



Welcome to the Big Beaver Falls Area School District

1503 8th Avenue
Beaver Falls, PA 15010
724-843-3420
www.tigerweb.org

To complete your child's registration, you will need to bring the following required items:

- Birth Certificate
- Proof of Residency (item mailed to home with name and address)
- Valid Driver's License or Photo ID (parent/guardian)
- Immunization Records
- Current Custody Papers (if applicable)

Once you complete the registration forms and have the required items above, please call Kylei Miller at 724-843-7470 extension *1209 to schedule an appointment or email at millerk@tigerweb.org

Thank you.

A message from Dr. Donna Nugent, BBFASD Superintendent:

Welcome to the Big Beaver Falls Area School District where we have a rich tradition of high academic and athletic excellence. We are a close-knit community in Beaver Falls, where we are all working together for our children to become successful. Our teachers are loving, compassionate, and encourage our students to perform at very high academic levels. We have high academic expectations of our students and celebrate their successes with them. Our academic curriculum is extensive in its offering, including a Pre-Kindergarten program and full day kindergarten within our elementary buildings as well as AP course offerings within our high school. Our curricular and extracurricular successes, which have generated our District-wide, State, and National recognition and awards have been possible because of the dedication and efforts of our School Board, Administration, faculty, and the performance of our students.

Registration and enrollment will be in accordance with the Big Beaver Falls Area School District Board of Education Policies, which can be found on the district website at www.tigerweb.org.

Student's Name _____ **DOB** _____

BIG BEAVER FALLS AREA SCHOOL DISTRICT REGISTRATION

Date: _____ School: BB CE MS HS

Student Name: _____ Date of Birth: _____ Age: _____
Last First

Gender: Male Female

| |
|-----------------------|
| Homeroom: _____ |
| Teacher: _____ |
| Grade: _____ |
| Bus Number: _____ |
| Student Number: _____ |

FOR OFFICE USE ONLY

Parent/Guardian email address for gradebook program: _____

Complete Parent or Guardian Information:

Father's Name: _____
 Father's Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____
 Place of Employment: _____ Work Phone: _____

Mother's Name: _____
 Mother's Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____
 Place of Employment: _____ Work Phone: _____

Guardian's Name: _____
 Guardian's Address: _____ City: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____
 Place of Employment: _____ Work Phone: _____
 Relationship to Child: _____

With whom does the child live? Mother Father Grandparent Stepmother Stepfather Other
 (Please check all that apply)

If other, name: _____ Custody Papers on File

Is the parent/guardian a member of the armed service? Circle one: Yes No

Part 1: Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino

Part 2: Ethnicity (check all that apply):

- American Indian or Alaskan Native
- Black/African American Non-Hispanic
- White Non-Hispanic
- Asian
- Native Hawaiian or other Pacific Islander

Did Student attend a Big Beaver Falls School District school previously? Yes No
 If "yes", what grade(s)/school(s)? _____

 Has Student repeated a grade? Yes No If "yes", what grade was repeated? _____

 City of Birth: _____
 State of Birth: _____
 Country of Birth: _____
 If born or entered from another state, Date of Entry into State: _____
 Have you ever been educated in a Pennsylvania Public School? _____
 If born in another country, Date of Entry into Country: _____

PIMS Information

School Last Attended: _____
 Address: _____ City: _____ State: _____

Special Services he/she received while attending previous school (check all that apply):

- | | |
|------------------------------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Gifted Program | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Learning Support/has an IEP (Individualized Education Program) | <input type="checkbox"/> Title I Reading |
| <input type="checkbox"/> Emotional Support/has an IEP (Individualized Education Program) | <input type="checkbox"/> Title I Math |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Instrumental Music |
| <input type="checkbox"/> Physical Therapy | |

You must provide the following information to enroll a child/children. Copies will be made.

- | | | |
|------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Social Security Card |
| <input type="checkbox"/> Proof of Guardianship | <input type="checkbox"/> Proof of Residency | <input type="checkbox"/> Proof of Withdrawal |
| <input type="checkbox"/> Grades/Transcript | <input type="checkbox"/> Attendance Record | <input type="checkbox"/> Valid Driver's License # |
| | | Access Card _____ |

EMERGENCY CONTACT: _____ PHONE #: _____

Signature of Parent/Guardian: _____ Date: _____

BIG BEAVER FALLS AREA SCHOOL DISTRICT

HEALTH AND STUDENT INFORMATION

DATE _____

STUDENT NUMBER _____

TO THE PARENTS OR GUARDIANS: PLEASE COMPLETE THE ENTIRE FORM, ON BOTH SIDES, IN BLACK PEN, AND SIGN IT. THIS INFORMATION IS NECESSARY FOR SCHOOL AUTHORITIES TO MAKE COMPLETE RECORDS FOR YOUR CHILD.

Student Name _____ Sex: M F
Last First Middle

Home Address _____ Phone: _____
House Number and Street City

Birth date _____ Place of Birth _____ Birth Certificate No. _____

CIRCLE: Indian Asian Black Hispanic White Multi-Racial

Father's Name _____ Place of Employment _____ Phone _____

Mother's First Maiden Last _____ Place of Employment _____ Phone _____

With whom does the child live? Mother Father Other
(name) _____

Stepfather's Name _____ Stepmother's Name _____

How many children are in the family? _____

Please list an emergency person. This is the person, that the school can contact in case of illness or accident, if the parent cannot be reached.

Name _____ Relationship to child _____ Phone _____

Children will not be released from school during school hours unless a note has been brought to school by your child designating who may pick up the child. If there is anyone the child may not leave with, please list names:

If you live in an area in which your child will ride a bus to school, please name a landmark or another road that is near your home:

MEDICAL HISTORY

A complete health and emotional history enables us to understand your child better, and helps him/her to make a better adjustment to school. Please check, if your child has any of the following conditions:

- | | | |
|----------------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox (when) | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mouth Breather |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Bleeder | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Convulsions/ High Fever |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Frequent Nose Bleed |
| <input type="checkbox"/> Seizures/ Fainting Spells | <input type="checkbox"/> Frequent Earache | <input type="checkbox"/> Tires Easily |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Frequent Headache |
| | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Frequent Urination |

Was there a health problem or handicap present at birth? Yes No
If yes, please explain

Is he/she presently under care of a physician? Yes No
List any injury, operations or hospitalizations – give dates

Is your child on any medication? _____ If yes, name of medication _____
Dosage and time to be give _____

Does your child have special dietary needs? Yes No

Does your child wear glasses? Yes No

Check the following, if it pertains to your child:

EYES

- Squint
- Cross Eyes
- Difficulty Seeing
- Red Eyes

EARS

- Difficulty Hearing
- Frequent Ear Infections
- Draining Ears

ADDITIONAL COMMENTS:

SIGNATURE OF PARENT OR GUARDIAN _____

Big Beaver Falls Area School District
STUDENT RESIDENCY QUESTIONNAIRE



Dear Parent/Guardian,

Your responses to the following questions will help staff determine what residency documents are necessary for the enrollment of your child(ren.) Thank you for your cooperation.

1. Student's name: _____ Birthdate: _____

2. Person completing form: _____ Relationship to child: _____

3. What type of setting is the student currently living? (Please check one of the boxes below.)
This information will be used to provide support for your child.

| SECTION A | SECTION B |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input type="checkbox"/> In emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing housing of other persons due to loss of housing, economic hardship or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a park, public spaces, abandoned building, substandard housing, bus/train station or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p>Please continue to Question 4, if you checked any box in SECTION A.</p>  | <p><input type="checkbox"/> None of the choices in SECTION A apply.</p> <p>If you checked the box above in SECTION B, you do not need to complete the remainder of this form. Please submit the form to school personnel now.</p>  |

4. Contact number for the person completing this form: _____

Address where student is currently living: _____

5. The student is currently living with: (Check all that apply.)

- Parent(s) or legal guardian
- Relative, friend(s) or other adult(s)
- Alone
- Other: _____

Please continue on the back.

6. School and district student last attended: _____
Address of school last attended: _____

Telephone number of school: _____
Contact person at school (if known): _____

7. Does the student have an IEP or a Chapter 15/504 agreement?
 No
 Yes, please explain: _____

Parent/Legal Guardian signature: _____
Date: _____

Note to Staff: For all forms with a box checked in Section A, please send a copy of this document to the school counselor upon completion.

BIG BEAVER FALLS AREA SCHOOL DISTRICT

OCR REPORTING FORM

Student Information:

Student Name: _____

Parent's Name: _____

Address: _____

Phone: _____

Date of Request for Admission: _____

Date Student Enrolled: _____

Placement of Student: _____

Building: _____

Grade: _____ Teacher: _____

District Personnel Enrolling Student: _____

SPECIAL EDUCATION STATUS:

Was student in special education in another district? Yes No

Was student ever tested for special education in another school district? Yes No

If yes, what was the outcome of the evaluation? Non Exceptional Exceptional

Signature of Building Administrator: _____ Date: _____

Date submitted to Pupil Services Office: _____

SPECIAL EDUCATION PLACEMENT TRANSFER OF OUT-OF-STATE STUDENT

The Big Beaver Falls Area School District will continue to provide special education services comparable to those described in _____ existing Individual Education Program

Student's Name

(IEP), until evaluation is completed, if determined necessary and a new IEP developed if appropriate. The time allotted will fall within the procedural timelines as per Pennsylvania Chapter 14 State Regulations and Standards.

Parent Signature: _____

Phone/Cell Number: _____

Date: _____



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

BIG BEAVER FALLS AREA SCHOOL DISTRICT
SUSPENSION/ EXPULSION STATEMENT

Name: _____ Student ID: _____

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously suspended or expelled from any public or private school of this Commonwealth or any other state for an act of 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."

Please complete the following:

I hereby swear or affirm that my child was ___ was not ___ previously 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. * I make this statement subject to the penalties of 24 P.S. §13-304-A(b) and 18 Pa. C.S.A. ^4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

Parent's/ Guardian Name (printed): _____
Parent's/ Guardian Name (signature): _____ Date: _____

*Name of the school from which student was suspended or expelled; reason for suspension/expulsion; and dates of suspension or expulsion (optional).

Any willful false statement made above shall be a misdemeanor of the third degree and may effect the student's placement in the Big Beaver Falls Area School District. This form shall be maintained as part of the student's disciplinary record

SCHOOL COUNSELOR REGISTRATION FORM

Student Name: _____ Date: _____ Grade: _____

Check any areas of concern that you have with your child.

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>BEHAVIOR</u></p> <p><input type="checkbox"/> Fighting/Aggressive</p> <p><input type="checkbox"/> Acting Out</p> <p><input type="checkbox"/> Impulsive</p> <p><input type="checkbox"/> Withdrawn</p> <p><input type="checkbox"/> Hyperactive</p> <p><input type="checkbox"/> Unusual/Odd Behavior</p> | <p><u>SCHOOL</u></p> <p><input type="checkbox"/> Academic Progress</p> <p><input type="checkbox"/> Organizational Skills</p> <p><input type="checkbox"/> Peer Relations</p> <p><input type="checkbox"/> Authority Figure Relationships</p> <p><input type="checkbox"/> Poor Attention</p> |
| <p><u>HOME</u></p> <p><input type="checkbox"/> Death/Loss</p> <p><input type="checkbox"/> Separation/Divorce</p> <p><input type="checkbox"/> Conflict</p> <p><input type="checkbox"/> Other</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p><u>EMOTIONAL</u></p> <p><input type="checkbox"/> Sadness</p> <p><input type="checkbox"/> Nervous/Anxious</p> <p><input type="checkbox"/> Angry</p> <p><input type="checkbox"/> Fearful</p> <p><input type="checkbox"/> Mood Swings</p> <p><input type="checkbox"/> Other</p> |

List anything additional you would want the school counselor to know about. _____

Does your child currently receive counseling/therapy services? YES NO

If yes, what is the agency/counselor/therapist or doctor's name? _____

Has a doctor diagnosed your child with any disorders that make it difficult for them to be successful in school?
 YES NO If yes, list diagnosis _____

Is your child on any medications for above diagnosis? YES NO

If yes, list medication, dosage, and what time it is given _____

Please circle if your child has any of the following services: BSC MT TSS FAMILY BASED

Circle any special services that your child receives at school:

IEP (special education/learning support) 504 OT(occupational therapy) SPEECH

PT(physical therapy) GIFTED EMOTIONAL SUPPORT CLASS LIFE SKILLS CLASS

Has your child ever been placed in an outside facility for behavior or emotional needs? YES NO

If yes, name facility and length of stay _____

BIG BEAVER FALLS AREA SCHOOL DISTRICT
AUTHORIZATION OF RELEASE OF INFORMATION

NAME _____ **BIRTHDATE:** _____
GRADE _____ **DATE OF LAST ATTENDANCE** _____

FORMER SCHOOL INFORMATION:

NAME OF SCHOOL _____

ADDRESS _____

Please release the following records to the guidance office of the school listed in the box below:

- Grades/Transcripts
- Test scores
- Attendance Records
- Immunization and Health Records
- IEP's psychological reports
- Disciplinary Records (as per Act 61)

Return completed form to:

Kylei Miller, District Enrollment

Big Beaver Falls Area School District

1503 8th Avenue, Beaver Falls, PA 15010

PHONE: 724-843-7470 EXT. 1209 FAX: 724-843-0892 EMAIL: millerk@tigerweb.org

Date

Signature of Parent/ Guardian

According to the Final Regulations – Family Educational Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials including teachers within the educational institution and officials of other schools in the system in which the students may intend to enroll may receive a student's record without written consent for such release.

- Has this student ever been enrolled in any special program(s)? Yes No
- Special Education Occupational Therapy Gifted Program
- Speech Physical Therapy

If so, please send any information you have to authorize such placement. Please forward current copies of the student's IEP, NOREP, and psychological evaluation. BBFASD utilizes IEP Writer.

Federal Programs - Family Program Form

| | |
|----------------------|---------------------------|
| Student Name | Date |
| Guardian Name | Guardian Signature |

The Big Beaver Falls Area School District receives federal and state funding to help provide services such as free meals and other programs. The PA Dept. of Education now requires that we collect specific information, per family, to ensure funding.

Please circle the program(s) that your family currently participates in:

SNAP TANF Medicaid Foster Care

If you do not participate in any of the above programs, please review the following family income chart. Circle **YES** if your family income is the same or less than the amount listed for your household size (including children and adults). If your family income is more than the amount listed, please circle **NO**. If you participate in any of the above programs, you do not need to review your family income below. You can select **OTHER** below.

| <i>2026 Household Size</i> | <i>2026 Family Income</i> |
|----------------------------|---------------------------|
| 2 | \$21,640 |
| 3 | \$27,320 |
| 4 | \$33,000 |
| 5 | \$38,680 |
| 6 | \$44,360 |
| 7 | \$50,040 |
| 8 | \$55,720 |
| 9 | \$61,400 |
| 10 | \$67,080 |

Please circle one of the following:

- YES - Our household income is the **same or less than** the amount listed above for our family size.

- NO - Our household income is **more than** the amount listed above for our family size.

- OTHER - We selected at least one of the programs listed above the chart. Therefore, we did not review the family income chart.