

ID# _____ School _____ Residency _____ Enrollment Date _____

STATE COLLEGE SCHOOL DISTRICT STUDENT REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

STUDENT LAST NAME			FIRST NAME		MIDDLE NAME	
GENDER	GRADE ENTERING	DATE OF BIRTH	PREFERRED OR NICKNAME		MUNICIPALITY	
NAME OF PARENT/GUARDIAN STUDENT RESIDES WITH			NAME OF PARENT/GUARDIAN STUDENT RESIDES WITH			
RELATION TO STUDENT			RELATION TO STUDENT			
HOME STREET ADDRESS, INCLUDING MAILING ADDRESS (if different)						
This residence is a: _____ Single-Family _____ Multi-Family _____ Shelter _____ Hotel/ Motel						

Phone A () _____	Phone A () _____ - _____
Phone B () _____	Phone B () _____ - _____
Email _____	Email _____
Occupation _____	Occupation _____
Active Military YES NO	Active Military YES NO

STUDENT STARTED 9TH GRADE *(If applicable)* _____ / _____ / _____

ASIAN	BLACK	HISPANIC	MULTI-RACIAL	WHITE	UNDISC
AMERICAN INDIAN/ALASKAN NATIVE			HAWAIIAN NATIVE/PACIFIC ISLANDER		

ACT 26 SWORN STATEMENT

I affirm that (student's name) _____ has _____ has not _____ been suspended or expelled from any public or private school of this commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property.

The parent/guardian signature below verifies the accuracy of all information provided in this packet and permits release of all educational records (including school nurse records) from previous school to the State College Area School District.

Parent/Guardian Signature _____ Date _____

OTHER PARENT/GUARDIAN NOT RESIDING WITH STUDENT

GUARDIAN NAME _____ RELATION TO STUDENT _____

RECEIVE MAILINGS YES NO PHONE _____ EMAIL _____

HOME STREET ADDRESS INCLUDING MAILING ADDRESS _____

CITY, STATE & ZIP CODE _____

If additional information is required to complete this section, please use back of this paper

EMERGENCY INFORMATION

LOCAL CONTACTS ONLY

NAME _____ PHONE NUMBER _____

NAME _____ PHONE NUMBER _____

LIST ANY SPECIAL INTERESTS/TALENTS OF STUDENT/OTHER IMPORTANT INFORMATION _____

PLEASE LIST ANY SPECIAL AREAS OF SUPPORT NEEDED _____

FAMILY INFORMATION

LEGAL RESTRICTIONS/COURT ORDERS YES NO

SPECIAL INFORMATION REGARDING PARENT/GUARDIAN WHICH MAY IMPACT STUDENT EDUCATION

SIBLINGS LIVING AT HOME UNDER AGE 17 CURRENTLY ATTENDING SCASD

SERVICES

INDICATE **ACTIVE** SERVICES ONLY: 504 IEP Provided by _____ GIEP Provided by _____

PREVIOUS SCHOOL INFORMATION

HAS YOUR CHILD **PREVIOUSLY** ATTENDED STATE COLLEGE AREA SCHOOL DISTRICT? YES NO

MOST RECENT SCHOOL _____

ADDRESS _____

DATES ATTENDED _____

PREVIOUS SCHOOL _____

ADDRESS _____

DATES ATTENDED _____

KD ONLY: DAYCARE/PRESCHOOL _____

ADDRESS _____

DATES ATTENDED _____

HOME LANGUAGE SURVEY

DOES THE CHILD SPEAK A LANGUAGE OTHER THAN ENGLISH? YES NO

IF YES, PLEASE SPECIFY _____
(not languages learned in school)

WHAT IS THE CHILD'S FIRST LANGUAGE? _____

WHERE WAS YOUR CHILD BORN? _____

WHAT IS YOUR HOME COUNTRY? _____

WHAT LANGUAGE(S) ARE SPOKEN IN YOUR HOME? _____

HAS THE CHILD ATTENDED ANY UNITED STATES SCHOOLS? YES NO

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/moral beliefs fill out and sign the back of this form

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

STUDENT SERVICES

240 Villa Crest Drive • State College, Pennsylvania • 16801
Telephone: 814-231-1054 • Fax: 814-231-4103

IMMUNIZATION EXEMPTION LETTER

Re: Exemption

Date: _____

I, _____, being the legal guardian of _____
object to the immunization requirements as outlined by the Department of Health
of the Commonwealth of Pennsylvania as defined in **28 PA. CODE CH. 23** on the
basis:

Religious Conviction

Philosophical/Strong moral or ethical Conviction

as outlined in section § 23.84 Exemption from immunization.

Parent/Guardian Signature

*If your child is exempt from immunizations, he/she may be removed from school
during an outbreak, under the direction of the Pennsylvania Department of
Health.

§ 23.84. Exemption from immunization. [28 PA. CODE CH. 23]

(a) *Medical exemption:* Children need not be immunized if a physician or
the physician's designee provides a written statement that immunization may be
detrimental to the health of the child. When the physician determines that
immunization is no longer detrimental to the health of the child, the child shall be
immunized according to this subchapter.

(b) *Religious exemption:* Children need not be immunized if the parent,
guardian or emancipated child objects in writing to the immunization on religious
grounds or on the basis of a strong moral or ethical conviction similar to a
religious belief.

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.

ADDRESS: _____

This address reflects the following guardians and students:

	Mother	Father	Other Guardian
Student Name			
Student Number			
Current School			
New School			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Guardian Signature

Date

This completed form along with proof of residency should be turned into the Registration Office