STATE COLLEGE AREA SCHOOL DISTRICT STUDENT REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

STUDENT LEGAL LAST NAME	STUDENT LEGAL FIRST NAME	MIDDLE NAME

BIRTH GENDER	GRADE ENTERING	DATE OF BIRTH	PREFERRED FIRST NAME

Student Ethnicity: Select one

Asian Black Hispanic American Indian/Alaskan Native

Multi Racial White Hawaiian Native/Pacific Islander

HOME STREET ADDRESS, INCLUDING MAILING ADDRESS (if different)

Type of Residence: ____Single-Family ____Multi-Family ____Shelter ____Hotel/Motel

Name of PARENT/GUARDIAN Student ***RESIDES WITH***	Name of PARENT/GUARDIAN Student ***RESIDES WITH***
RELATION TO STUDENT:	RELATION TO STUDENT:
PREFERRED GUARDIAN LANGUAGE: _____	PREFERRED GUARDIAN LANGUAGE: _____
PHONE A (____) _____	PHONE A (____) _____
PHONE B (____) _____	PHONE B (____) _____
EMAIL_____	EMAIL_____
ACTIVE MILITARY ( ) YES ( ) No	ACTIVE MILITARY ( ) YES ( ) No

Act 26 Sworn Statement

I affirm that the above-named student HAS NOT _____ HAS _____been previously/currently been suspended or expelled from any public or private school with any state for an act or offense involving weapons, alcohol, or drugs, or for the willful infliction of injury to another person or any act of violence committed on school property. Any willful false statement made under this section shall be misdemeanor of the third degree. If YES, please provide details:_____

_____

The parent/guardian signature below verifies the accuracy of all information provided and permits the release of all education and health records from the student's previous school to State College Area SD. This signature also allows for the creation of district accounts including but not limited to (Google, Clever, etc.) as required by COPPA (Children's Online Privacy Protection Rule).

Parent/guardian signature _____ Date _____

PARENT/GUARDIAN NOT RESIDING WITH STUDENT

Name: _____Relation to student _____

Street/mailing address: _____

Phone number _____ Email _____

LOCAL EMERGENCY CONTACTS

Guardians listed above are contacted first

Name _____ Phone number _____

Name _____ Phone number _____

MOST RECENT SCHOOL INFORMATION

School name/address: _____

_____

Enrollment dates: _____

Type of school: _____ Private _____Public/Charter _____Daycare/preschool

ACTIVELY IMPLEMENTED SERVICES

Does your child currently (or formally) receive any of the following support services?

___ 504 Plan ____ IEP ____ GIEP ___ ESL/ELD ___Title 1 Reading/Math (K-5 only)

HOME LANGUAGE

REQUIRED BY ALL STUDENTS
does not include languages learned in school

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

FAMILY INFORMATION

Legal restrictions/court orders ____ No ____ Yes if yes, please provide school with court order

Are there currently any siblings enrolled in State College Area School District: ____ No ____ Yes

Number of younger children (age 0-4) residing in the home? _____

HEALTH INFORMATION

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

MEDICAL INFORMATION

DOES YOUR CHILD HAVE ANY MEDICAL CONDITION WE SHOULD BE AWARE OF? ☐ YES ☐ NO
(IF YES, PLEASE SPECIFY BELOW. Please be aware, information is disclosed to nurses and teachers)

IS YOUR CHILD TAKING ANY MEDICATIONS? ☐ YES ☐ NO *(IF YES, PLEASE LIST BELOW)*

NAME OF MEDICATION
WHAT CONDITION IS BEING TREATED?

****IF MEDICATION IS NEEDED DURING THE SCHOOL DAY, PLEASE CONTACT THE SCHOOL NURSE****

IMMUNIZATIONS INFORMATION

***Please list in chronological order**; if objecting to immunizations for medical reasons please provide documentation from doctor, if for religious/philosophical/moral beliefs a separate form is required. This is optional to fill in as we **require** doctor documentation for immunizations.*

DTAP (last dose must be after age 4 yrs)	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
IPV (OPV) (last dose must be after age 4 yrs)	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
MMR (1st dose must be after age 1 yr)	MM/DD/YY	MM/DD/YY	**Measles dates:** **Mumps dates:** **Rubella dates:**		
HEP B (last dose must be after 6 months of age)	MM/DD/YY	MM/DD/YY	MM/DD/YY		
Varicella (1st dose must be after age 1 yr)	MM/DD/YY	MM/DD/YY	**CHICKEN POX DISEASE DATE:**		
Tdap or Td (one dose must be after 11 yrs old)	MM/DD/YY	MM/DD/YY			
MCV (1st dose at 11yrs old) (2nd dose at 16 yrs old)	MM/DD/YY	MM/DD/YY			

State College Area School District

Statement of District Residency

The State College Area School District is proud to offer a high quality public education to our residents. The District also has a very active residency verification program to protect our community resources and abide by state auditing procedures. This program can include, but is not limited to, complete documentation verification, investigation by District personnel, independent investigation by law enforcement officials and surveillance.

It is the intent of the District to prosecute to the fullest extent of the law, any individual furnishing false information for the purpose of enrolling non-resident students. In accordance with Public School Code Section 1302, *penalties* for providing false information are as follows:

- **Immediate removal from school after notice and an opportunity to appeal**
- **A criminal penalty of a fine of up to $300 and/or up to 240 hour of community service**
- **Any individuals involved in filing the false statement will be liable for tuition during the period of enrollment**

I certify that I have read and understand the above notice. Additionally, I agree to pay the District its full tuition cost as well as any other applicable costs, penalty, or amounts if the student enrolled is found to be a non-resident.

____ Newly registered _____ Change of address for current students

ADDRESS: _____

The student(s) and parent(s) listed below will have their address changed to reflect the new address

Parent/Guardian Name(s): _____

Student Name	Student Number	Current School	New School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Guardian Signature Date

This completed form must be accompanied by a new proof of residency.