

Dear Parents/Guardians

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 to the school at your earliest convenience.

Other documentation needed:

1. **Proof of Age** - Any one of the following constitutes acceptable documentation: birth certificate; notarized copy of birth certificate; baptismal certificate; copy of the record of baptism – notarized or duly certified and showing the date of birth; notarized statement from the parents or another relative indicating the date of birth; a valid passport; a prior school record indicating the date of birth.
2. **Two Proof of Residency** - Driver's license and any of the following documentation that include your current street address: a deed, a lease, current utility bill, current credit card bill, property tax bill, vehicle registration, driver's license, Department of Transportation identification card.
3. **Immunizations required by law**
If you do not have your immunizations at this time, you can still complete the registration process. Your child will not be permitted to enter school without the required immunizations or proper exemption documentation. Please make sure the school nurse has these records before the start of school.

Acceptable documentation includes: either the child's immunization record, a written statement from the former school district or from a medical office that the required immunizations have been administered, or that a required series is in progress, or verbal assurances from the former school district or a medical office that the required immunizations have been completed, with records to follow.
4. **Copy of child custody papers if applicable.**

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.

Shanksville-Stonycreek School District

P.O. Box 128

1325 Cornerstone Road

Shanksville, Pennsylvania 15560-0128

Phone – 814.267.4649

Fax – 814.267.4372

Registration Check List

Student's Name _____

- Original Birth Certificate
- Student Enrollment Form
- Current Certificate of Immunization
- Health Questionnaire; Medical / Development History
- Home Language Survey
- Proof of Residence (taxes, lease, utility bill)
- Parents/Guardians Photo ID (driver's license, PA Photo ID, Military ID)
- Custody Papers (if applicable)

The following medical forms must be turned into the school nurse on or before kindergarten orientation, which will be held in August:

- Physical Form with current proof of immunization
- Dental Form
- Vision exam by an eye care professional

CONFIDENTIAL STUDENT DATA SHEET
New Student Enrollment

Male
Female

Student Name _____

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



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



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. Comuníquese 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. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: <input type="checkbox"/> Chopped/Cut into bite-sized pieces <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Pureed <input type="checkbox"/> 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
<p><i>Signing the following section is optional but may prevent delays by allowing the school to speak with the physician/medical authority.</i></p> <p>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.</p> <p>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.</p> <p>Parent/Guardian Signature: _____ Date: _____</p>		

**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:** _____

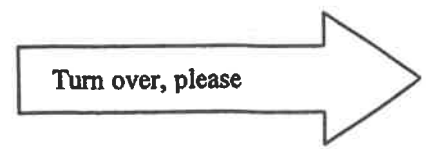
_____ **Alternate Contact Person:**
 _____ **Name:** _____
 _____ **Address:** _____
 _____ **Phone:** _____

_____ **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)**



Brothers and Sisters

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

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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Tylenol (Acetaminophen) as needed for headache, menstrual cramps, toothache, earache, or fever. Dose will be age/weight appropriate. |
| <input type="checkbox"/> | <input type="checkbox"/> | Tums, Mylanta, or similar product for upset stomach/nausea. Dose will be age/weight appropriate. |
| <input type="checkbox"/> | <input type="checkbox"/> | Advil (Ibuprofen) as needed for headache, menstrual cramps, fever, or orthopedic injuries. Dose will be age/weight appropriate. |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough Drops |
| <input type="checkbox"/> | <input type="checkbox"/> | Benadryl (Diphenhydramine) Dose will be age/weight appropriate for allergic reactions. |
| <input type="checkbox"/> | <input type="checkbox"/> | Throat Lozenges for sore/irritated throat. |
| <input type="checkbox"/> | <input type="checkbox"/> | Orajel or Ambesol for toothaches. |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaseline Petroleum Jelly for chapped lips. |
| <input type="checkbox"/> | <input type="checkbox"/> | Caladryl Lotion for insect bites/stings, rash or skin irritations, and itching lesions. |
| <input type="checkbox"/> | <input type="checkbox"/> | Bacitracin Ointment for superficial wounds/abrasions. |
| <input type="checkbox"/> | <input type="checkbox"/> | Epipen & Epipen Jr. for severe anaphylactic reaction |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcan for opioid overdose |

(Signature of Parent/Guardian)

(Date)

Shanksville-Stonycreek School District

P.O. Box 128

1325 Cornerstone Road
Shanksville, Pennsylvania 15560-0128

Samuel J. Romesberg III, D.Ed.
Superintendent

Sidney M. Clark, PCSBA
Business Manager/Board Secretary

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

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

"Equal Opportunity Employer"

It is the policy of the Shanksville-Stonycreek School District not to discriminate in employment or program services for reasons of race, color, sex, age, religion, national origin, or handicapping condition.

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)

SHANKSVILLE- STONYCREEK SCHOOL DISTRICT

SECTION: COMMUNITY

TITLE: PARENTAL/FAMILY INVOLVEMENT

ADOPTED: November 11, 2008

REVISED:

917. PARENTAL/FAMILY INVOLVEMENT	
1. Purpose	The Board recognizes the vital role parents/guardians and family play in the education, welfare and values of their children. The district is committed to the belief that all students can learn and acknowledges that schools and families share a commitment to the educational success of students.
2. Definition	Parental and family involvement shall be defined as an ongoing process that assists parents/guardians and families to meet their basic obligation as a child's first educator, promotes clear two-way dialogue between home and school, and supports parents/guardians as leaders and decision-makers concerning the education of their children at all levels.
3. Authority	The Board recognizes that the responsibility for each student's education is shared by the school and the family and acknowledges that schools and families must work as knowledgeable, cooperative partners to effectively educate all students. To this end, the Board shall support the development, implementation, and continuing evaluation of a parental and family involvement program that will involve parents/guardians at all grade levels in a variety of roles.
4. Guidelines	<p>Because parents/guardians are familiar with the needs, problems and abilities of their children, staff should communicate with and seek their input throughout the school year.</p> <p>The parental and family involvement program may include the following:</p> <ol style="list-style-type: none"> 1. Support for parents/guardians as school leaders and decision-makers, in addition to serving in advisory roles. 2. Promotion of clear two-way communication between the school and the family about school programs and student progress. 3. Assistance to parents/guardians and families in developing parenting skills to foster positive relationships at home, to support children's educational efforts, and to assist their children with learning at home.



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>



Parent Acknowledgement of Receipt of Parent Involvement Policy

Dear Parent/Guardian:

Your participation in your child’s education is important to us. Because of this, the Shanksville-Stonycreek School District has developed a parental involvement policy for the district. This policy explains how we plan to work with parents to review and improve parent programs and describes how you can participate in planning these programs. We value your involvement and urge you to take the time to read this policy.

The Every Student Succeeds Act of 2015 is federal law that requires us to distribute our parental involvement policy to parents. Please sign the form below and return with the enrollment papers so that we can be sure you received this important information.

If you have any questions, please feel free to call Mr. Reno Barkman at 814-267-4649.

Sincerely,
Samuel J. Romesberg, III
Superintendent

ACKNOWLEDGEMENT

I have received the parental involvement policy described in this letter.

Signature of Parent or Guardian _____ Date _____

Printed Name of Parent or Guardian _____

Student’s Name _____

Teacher _____

School _____ Grade _____

“Equal Opportunity Employer”

It is the policy of the Shanksville-Stonycreek School District not to discriminate in employment or program services for reasons of race, color, sex, age, religion, national origin, or handicapping condition.

**CENSUS ENUMERATION
(PLEASE LIST ALL RESIDENTS)**

SHANKSVILLE-STONYCREEK SCHOOL DISTRICT
 PO BOX 128 / 1325 Corner Stone Rd
 Shanksville, PA 15560-0128 (814) 267-4649

Must Check One ✓

Owns & Resides	<input type="checkbox"/>
Owns but 2 nd Home	<input type="checkbox"/>
Rents	<input type="checkbox"/>

HOME PHONE

Please complete this form with names of everyone residing at this address, including adults and children, even if there are no children in your household. Also, please list any college students residing in your household.

↓ MEMBERS OF THE HOUSEHOLD OVER 18 ↓

LAST NAME, FIRST, MI	SEX	DATE OF BIRTH: Month / Day / Year	NAME OF EMPLOYER

↓ MEMBERS OF THE HOUSEHOLD UNDER THE AGE OF 18 ↓

LAST NAME, FIRST, MI	SEX	DATE OF BIRTH: Month / Day / Year

PHYSICAL ADDRESS:

MAILING ADDRESS (if different, i.e. PO Box):
