

Mercer Area Elementary School Registration
301 Lamor Road, Mercer, PA 16137

Today's Date _____

Entering Grade _____

Student's (Legal) Last Name First Middle

Male Female

Home Address — Proof of Residency (2 Required)

Age Birth Date

City State Zip code

Place of Birth — City/State/Country
Pennsylvania Entry Date: _____

Legal Residence/Township:

- Mercer Borough
- Coolspring
- East Lackawannock
- Findley
- Jefferson

Ethnicity of Student (check all that apply):

- American Indian/Alaskan Native
- Asian
- Black (Non-Hispanic)
- Hispanic
- Native Hawaiian/Pacific Islander
- White (Non-Hispanic)

Child Resides With:

- Both Parents
- Mother*
- Father*
- Other* - _____

Provide Custody Agreement or proof of Guardianship

Parent/Guardian's Name

Parent/Guardian's Name

Mailing Address

Mailing Address

City/State/Zip Code

City/State/Zip Code

Home Phone/Cell Phone

Home Phone/Cell Phone

Work Place/Phone (extension or department)

Work Place/Phone (extension or department)

Email Address

Email Address

Emergency Contact (Other than parent)

Phone Number

List all children residing at this address:

First Name	Last Name	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous School (including preschool): _____

Complete Address - _____

Is the student's parent/guardian an active duty member of a branch of the United States Armed Forces (Army, Navy, Air Force, Marine Corp. and Coast Guard) including full-time National Guard? _____ YES _____ NO



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 Date 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



301 Lamor Road
Mercer, PA 16137

Phone: 724-662-5102
Fax: 724-662-5103

Gregory R. Acre
Ext. 3010

Principal
gacre@mercer.k12.pa.us

Shirley A. Spiegel
Ext. 3020

Assistant Principal
Special Education Coordinator
sspiegel@mercer.k12.pa.us

RE: _____
(Student Name)

Date of Birth: _____

I hereby authorize Mercer Area Elementary School to Release information to and/or obtain information from:

(Name of Preschool)

The purpose of this release authorization is to aid in the assessment and coordination of service delivery. Information to include the following:

School Records/Reports Verbal Communications
 Progress Notes/Reports Other: _____

This release will be valid for the period: 3/25/2024 to 3/24/2025

A photocopy of this authorization will be considered valid. All information will be held in strict confidence as protected by law. My signature below indicates that I understand the nature of this release.

_____ Yes, I authorize this Release of Information

Parent/Guardian: _____ Date: _____

OR

_____ No, I do not authorize this Release of Information.

Parent/Guardian: _____ Date: _____

School Representative: _____ Date: _____

Mercer Elementary School Parent Questionnaire
Kindergarten Registration

Today's Date _____

Child's Full Name _____ Birth Date _____

Name to be used in school _____

Parent's Full Name(s) _____

1. Child resides with(check):Parents Mother Father Grandparents Foster Parents
Other _____

2. Siblings (Names/Ages) _____

Address _____

Home Phone _____ Cell Phone _____

Pre-School History

3. Circle Preschools attended and indicate number of years attended:

<u>Check Pre-School(s)</u>	<u>List number of years</u>
Jumpstart Child Care	_____
Son-Shine Preschool	_____
Mercer County Career Center	_____
Pre – K Counts at Mercer Elementary	_____
Head Start at Mercer Elementary	_____
Other _____	_____

Early Intervention- Does your child receive special services through IU-4? Yes _____ No _____
Please describe special services here:

Guidance and/or Counseling Services- Does your child receive any mental health services (i.e. individual counseling, wrap around/TSS, mobile therapy or other)? Yes _____ No _____

If yes, Agency's name - _____

We would like to know a little more about your child before Kindergarten starts. Please help us by answering these questions. If you would like to add more information or clarify answers, please do so.

My Child:

- | | | |
|---|------------|-----------|
| • Can put on (and take off) his/her own shoes, coat, etc. | YES | NO |
| • Can use bathroom without help | YES | NO |
| • Can follow directions | YES | NO |
| • Can obey rules | YES | NO |
| • Can play and get along with others | YES | NO |
| • Can communicate needs | YES | NO |
| • Can easily separate from parents without becoming upset | YES | NO |
| • Can count to 10 | YES | NO |
| • Can name basic colors | YES | NO |
| • Can recognize own name in print | YES | NO |
| • Can listen to stories read to him/her | YES | NO |
| • Can hold a pencil / crayon and write or color | YES | NO |

My child's strengths are: _____

My child may need extra help with: _____

Additional comments or questions are always welcome. We appreciate your willingness to share information with us.



Dear Families,

2024-2025

To ensure a safe and efficient dismissal of our students, we ask all parents to fill out the form below. Each child must return a completed form. Please make sure to include people on the form who are **ALWAYS** permitted to pick up your child for dismissal.

Also, please do not forget to include parent/guardian names and sign the bottom.

Information about our dismissal procedure...

- If you will pick up your child every day, please send a note/email to your child's teacher on or before the first day of school.
- If your child normally rides the bus, please send a note with your child on days they will be picked up. **Any student WITHOUT a note will be put on the bus.**
- Dismissal for Pony Express Riders (parent pick-ups) will be at 3:00 using the main office entrance. If you arrive early, please wait in the soccer field lot until the buses have left, and then drive or walk over to the office.
- **PLEASE REMEMBER AND/OR REMIND** THE PICK-UP PERSON TO BRING A FORM OF **PHOTO I.D.**

-----Please Print-----

Student's Name: _____ Grade: _____
Last, First

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, _____, give Mercer Area School District permission to dismiss my child to those listed above for the 2024-25 school year. I will contact the elementary office should any changes need to be made.

Parent Signature: _____

Date: _____

MERCER AREA SCHOOL DISTRICT

Request for Transportation

Mr. Mark Roman, Transportation Director

724-662-5100 ext. 40

Student Name(s):	Grade		Home Address:		
			Street	Apt. #	
			City	State	ZIP
Parent/Guardians Name(s)	Relationship		Telephone Number:		
Today's Date _____	Reason for Request: <u>Kindergarten Registration</u>				

<input type="checkbox"/> HOME (Address listed above)		<input type="checkbox"/> HOME (Address listed above)
Requested PICK-UP Address		Requested DROP OFF Address
Street _____ Apt. # _____		Street _____ Apt. # _____
City _____		City _____

PLEASE DO NOT WRITE BELOW THIS LINE—TRANSPORTATION DEPT. ONLY

NEW: AM BUS# _____ TIME: _____ PARENT _____

NEW: PM BUS# _____ TIME: _____ SCHOOL _____

EFFECTIVE DATE: _____ BUS _____

Mooooooooosetracks _____

Speech & Hearing Screening Form for Kindergarten Registration

Name of Child: _____

Has / or is your child enrolled in a speech and/or language program? Yes No

If yes, please list the name of the program: _____

Has your child had difficulties with hearing in the past? Yes No

Does your child have difficulties with hearing at this time? Yes No

Has your child had tubes in his / her ears in the past? Yes No

Does your child have tubes in his / her ears at this time? Yes No

Is your child currently under a doctor's care for any of the above? Yes No

If yes, please list the name of the doctor: _____



To be completed by Screening Personnel

	Passed	Recheck	Comments
Vision	_____	_____	_____
Speech	_____	_____	_____
Hearing	_____	_____	_____

	250	500	1000	2000	4000	8000
Right Ear						
Left Ear						

**Mercer Elementary School
Initial Health History Form**

Name _____ Date of birth _____ Sex _____
Last First Middle Male Female

Parent 1 Name _____ Parent 2 Name _____

Parents are: Married Single Divorced Separated Widowed

Child is living with: Parent Mother Father Guardian

If living with guardian, list name and relationship:

Please list information for others

Name	Date of birth	Name	Date of birth

Please complete the health history chart, check all that apply.

<input type="checkbox"/>	ADD/ ADHD
<input type="checkbox"/>	Arthritis/Rheumatic Disease
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Bleeding disorder/Cooley's Anemia
<input type="checkbox"/>	Bone/joint disease
<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	Chicken Pox date: _____
<input type="checkbox"/>	Chronic constipation
<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Cystic Fibrosis
<input type="checkbox"/>	Convulsions/seizures
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Ear infections
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Emotional/behavior
<input type="checkbox"/>	Epilepsy/other seizure disorders
<input type="checkbox"/>	Fainting spells

<input type="checkbox"/>	Headaches (frequent)
<input type="checkbox"/>	Headaches (migraine)
<input type="checkbox"/>	Hearing loss/hearing aid
<input type="checkbox"/>	Heart defect/disease
<input type="checkbox"/>	Kidney disorder
<input type="checkbox"/>	Life-Threatening Food Related Allergy
<input type="checkbox"/>	Life-Threatening Allergy-(example:Bees/Latex)
<input type="checkbox"/>	Nosebleeds (severe)
<input type="checkbox"/>	Psychiatric disorder
<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	Tourettes's Syndrome
<input type="checkbox"/>	Vision loss (uncorrectable)
<input type="checkbox"/>	Visual problem/glasses
<input type="checkbox"/>	Other:
<input type="checkbox"/>	Operations:

Please explain in detail any above condition _____

List any allergies (not life threatening) your child may have, what type of reaction and what treatment is necessary:

List medications that your child is currently taking

Medication	Dose	Time Given	Diagnosis/Why Given

If your child is required to take medications during the school day the school's medication policy must be followed. A medication policy/consent form is available from the school nurse, the office or on the school website.

Turn to the other side...

Does your child have any bowel or bladder control issues? Please explain _____

Is there anything else you would like us to know about your child? _____

MANDATED SCHOOL HEALTH SERVICES

Every child of school age attending or who should attend a public or private/non public school within the Commonwealth of Pennsylvania must receive the following health services.

Service	K	1	2	3	4	5	6	7	8	9	10	11	12
Dental Examination	X			X				X					
Growth Screen	X	X	X	X	X	X	X	X	X	X	X	X	X
Hearing Screen	X	X	X	X				X				X	
Immunization Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X
Maintenance of Health Record	X	X	X	X	X	X	X	X	X	X	X	X	X
Medical Examination	X						X					X	
School Nurse Services	X	X	X	X	X	X	X	X	X	X	X	X	X
Scoliosis Screen							X	X					
Tuberculin Test (Unless approved to discontinue)	X									X			
Vision Screen	X	X	X	X	X	X	X	X	X	X	X	X	X

§ 23.84. Exemption from immunization. This code allows for the medical, religious and conscientious exemptions to immunizations as condition for school attendance, provides as follows:

- (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.

Information that is health related and may affect your child during the school day will be shared with appropriate school personnel in a confidential manner.

Parent/Guardian signature _____ Date _____

The Mercer Area School District does not discriminate on the basis of race, sex, color, creed, age, handicaps, or national origin in administration of its education or employment policies.



MERCER ELEMENTARY SCHOOL

SCHOOL SUPPLY LIST

If possible please send these supplies with your child on the first day of school



KINDERGARTEN

- 1 – pack of colored pencils (12 count - boys)
- 1 – pack of washable markers (10 count - girls)
- 1 – box of **Crayola** crayons (24 count)
- 4 – large WHITE glue sticks (or 8 small)
- 2 – 6 oz. cans of Play Dough
- 1 – box of tissues
- 1 – box of sandwich Ziploc bags (boys)
- 1 – box of gallon Ziploc bags (girls)
- 1 – full change of clothes in a labeled gallon bag
- 1 – bottle of hand sanitizer