



IN ADDITION TO THE COMPLETED REGISTRATION FORMS, THE FOLLOWING DOCUMENTS ARE REQUIRED FOR REGISTRATION:

- 1. PROOF OF CHILD'S AGE (acceptable documentation includes):**
 - a. Original or copy of Birth Certificate
 - b. Original or copy of Baptismal Certificate (showing date of birth)
 - c. Valid Passport

- 2. IMMUNIZATIONS REQUIRED BY LAW (acceptable documentation includes):**
 - a. The child's original immunization record
 - b. Immunization record from former school district or medical office

- 3. PARENT'S PHOTO IDENTIFICATION (acceptable documentation includes):**
 - a. Valid Driver's License
 - b. Penn-DOT Identification Card
 - c. Valid Passport
 - d. Permanent Resident Card (Green Card)

- 4. PROOF OF RESIDENCY – TWO REQUIRED (acceptable documentation includes):**
 - a. A dated deed, lease, sales agreement, mortgage information
 - b. Recent utility bill, credit card bill, property tax bill
 - c. Recently dated vehicle registration or vehicle insurance card
 - d. If residing with a district property owner/resident, the district property owner/resident must be present, prove their residency as stated above and sign a notarized 'Multiple Occupancy Form'. **BOTH PARTIES MUST HAVE A VALID DRIVER'S LICENSE OR STATE ISSUED PHOTO ID TO FILL OUT A MULTIPLE OCCUPANCY FORM TO BE NOTARIZED IN OUR OFFICE. MULTIPLE OCCUPANCY FORM CANNOT BE COMPLETED IF EITHER PARTY HAS AN EXPIRED ID.**

- 5. PARENT REGISTRATION STATEMENT** (included in packet)

- 6. HOME LANGUAGE SURVEY** (included in packet)

Other documents that will be helpful for the success of your child: Report cards/transcripts, all special education documents (IEP, ER, RR, NOREP), attendance records and any other records relevant to your child's education.

CONTACT 874-6150 WITH QUESTIONS

Registration Form -- Student Census / Enrollment Information

School: _____ Student ID#: _____

Grade: _____ Homeroom: _____

SPECIAL EDUCATION SERVICES INFORMATION

Is your child receiving special education services? Yes No If yes - specify _____

Does your child have an IEP? Yes No Does your child have a 504 Plan? Yes No

STUDENT CENSUS / ENROLLMENT INFORMATION

PLEASE PRINT

Student's Full Legal Name: _____
Last First Middle

Home Phone: _____

Gender: M F

Birth date: _____
Month Day Year

State / Country of Birth: _____ Date Entered U.S.: _____

Resident Address: _____

Apt/Bldg: _____ City: _____ State: _____ Zip: _____

Shelter Motel/Hotel Relative/Friends Living in Vehicle

Birth Verification: Birth Certificate Other Please specify: _____

ETHNICITY (RACE) *Must choose one*

- American Indian or Alaskan Native *A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.*
- Asian or Pacific Islander *A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent, or Pacific Islands. This includes people from China, Japan, Korea, the Philippine Islands, Samoa, India, Vietnam, Guam, Cambodia, Malaysia, Thailand*
- Black (not of Hispanic origin) *A person having origins in any of the black racial groups of Africa (except those of Hispanic origin) Mogadisho, Ethiopian, Sudan*
- Hispanic *A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.*
- White (not of Hispanic origin) *A person having origins in any of the original peoples of Europe, North Africa or the Ukraine, Arabic, Iraqi, Bosnia, Lebanese, Russia (except those of Hispanic origin).*

In addition to the box you checked above, if you are multi-racial, please check all that apply

American Indian Asian Black Hispanic White

If Pacific Islander, please check this box

PREVIOUS SCHOOL INFORMATION

Has the student ever attended another Erie School District School? Yes No

School: _____ Grade: _____ Year: _____

Last School Attended Outside the Erie School District

School: _____ Grade: _____ School Year: _____ City: _____ State: _____

List the **first time** the student was enrolled

in any school in the US (including preschool and kindergarten)

Month Year Grade (Preschool - 12)

List the **most recent** time the student was enrolled

in any school in the US (NOT including preschool and kindergarten)

Month Year Grade (1 - 12)

List the most recent time the student was enrolled

in a **Pa. public school** (NOT including preschool and kindergarten)

Month Year Grade (1 - 12)

Is your child presently involved in the Juvenile Justice system? Yes No

Parent/Guardian Signature: _____ Date: _____

Registration Form -- Student Census Information

School: _____

Student Name: _____

PARENT/GUARDIAN HOUSEHOLD INFORMATION FOR ADULTS LIVING WITH THE STUDENT

STUDENT LIVES WITH: *Please check one box*

- Parents (both, same household) Parents (both, separate household)
 Father Only Mother Only Grandparent(s) Guardian
 Mother/Stepfather Father/Stepmother Relatives Foster Group home
 Other _____

If FOSTER, please indicate the district where the child's legal guardian resides: _____

Are there any custody orders regarding this child Yes No If yes, a copy must be provided

Parent/Guardian Name: _____ Relationship to Student: _____ Yes No Legal Guardian

Work Telephone: _____ Cell Telephone: _____

Name: _____ Relationship to Student: _____ Yes No Legal Guardian

Work Telephone: _____ Cell Telephone: _____

LIST NAMES OF OTHER CHILDREN LIVING IN THIS HOUSEHOLD

Last	Name	First	Date of Birth	Last	Name	First	Date of Birth

HOUSEHOLD INFORMATION FOR ADULTS NOT LIVING WITH THE STUDENT

Name: _____ Relationship to Student: _____ Yes No Legal Guardian

Resident Address _____

Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Name: _____ Relationship to Student: _____ Yes No Legal Guardian

Work Telephone: _____ Cell Telephone: _____

The School District of the City of Erie, Pennsylvania
Registration Form -- Student Family Data

School: _____

Student Name: _____

Email Address: _____

ADDITIONAL EMERGENCY CONTACT INFORMATION

Emergency Contact # 1

Legal Guardian

Name: _____ Relationship to Student: _____ Yes No

Resident Address: _____

Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Additional Information: _____

Emergency Contact # 2

Legal Guardian

Name: _____ Relationship to Student: _____ Yes No

Resident Address: _____

Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Additional Information: _____

Registration Form -- Student Health Information

School: _____ Teacher/Homeroom _____
 Room # _____
 Student Name: _____ Student ID#: _____

MEDICAL ALERTS (ASTHMA, ALLERGIES, PHYSICAL LIMITATIONS, MEDICATIONS, MEDICAL CONDITIONS, ETC.).

Medical Alert 1: _____
 Medical Alert 2: _____

MEDICATION INFORMATION

Is your child taking any medication regularly? Yes No

If yes, please list the medication(s): _____

Is your child allergic to any medication(s)? Yes No

If yes, please list the medication(s): _____

Indicate allergic reaction: _____

Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

IMMUNIZATION INFORMATION

In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is NOT complete, the student MUST see the school nurse or designee before enrollment can be completed.

INSURANCE

Does your child have health coverage? Yes No

Private Access Gateway Med Plus Ion

If no, healthcare may be available through CARING PROGRAM.

Call toll-free 1-800-986-5437 or 1-800-543-7105

PHYSICAL EXAM

In accordance with PA School Code, a physical examination must be completed on entry into school, and in grades 6 and 11. I wish this examination to be done by the School Physician at no cost to me. Yes No

DOCTOR / PRIMARY CARE PROVIDER

Name: _____

Telephone: _____ Extension: _____

Hospital: _____

In an emergency situation, to which hospital do you want your child sent? Indicate on the line above.

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911. However, the Erie School District will in no case accept financial responsibility for care.

Parent/Guardian Signature: _____ Date: _____

This form will be given to the Nurse after registration

Registration Form -- Student Health Information

Teacher/Homeroom _____

School: _____

Room # _____

Student Name: _____

Student ID#: _____

Health Concerns *Parents/Guardians are responsible for providing full details on any medical conditions to the school nurse*

Does your child have a health problem?

Check and explain where appropriate	Medication(s)	Medication Given At Home		Medication Given At School	
		YES	NO	YES	NO
<input type="checkbox"/> Allergies					
<input type="checkbox"/> Asthma					
<input type="checkbox"/> Attention Deficit Disorder					
<input type="checkbox"/> Bowel/Bladder					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Emotional/Behavioral					
<input type="checkbox"/> Fractures					
<input type="checkbox"/> Head Injury					
<input type="checkbox"/> Hearing					
<input type="checkbox"/> Headaches					
<input type="checkbox"/> Heart					
<input type="checkbox"/> Hyperactivity					
<input type="checkbox"/> Seizures or Fainting					
<input type="checkbox"/> Skin Conditions					
<input type="checkbox"/> Speech					
<input type="checkbox"/> Surgeries / Hospitalizations					
<input type="checkbox"/> Tuberculosis					
<input type="checkbox"/> Varicella (Chickenpox)					
<input type="checkbox"/> Vision					
<input type="checkbox"/> Other					

Student has **NO** health concerns

Please check all that apply

Glasses Contacts Hearing Aids

Prosthesis or Physical Aids (please list) _____

Other _____

Information obtained on the Health History is solely used by the school nurse to ensure that sound decisions are made to meet the health needs of your student. Health information will only be shared with school staff on a "need to know basis" and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns please contact your student's school nurse.

Parent/Guardian Signature: _____

Date: _____

This form will be given to the Nurse after registration

ERIE'S PUBLIC SCHOOLS HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charters/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 and the method for identification.

School District: _____ **Date:** _____

School: _____

Student 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 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.

IMMUNIZATION REQUIREMENTS

The Pennsylvania Department of Health requires the following immunizations as a condition of attendance for all children entering school.

Diphtheria.....	4 doses - one dose after age 4
Tetanus.....	4 doses – one dose after age 4
Polio.....	3 doses – one dose after age 4
Hepatitis.....	3 doses – doses correctly spaced
Measles, Mumps, Rubella (MMR)...	2 doses
Varicella (Chicken Pox).....	2 doses given after age 1 OR mo./yr. of chicken pox signed by parent or doctor

Exceptions:

Medical- a medical contraindication because of rare conditions.

Requires a statement from a physician or clinic.

Religious- which requires a statement from parents/guardians

PHYSICAL AND DENTAL EXAMS

A physical exam is required before entering kindergarten to make sure your child is healthy and ready for school. Take the enclosed form to your physician/clinic and have the doctor complete it. The form can then be mailed to school or returned to the school on the first day of school. Physical exams completed from 9/1/13 to the present are acceptable. Your child will be scheduled for this exam at school if we do not receive a report.

A dental exam is required before entering kindergarten to make sure your child is healthy and ready for school. Take the enclosed form to your dentist/clinic and have the dentist complete it. The form can then be mailed to school or returned to the school on the first day of school. Dental exams completed from 9/1/13 to the present are acceptable. Your child will be scheduled for this exam at school if we do not receive a report.

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
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

ADDRESS

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

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K	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



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?		
HEART/LUNGS: <i>Has the student...</i>	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/JOINT: <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 HEALTH:	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 _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

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

