Language Support	☐ Probation
☐ Drug & Alcohol	☐ Chapter 15 Service Agreement	☐ Other ________

IMPORTANT: ☐ In the event of separation or divorce, check box if you have primary physical custody.

List name and address of non-custodial or shared custodial parent.

NAME:______________________________

ADDRESS :____

PHONE #:____________________ Does the person listed have shared custodial rights? ☐ Yes ☐ No

If the person listed is non-custodial, does s/he continue to have legal rights concerning this child? ☐ Yes ☐ No

Documentation is <u>required</u> to support information provided in this section, such as a court order or a notarized affidavit.

NOTICE: Except as required by law or allowed under express written policy of this School District, no nonresident may be enrolled as a pupil in this School District (SD). The parent or guardian of any nonresident child who is enrolled as a pupil of this SD in violation of this policy shall be liable for payment of tuition on account of such unlawful attendance. Any non-resident adult who unlawfully enrolls as a pupil of this SD also shall be liable for payment of tuition. In addition, such persons shall be responsible for payment of all costs and expenses incurred in the collection of tuition, including reasonable attorneys' fees. Violations of this policy shall be reported to the appropriate authorities for possible prosecution whenever false or misleading information has been given during the school enrollment process, or where the facts of nonresidence otherwise have been misrepresented or concealed. If guilty, additional fines may be levied.

YOUR SIGNATURE BELOW INDICATES THAT THE ABOVE PROVIDED INFORMATION IS TRUE AND ACCURATE.

Parent/Guardian Signature/Date:

SCHOOL USE ONLY

The following documents have been secured:

1. Birth Certificate/Verification: ______(initials)
2. Releases for appropriate agencies (list):
   ____
   ____
   ______________________________ ______(initials)
3. Signed and notarized Act 26 of 1995 Registration Form: ______(initials)
4. Court documents (in event of custody issues, foster care, etc.): ______(initials)
5. Proof of immunization: ______(initials)

Student ID #: ____________

PA Secure ID # ____________

Date Enrolled: ____________

Homeroom Teacher:

____

Homeroom #: ____________

Grade: ____________

Bus #: ____________

Original with Act 26 Form Attached: Cumulative Folder **Copies To:** School Nurse, Guidance Counselor, Office of Student Services, Receiving Teacher

HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

School District: 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?
   (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

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

Parent/Guardian signature:

*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.

RIDGWAY AREA SCHOOL DISTRICT
Confidential Health History

Student Name_______________________________ Birth date____________

Family Physician_______________________ Dentist__________________

<u>Allergies</u>: Please list & indicate type of past reaction

Medications____

Foods____

Environmental____

Insects____

Has a bee sting kit been ordered by a physician? Yes____ No____

Please mark any of the following health problems that are relative to your child. Indicate if it is a current (C) problem or a past (P) problem.

Seizure	_____	Hearing Problems	_____	Pneumonia	_____
Heart condition	_____	Bowel Problems	_____	Vision Problems	_____
Heart Murmur	_____	Congenital Defects	_____	Operations	_____
Kidney/bladder problems	_____	Attention Deficit Disorder	_____	Mental Health Problems	_____
Blood Disorder	_____	Diabetes	_____	Serious Illnesses	_____
Asthma	_____	Treatment for Tb	_____	Behavior Problems	_____

Other____

Explain any above problem- include any information you feel the teacher should be aware of:____

____

____

<u>Childhood Diseases</u>- please give dates if your child has had the disease

Measles (9 day)	_____	Rheumatic Fever	_____	Pneumonia	_____
Mumps	_____	German Measles	_____	Chicken Pox	_____
Whooping Cough	_____				

<u>Family History</u>

Include child's parents, grandparents, immediate aunts and uncles, and siblings.

Disease	Yes	No	Relationship to Student
Allergies			
Asthma			
Diabetes			
Epilepsy			
Heart Disease			
Kidney Conditions			
Tuberculosis			
Cancer			
Mental health (depression, bipolar)			
Learning problems			

Pre and Post Natal History/Child Development

Did the mother have any illness during pregnancy? ___no ___yes If yes, please explain the illness and any medications used to treat the illness: ______________________

Did the mother have any difficulty carrying the child during pregnancy?_____no ___yes If yes, please explain: ______________________

Was the child full term? ___no ___yes If no, how early was the child delivered?________

Was labor or delivery abnormal? ___no ___yes If yes, please explain:______________________

Did the child require oxygen at birth? ___no ___yes

Were any problems noted after birth? ___no ___yes If yes, what were the problems: ______________________

Were any problems noted during the child's development (speech/language delays, motor delays, vision or hearing problems)? ___no ___yes If yes, what problems were noted and at what age?______________________

Were any advancements in the child's development noted? (i.e.: talked early, walked early, read at an early age) ___no ___yes If yes, please describe:______________________

Were there any instances after birth or during child's early development that your child stopped breathing? ___no ___yes If yes, please describe:______________________

Has child sustained any injuries related to an accident or fall? ___no_____ yes If yes, please explain:______________________

Is your child currently taking any medication? ___no ___yes If yes, please list medication and reason prescribed: ______________________

Parent/Guardian Signature______________________

Date________________

Name of Child____

LETTER OF ACKNOWLEDGEMENT

By your signature you acknowledge the following health services to be provided to your child by the Ridgway Area School District. At their respective grades you will be informed of the physical and dental examinations, these exams should be done by the student's own physician and dentist and the reports sent to the school. If at any time, you have questions concerning specific health services provided by the school district, please contact the school nurse.

Grade	Test/Examination				
K	Vision-Hearing	Height-Weight	Body Mass Index	Physical	Dental
1	Vision-Hearing	Height-Weight	Body Mass Index		
2	Vision-Hearing	Height-Weight	Body Mass Index		
3	Vision-Hearing	Height-Weight	Body Mass Index		Dental
4	Vision	Height-Weight	Body Mass Index		
5	Vision	Height-Weight	Body Mass Index		
6	Vision	Height-Weight	Body Mass Index	Physical	Scoliosis screening
7	Vision-Hearing	Height-Weight	Body Mass Index	Dental	Scoliosis screening
8	Vision	Height-Weight	Body Mass Index		
9	Vision	Height-Weight	Body Mass Index		
10	Vision	Height-Weight	Body Mass Index		
11	Vision-Hearing	Height-Weight	Body Mass Index	Physical	
12	Vision	Height-Weight	Body Mass Index		

____ ____________________

Parent/Guardian Date

Preschool Information

Child's name:______________________________ Date of birth:_______________

Did your child attend preschool? ___________Yes ___________No

If yes, please answer the following:

- Where:______________________________________
- Dates attended:_______________________________
- How many days per week:_______________________

If no, please answer the following:

- What types of school readiness activities has your child experienced at home or through daycare (ie: letter recognition, identifying colors, number recognition, counting, etc.) ____
____
____