Dear Parents,

Welcome to the Shanksville-Stonycreek School District. We look forward to having your family become part of our school.

Please fill out the attached forms and return back to the school at your earliest convenience.

Other documentation needed:

1. Copy of birth certificate
2. Copy of child custody papers if applicable
3. Proof of residency – copy of driver's license or mailing statement with current address

If you do not have access to a copy machine, please bring the documents to the school and we will make copies for you.

If you have any questions please call the school at 267-4649.

# CONFIDENTIAL STUDENT DATA SHEET

## New Student Enrollment

**Student Name** _____ Male ☐ Female ☐

Home Address _____

_____ Grade _____

Mailing Address _____

_____

Home Phone # _____ Birthdate _____

**Mother's Name** _____ Home Phone #_____

Address (If different from student): _____

_____

Employer _____

Work Phone #_____Cell Phone #_____

Email Address_____

**Father's Name** _____ Home Phone #_____

Address (If different from student) _____

_____

Employer _____

Work Phone #_____Cell Phone # _____

Email Address _____

**Step-Parent** (if applicable)_____

**Student Lives With:** ☐ Both Parents ☐ Mother ☐ Father

☐ Guardian _____

**Is the student Hispanic or Latino?** Yes _____ No _____

**What is the student's race**?

_____ Asian
_____ Black/African American
_____ American Indian/Alaska Native
_____ Native Hawaiian/Other Pac Islander
_____ White

## * ALTERNATE EMERGENCY CONTACT INFORMATION *

| Name | Relationship | Phone Number(s) |
|---|---|---|
| | | |

| Name | Relationship | Phone Number(s) |
|---|---|---|
| | | |

Date of Registration _____

Last School Attended _____

Address _____

_____

Previous School Phone # _____

Date child entered school in PA _____ Grade _____

Please check any of the following services that your child received at his/her previous school.

_____ Reading Support

_____ Speech Support

_____ Hearing Support

_____ Learning Support

_____ Gifted Support

_____ Occupational Therapy

_____ Physical Therapy

_____ Autistic Support

_____ Has an IEP

**SHANKSVILLE-STONYCREEK SCHOOL DISTRICT**
**INFORMATION FOR MEDICAL EMERGENCIES**

Student's Last Name _____ First _____ Birth Date _____

Teacher _____ Grade _____

In case of emergency, illness or accident to the student named above, the school is authorized to proceed as indicated below. Number each item from 1-7 in order of desired action.
*(Medical and health related emergency policy adopted 12/13/94.)

Parents (or Guardians):

Mother's Name: _____
_____ Home Address: _____
_____
Home Phone: _____
_____ Place of Work: _____
Work Phone: _____

Father's Name: _____
_____ Home Address: _____
_____
Home Phone: _____
_____ Place of Work: _____
Work Phone: _____

Alternate Contact Person:
_____ Name: _____
Address: _____
_____
Phone: _____

_____ Activate EMS (Dial 911)

_____ Other Desired Procedures _____

*If the emergency is urgent enough to require immediate action, school personnel will act in a prudent manner using all knowledge and skills at their disposal to meet the injured/ill person's needs; this includes calling 911 or the nearest medical facility. The person rendering such assistance should then contact the nurse and notify the parents as per instructions on the student's emergency card.

_____

(Signature of Parent/Guardian) (Date)

Turn over, please

Brothers and Sisters

| Name | | | |
|---|---|---|---|
| 1. | _____ | Grade | Age _____ |
| 2. | _____ | Grade | Age _____ |
| 3. | _____ | Grade | Age _____ |
| 4. | _____ | Grade | Age _____ |

List any health conditions/allergies: (Describe symptoms of allergic reaction and specific treatment required.) _____

_____

_____

Student's Doctor _____ Student's Dentist _____

Phone Number _____ Phone Number _____

Students needing over-the-counter medication during school hours may receive the following medication from the nurse with parent permission. Please check yes or no for each medication listed.

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Tylenol (Acetaminophen) as needed for headache, menstrual cramps, toothache, earache, or fever. Dose will be age/weight appropriate. |
| ☐ | ☐ | Tums, Mylanta, or similar product for upset stomach/nausea. Dose will be age/weight appropriate. |
| ☐ | ☐ | Advil (Ibuprofen) as needed for headache, menstrual cramps, fever, or orthopedic injuries. Dose will be age/weight appropriate. |
| ☐ | ☐ | Cough Drops |
| ☐ | ☐ | Benadryl (Diphenhydramine) Dose will be age/weight appropriate for allergic reactions. |
| ☐ | ☐ | Throat Lozenges for sore/irritated throat. |
| ☐ | ☐ | Orajel or Ambesol for toothaches. |
| ☐ | ☐ | Vaseline Petroleum Jelly for chapped lips. |
| ☐ | ☐ | Caladryl Lotion for insect bites/stings, rash or skin irritations, and itching lesions. |
| ☐ | ☐ | Bacitracin Ointment for superficial wounds/abrasions. |
| ☐ | ☐ | Epipen & Epipen Jr. for severe anaphylactic reaction |
| ☐ | ☐ | Narcan for opioid overdose |

_____

(Signature of Parent/Guardian) (Date)

pennsylvania
DEPARTMENT OF EDUCATION

# HOME LANGUAGE SURVEY

**ALL newly registering students regardless of race, nationality, or language origin MUST complete this form.** Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

**Student Information (Parents/Guardians should complete this section):**

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

**Questions for Parents or Guardians**

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____
2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____
3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

# Shanksville-Stonycreek School District

P.O. Box 128
1325 Cornerstone Road
Shanksville, Pennsylvania 15560-0128

Phone – 814.267.4649
Fax – 814.267.4372
http://www.sssd.com

**Samuel J. Romesberg III, D.Ed.**
*Superintendent*

**Sidney M. Clark, PCSBA**
*Business Manager/Board Secretary*

**Reno J. Barkman**
*PreK-12 Principal*

**Marty Petrosky**
*Director of Technology and Curriculum*

Dear Parents:

Please fill out the information forms for each student being registered. The Affidavit of Information form will need to be notarized and may be done by our high school secretary, Natalie Custer. Please call the school at 267-4649 ext. 232 for her availability.

Proof of residency within the school district is also required. Any document showing your name and address such as a driver's license, utility bill, tax statement, or pay stub may be used. Please return all information forms to the guidance office as soon as possible.

If you have any questions, please contact me at 267-4649 ext. 217.

Thank You,

Megan Ervin
Guidance Counselor

**SHANKSVILLE-STONYCREEK SCHOOL DISTRICT**
**Box 128 Main Street**
**Shanksville, PA 15560**

## AFFIDAVIT OF INFORMATION

Under the provisions of Article XIII-A of Act 26 of 1995, prior to the student's admission to any school entity, a sworn statement is required concerning the student's prior disciplinary record.

## AFFIDAVIT

Commonwealth of Pennsylvania
Somerset County

Before me, the undersigned authority, personally appeared _____
(Name of Parent/Guardian)
who being duly sworn according to law, deposes and says as follows:

_____ is requesting admission as a student to the Shanksville-
(Name of Student)
Stonycreek School District, in grade _____.

_____ was previously enrolled as a student in the following school
(Name of Student)
district(s):

| Name of Districts/ Private/Parochial Schools | Grade | Building |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____ **was/was not** previously suspended or expelled from any school
(Name of Student)
for an act regarding weapons, alcohol or drugs or for violence to persons or property. That I understand that a certified copy of _____'s disciplinary record will be transmitted
(Name of Student)
to the Shanksville-Stonycreek School District and that it will be inspected only by the student, school officials, state and local law enforcement officials or me, as parent/guardian.

_____
(Signature of Parent/Guardian)

Sworn to and subscribed
before me this_____day
of _____, 20__

_____
(Notary Public)

pennsylvania
DEPARTMENT OF EDUCATION

# Children with Disabilities and Special Dietary Needs

Schools participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school meals because of a disability that restricts the diet.

**1. Licensed Medical Authority's Statement for Children with Disabilities**
U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for School Food Service") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

**2. Other Special Dietary Needs**
School food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests, including those related to general health concerns, personal preferences, and moral or religious convictions, are not disabilities and are optional for school food authorities to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

**3. Rehabilitation Act of 1973 and the Americans with Disabilities Act**
Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

*Major life activities* include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

**4. Individuals with Disabilities Education Act**
A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that school food service staff is involved early in decisions regarding special meals. If an IEP or 504 plan includes the same information that is required on a medical statement (see section 1, above), then it is not necessary to get a separate medical statement.

**School Nutrition Program Contact**
For more information about requesting accommodations to school meals and the meal service for students with disabilities, contact:
*Click here to enter local contact name and information.*

Christa Adomnik, CafeManager 814-267-4649 Chloe Koval, School Nurse 814-267-4649 ext 219

**USDA Nondiscrimination Statement**
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail**:
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **fax**: (833) 256-1665 or (202) 690-7442; or

3. **email**: program.intake@usda.gov.

This institution is an equal opportunity provider.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Contact your child's school.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Communiques con la escuela de su niño.

## Medical Plan of Care for School Food Service

*Please read pages 1 and 2 before completing this form.*

| Student's Name | Date of Birth | Grade Level/Classroom |
|---|---|---|
| Name of School/Site | | |
| Name of Parent/Guardian | Phone Number of Parent/Guardian | |
| Signature of Parent/Guardian | Date | |

1. Provide an explanation below of how the student's physical or mental impairment restricts the student's diet:

2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:

3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.
Foods to be omitted:

Suggested substitutions:

4. Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other:

5. List any required special adaptive equipment:

| Name of Physician/Medical Authority & Title (Please Print) | Provider Phone Number |
|---|---|
| Signature of Physician/Medical Authority | Date |

*Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.*

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ *(medical authority)* to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ *(school/program)* and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ *(date)*. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: _____ Date: _____