

PALMERTON AREA SCHOOL DISTRICT

Kindergarten Registration

Required Document Checklist

____ **Parkside**

____ **Towamensing**

In order for a student to begin school, we must have on file or have seen the following:

- Proof of Immunizations - **copy**
- Proof of Age & Name (birth certificate, baptismal certificate, passport) - **copy**
- Proof of Residency – 2 items from Lists below

Deed	PA Driver's License/ID
Mortgage	PA Auto Registration
Property Tax Bill	Utility Bill
Lease/Rental Agreement	Tax Return
Sales Agreement	Moving Permit

- Special Education paperwork (IEP, 504 plan)-if applicable – **copy**
- Busing instructions for before or after school

Student Name: _____

**PALMERTON SCHOOL DISTRICT
STUDENT REGISTRATION FORM**



Student Biographical Information

Student Name _____ Birthdate ____/____/____ Age ____
(Last) (First) (Middle) (mm) (dd) (yyyy)

Gender M F Grade Entering K Proof of Age Documentation **attached** Y N

Name of Last School Attended _____

Address of Last School Attended _____ Last School's Phone # _____
(City) (State) (Zip Code) Last School's Fax # _____

Has student ever attended in this school district? Y N If yes, which school. _____

Has student ever attended school in PA? Y N If yes, list school and grade _____

Did student ever attend school **outside** of the United States? Y N If yes, where. _____
 If yes, what year did student first attend a school in the United States? _____

The following two questions are for federal and state reporting purposes only:

Race (check all that apply): American Indian/Alaskan Native Asian Black/African America Caucasian/White
 Native Hawaiian/Pacific Islander Multi-Racial

Is the student of Hispanic/Latino Ethnicity? YES or NO

Building:

Palmerton High School Palmerton Jr. High School SS Palmer Elementary Parkside Education Center Towamensing Elementary

Student Miscellaneous Information

Student's Native Language _____ Is the student a U.S. Citizen? _____

Student's City, State and Country of Birth _____

Is there a Court Order involving this student? Y N **If YES, please provide a copy to the school office, otherwise we are unable to abide by its contents.**

Is this student in the custody of someone other than a parent? Y N If yes, what is the relationship

FOR OFFICE USE ONLY

Student ID# _____ Date Entered/Reentered _____ PASecure ID _____

Institutionalized Child (1306) Y N (If yes, complete PDE-4605 and submit to child accounting)

Foster Child (1305) Y N (If yes, attach 1305 – Affidavit)

Bus Assignment: **Bus #** _____ **Time** _____

AM _____

PM _____

Special transportation needs? NONE Wheelchair Door-to-Door Other

First Adult Resident with whom student resides

Name _____ Mr./Mrs./Ms./Dr.
(Last) (First) (Middle) (circle one)

Relationship to Child _____

Birthdate ____/____/____

Primary Phone Number's:

Home ____ - ____ - ____ Work ____ - ____ - ____ Ext ____; Cell ____ - ____ - ____

E-Mail Address _____

Second Adult Resident with whom student resides

Name _____ Mr./Mrs./Ms./Dr.
(Last) (First) (Middle) (circle one)

Relationship to Child _____

Birthdate ____/____/____

Primary Phone Number's:

Home ____ - ____ - ____ Work ____ - ____ - ____ Ext ____ Cell ____ - ____ - ____

E-Mail Address _____

Address of Adult Resident(s) with whom student resides

The Residence is: _____ Apartment _____ Campground/Campsite
_____ Single Family Home _____ Hotel/Motel
_____ Multi-Family Home _____ Car
_____ Shelter _____ Other

(Physical Address of Residence) (City) (State) (Zip Code)

(Mailing Address of Residence-if different from above) (City) (State) (Zip Code)

Exact Directions to Residence:

Name of Development/Subdivision: _____

Municipality to which you pay taxes: Palmerton Borough Bowmanstown Borough Towamensing Township
 Lower Towamensing Township

Additional Information

Do you live on federal property or work for the federal government? Y N

Other children living at this address:

- 1.) Full Name _____ Birthdate ____/____/____ Grade ____ School _____ M F
- 2.) Full Name _____ Birthdate ____/____/____ Grade ____ School _____ M F
- 3.) Full Name _____ Birthdate ____/____/____ Grade ____ School _____ M F
- 4.) Full Name _____ Birthdate ____/____/____ Grade ____ School _____ M F

Is the student going to/from school from somewhere other than your residence? Y N Pickup Drop Off Both

If yes, from where Day Care Name, location & phone # _____
 Babysitter Name, location & phone # _____

Second Parent Information (Parent student does NOT reside with)

Name _____ Mr./Mrs./Ms./Dr.
(Last) (First) (Middle) (circle one)

Relationship to Child _____ Is this parent to receive notices? Y N

Birthdate ____/____/____

Mailing Address: _____

Primary Phone Numbers:

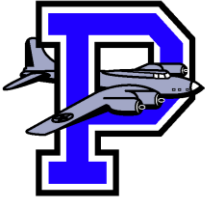
Home _____ - _____ - _____ Work _____ - _____ - _____ Ext _____ Cell _____ - _____ - _____

E-Mail Address _____

Student Program Information

Check ALL services that your child is currently receiving:

- Individualized Education Plan (Special Education Services)
- Gifted Individualized Education Plan (Gifted Education Services)
- Section 504/Chapter 15 Service Agreement (Special Accommodations for Health/Physical needs)
- ESL (English as a Second Language)
- Speech/Language Support
- Early Intervention Program
- Remedial Math (Extra Help)
- Remedial Reading (Extra Help)
- IST (Instructional Support Team)



PALMERTON AREA SCHOOL DISTRICT

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 (last) name: _____

Child's Date of Birth: _____

Questions for Parents/Guardians

1. Is a language other than English spoken in the child's home?

YES (language) _____ NO

2. Does your child communicate in a language other than English?

YES (language) _____ NO

3. What is the language that your child first learned to speak?

4. I would like all written communication from the school to be provided in my home language.

YES (language) _____ NO

5. I need the school to provide translation for talking with teachers or staff.

YES NO

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided: YES NO



PALMERTON AREA SCHOOL DISTRICT

GUIDANCE QUESTIONNAIRE

Student's Name: _____ Grade _____

List the schools that the student has previously attended. Please include Headstart, Project Connect or any preschool for those students in grades K-3.

School	Grade	Year(s) attended

Was the student ever retained (circle)? Yes No

If so, what grade(s) _____

Student presently lives with: Name _____

Relationship to student: _____

Is there presently a custody issue (circle)? Yes No

If yes, custody papers must be provided. Papers provided (circle): Yes No

Any comments or concerns you wish to make known to the Counselor?

Are there any special services that your child presently receives or has received in the past?

PALMERTON SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

SPECIAL HEALTH NEEDS

Student's Legal First, Middle, Last Name _____
Mother's Name _____
Father's Name _____
Whom Student Resides With _____
Address _____
DOB _____ Grade _____ Gender _____ Race _____ Phone Number _____
Previous School Attended _____

Name and phone number of Family Physician _____
Name and phone number of Family Dentist _____

Were there any problems or complications during pregnancy and/or delivery with mom and/or student? Yes No
If yes, explain _____

Did student have NICU stay? Yes No
If yes, explain _____

Premature? Yes No Gestation _____ weeks Birth Weight _____

Infancy and Early Childhood (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent Earaches | <input type="checkbox"/> Seizures or Convulsions | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Frequent Upset Stomach | <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> Short Attention Span |
| <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Frequency or Burning on Urination | <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Stuttering | <input type="checkbox"/> Difficulty separating from parents |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Difficulty carrying our directions |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Unusual Fears |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Defects | <input type="checkbox"/> Poor Coordination |
| <input type="checkbox"/> Nosebleeds | | <input type="checkbox"/> Frequent Stumbling or Falling |

Comments: _____

Was your child born with any birth defects? Yes No
If yes, explain _____

Has your child had any childhood diseases? Yes No
If yes, explain _____

Has your child ever had any serious illnesses, hospitalizations, fractures (broken bones) or operations? Yes No
If yes, explain _____

Does your child have any diagnoses or current health conditions? (Asthma, Diabetes, ADHD, ADD, Anxiety, Depression, Migraines, etc) Yes No

If yes, please list _____

If yes, are they currently under any treatment _____

Name of the treating provider _____

Please include any medications or accommodations required _____

Is there an Asthma Action Plan in place? Yes No If yes, we will need a copy.

Has your child ever had any convulsions or seizures? Yes No

If yes, explain appearance _____

When was the last seizure? _____

Name of Neurologist, if applicable _____

Please include any medications or accommodations required _____

Is there a Seizure Action Plan in place? Yes No If yes, we will need a copy.

Is your child receiving any therapies? (Speech, OT, PT, Counseling, etc) Yes No

If yes, please list _____

Does your child require any assistive devices? (Glasses, hearing aids, braces, etc) Yes No

If yes, please list _____

Does your child have any allergies? (Seasonal, food, insects, plants, medicines, etc) Yes No

If yes, please list _____

If yes, is there an Epi-Pen (Epinephrine) prescribed? Yes No

Name of the Allergist/treating provider _____

Is there an Action Plan in place? Yes No If yes, we will need a copy

Does your child need a special diet or have a food problem? Yes No

If yes, explain _____

Does your child have any activity restrictions? Yes No

If yes, please provide a note from his/her health care provider.

Please indicate if any relatives have or have had any of the following diseases:

M- Mother's family

F- Father's family

__Allergies __Asthma __Diabetes __Heart Disease __Lung Disease

__Psychological problems __Convulsive (seizure) disorders __Emotional problems

Does your child take any medication on a regular basis? Yes No

If yes, please include the name, dosage, timetable, and reason for taking the medication.

****If there are any changes to your child's health or any new diagnoses throughout their school years, please notify your child's nurse immediately.**

If your child needs to take any medication during the school day, we MUST have an order from a healthcare provider. The medication MUST be brought to the health office by an adult, and it MUST be in the original container. The label on the container must include the name of the child, the name of the medication, the dosage, and the timetable for dispensing the medication. If the medication is prescribed, a signed authorization from the healthcare provider must accompany the medication. Over the counter medications only need a written authorization from the parent or guardian.

Signature _____ Date _____

PALMERTON AREA SCHOOL DISTRICT
 680 FOURTH STREET
 PALMERTON, PA 18071
 610-826-7101

RESIDENCY QUESTIONNAIRE

NAME OF PARENT/GUARDIAN:			TELEPHONE #:
CURRENT ADDRESS:			
TOWNSHIP OR BOROUGH OF:			SINCE:
PREVIOUS ADDRESS:			
MY EMPLOYER:			OCCUPATION:
EMPLOYER ADDRESS:			
SELF EMPLOYED <input type="checkbox"/>	HOMEMAKER <input type="checkbox"/>	DISABLED <input type="checkbox"/>	RETIRED <input type="checkbox"/> STUDENT <input type="checkbox"/>
LIST <u>ALL</u> PERSONS LIVING AT THE ABOVE ADDRESS			
NAME	EMPLOYER	OCCUPATION	18 YEARS OF AGE OR OLDER
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No
6.			<input type="checkbox"/> Yes <input type="checkbox"/> No
7.			<input type="checkbox"/> Yes <input type="checkbox"/> No
8.			<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE INFORM YOUR EMPLOYER OF YOUR CORRECT TAXING DISTRICT – **NOT SCHOOL DISTRICT.**

I CERTIFY THAT ALL INFORMATION AND STATEMENTS HEREIN ARE CORRECT.

SIGNATURE:	DATE:
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FOR OFFICIAL USE

DATE MAILED:	NOTES:
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