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

1. **PROOF OF CHILD'S AGE (any one of the following):**
    a. Original or copy of Birth Certificate
    b. Original or copy of Baptismal Certificate (showing date of birth)
    c. Valid Passport
    d. Prior school record indicating date of birth

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. **PROOF OF RESIDENCY (TWO FORMS REQUIRED). Acceptable documentation includes (one from each group):**
    a. **GROUP ONE**:
        i. Valid Driver's License
        ii. Penn-DOT Identification Card
        iii. Valid Passport
    b. GROUP TWO:
        i. A dated deed, lease, sales agreement, mortgage information
        ii. Recent utility bill, credit card bill, property tax bill
        iii. Vehicle registration
        iv. 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 PHOTO ID TO FILL OUT A MULTIPLE OCCUPANCY FORM TO BE NOTARIZED IN OUR OFFICE.**

4. **PARENT REGISTRATION STATEMENT** (included in packet)

5. **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

revised 04/12/2012

The School District of the City of Erie, Pennsylvania

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, Somoa, 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 Ukrane, 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:_____ Legal Guardian Yes ❑ No ❑

Work Telephone:_____ Cell Telephone:_____

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

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: _____ Legal Guardian Yes ❑ No ❑

Resident Address _____

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

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

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 ❑

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

Resident Address: _____

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

Additional Information: _____

Emergency Contact # 2 ❑

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

Resident Address: _____

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

Additional Information: _____

The School District of the City of Erie, Pennsylvania

Registration Form -- Student Health Information

Teacher/Homeroom _____

School: _____ 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

The School District of the City of Erie, Pennsylvania

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
❑ Allergies						
❑ Asthma						
❑ Attention Deficit Disorder						
❑ Bowel/Bladder						
❑ Diabetes						
❑ Emotional/Behavioral						
❑ Fractures						
❑ Head Injury						
❑ Hearing						
❑ Headaches						
❑ Heart						
❑ Hyperactivity						
❑ Seizures or Fainting						
❑ Skin Conditions						
❑ Speech						
❑ Surgeries / Hospitalizations						
❑ Tuberculosis						
❑ Varicella (Chickenpox)						
❑ Vision						
❑ 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.

revised 03/17/14

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.

H514.027 (08/2011-under review)

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		☐ M ☐ 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 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 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

pennsylvania
DEPARTMENT OF HEALTH

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: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ***Has the student…***	**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: ***Has the student...***	**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: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ 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: ***Has the student...***	**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: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**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? ☐ Yes ☐ 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: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**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: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ 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: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ 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 PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**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 ☐				
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 ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	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)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)