

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 (check):**

- Both Parents
- Mother\*
- Father\*
- Other\* - \_\_\_\_\_

***Provide Custody Agreement or proof of Guardianship***

\_\_\_\_\_  
Mother's Name

\_\_\_\_\_  
Father's Name

\_\_\_\_\_  
Mother's Mailing Address

\_\_\_\_\_  
Father's Mailing Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Home Phone/Cell Phone

\_\_\_\_\_  
Home Phone/Cell Phone

\_\_\_\_\_  
Mother's Work Place/Phone (extension or department)

\_\_\_\_\_  
Father's Work Place/Phone (extension or department)

\_\_\_\_\_  
Mother's Email Address

\_\_\_\_\_  
Father's Email Address

Emergency Contact (Other than parent)	Phone Number	Relationship to the Child
_____	_____	_____
_____	_____	_____

**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



**Information Release Authorization**

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: 3/25/2025 to 3/24/2026

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(circle): Mother/Father, 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.

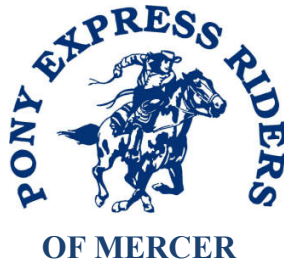
My Child:

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

**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,

2025-2026

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 2025-26 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)
<b>Requested PICK-UP Address</b>		<b>Requested DROP OFF Address</b>
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

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Parents are:  Married  Single  Divorced  Separated  Widowed

Child is living with:  Both  Mother  Father  Guardian

If living with guardian, list name and relationship: \_\_\_\_\_

Please list information for others living in the home:

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"/>	
<input type="checkbox"/>	Operations: _____
<input type="checkbox"/>	

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
<b>Dental Examination</b>	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
<b>Medical Examination</b>	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.*