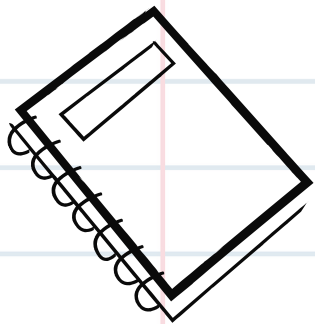
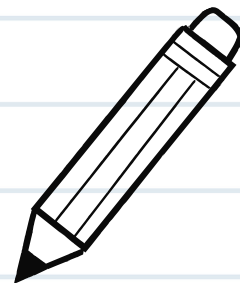




GETTYSBURG AREA SCHOOL DISTRICT



K-12 REGISTRATION CHECKLIST

Please note, that the following documents are **required** in order to complete all student enrollments:

- **Proof of student age** (ex. birth certificate, or passport)
- **Proof of residency in GASD** (ex. copy of lease, mortgage deed, sales agreement, tax bill, utility, or vehicle registration)
- **Immunization record**
- **Parent/Guardian photo ID**

You may attach the above documents in Skyward, email them to vlee@gasd-pa.org, bring them to the Administration Building, 900 Biglerville Road, Gettysburg, PA 17325, or fax documents to 717-334-5220.

**REGISTRATION OPENS
MARCH 16, 2026**



For any questions
please contact us:

Email: vlee@gasd-pa.org

Phone: 717-334-6254 ext. 1501

Register online at
[gettysburg.k12.pa.us/
register](https://gettysburg.k12.pa.us/register) or scan the
QR code:





GETTYSBURG AREA SCHOOL DISTRICT



FOOD SERVICE



Here's how the Food Service Department ensures every Warrior has fuel to learn and grow!

What are Free & Reduced Meals?

- ✓ Breakfast is universally free for all students, and no application process is necessary.
- ✓ Lunch is available at no cost for students from families that meet eligibility guidelines.

How to Apply:

1. Fill out the Free & Reduced Meals application.
2. Apply online through the QR code above or return paper form to district.
3. The online meal application is fast and easy, with notification results available quickly after submission.



Managing Your Student's Meal Account:

- Visit schoolcafe.com/GettysburgASD and click **Register**
- Select **I'm a Parent** and click **Next**
- Enter school district name and click **Next**
- Enter your name, contact information and click **Next Step**
- Follow steps to set up your username and password, select a **security question**, the reCAPTCHA prompts, agree to **Terms & Conditions**, and click **Create My Account**

schoolcafe

Add Your Student(s)

1. Click **Students** → **Student Accounts**
2. Click **Add a Student**
3. Enter your student's **Student ID**
4. Select your student's **School**
5. Click **Search & Verify Student**
6. Click **Add this Student**



Add Payment Source

1. Click **My Account** → **Payment Sources**
2. Click **Add a Card**
3. Enter a short **Friendly Card Name** to identify the card
4. Enter **Card information** and click **Add Card**

Questions?

Email: tsignor@gasd-pa.org
Phone: 717-334-6254 ext. 1204



WARRIOR TRANSPORTATION

Everything you need to know about the process that keeps our Warriors safe and moving.

IMPORTANT REMINDERS

Pick-up & Drop-off Times

Our bus drivers do their best to make every stop on time, but schedules may shift due to traffic and the number of students riding each day. We ask families to arrive at the bus stop 10 minutes prior to the scheduled pick-up time.

Bus Info & Notifications

- Student busing and transportation will be sent out **August 10, 2026**.
- That information will be available in Skyward on August 11, 2026.

Changes

Requests for transportation changes must be made **no later than July 27, 2026** in order to be guaranteed for the first day of school.

Student Rider Responsibilities

All students are expected to follow the GASD Student Code of Conduct and the rules of the bus.

Requesting Route Changes During School Year

Any pick-up/drop-off changes can be made by phone or email at **least two business days** in advance. For everyone's safety, bus drivers are not permitted to make unscheduled stops or change routes. Students may only get on and off the bus at their assigned stop.

Scan the QR code for Transportation information:



Questions?

Email: tdarnell@gasd-pa.org
Phone: 717-334-6254 ext. 1263

IS MY CHILD READY FOR KINDERGARTEN?

Here are some items your child should be able to do completely independently before coming to kindergarten. If they cannot, please begin working on these things at home over the next few months to set them up for success!

☒ FINE MOTOR SKILLS

- ☐ Hold a pencil
- ☐ Write first name
- ☐ Use scissors to cut basic shapes
- ☐ Trace lines, shapes, and letters
- ☐ Color a simple picture within lines

☒ SELF-HELP SKILLS

- ☐ Use the bathroom independently.
- ☐ Zipper his/her coat
- ☐ Button/fasten pants
- ☐ Recognize his/her first and last name

☒ ACADEMIC SKILLS

- ☐ Count to 20 and recognize numbers 1-10
- ☐ Sing and say ABC's
- ☐ Know what a letter is versus a number
- ☐ Sit and listen to a story/book being read for 5-10 minutes
- ☐ Recall events from a story

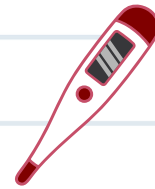
☒ SOCIAL SKILLS

- ☐ Complete 2 step directions
- ☐ Play a game and accept losing
- ☐ Take turns/share while playing
- ☐ Wait in a line at a store patiently
- ☐ Complete tasks without adult help
- ☐ Play with the same toy for 15 minutes or more
- ☐ Handle being told "no" without reasoning/arguing
- ☐ React accordingly to size of a problem
- ☐ Control emotions





GETTYSBURG AREA SCHOOL DISTRICT



SCHOOL HEALTH SERVICES



Kindergarten Information & Frequently Asked Questions

Q: What immunizations are required to start Kindergarten?

- ✓ Measles, Mumps, Rubella (MMR): 2 doses
- ✓ Hepatitis B: 3 doses
- ✓ Varicella (Chickenpox): 2 doses or evidence of immunity
- ✓ Polio (IPV): 4 doses (including one on or after 4th birthday)
- ✓ Tetanus, Diphtheria, Pertussis (DTaP): 4 doses (including one on or after 4th birthday)



Q: Can my child start on the first day if they have an appointment scheduled to complete their immunizations after the first day of school?

A: Compliance: Students must meet these requirements or have a specific medical plan to complete them **within the first five days** of school to avoid exclusion. Talk to your school nurse for more detailed information.

➔ **Physicals:** Requires that students upon original entry be given a "comprehensive appraisal" of their health. The physical is to be completed within 12 months prior to the start of the school year. Forms are available online and at each school building.

➔ **Dental Examinations:** In Pennsylvania public schools, dental exams are **mandatory for students entering school (Kindergarten/1st Grade)**. This requires check-up by a private dentist or a school screening, with forms available online or in school offices for private dentist completion. If the private dentist form is not returned, a school screening will be completed in the Fall.

Kindergarten Health Habit Requirements

For the health, safety and well-being of the students, it is imperative that a student entering school shall have mastered essential health habits. These habits include:

- ✓ Students shall have hand washing skills using soap and warm water.
- ✓ Students shall be able to use a tissue to blow their nose.
- ✓ Students shall be toilet trained for bladder and bowels.
- ✓ Students shall cover mouth when coughing or sneezing.
- ✓ Students shall have good hygiene when using the bathroom.

These essential habits will promote health and positive self-esteem for all the students in the classroom. It is the parent's responsibility to see that these skills are mastered before entrance to school.

Contacts

James Gettys Nurse:
Phone: 717-334-6254,
opt 5 ext. 1227
Email: mweikert@gasd-pa.org

Franklin Twp Nurse:
Phone: 717-334-6254,
opt 6 ext. 3284
Email: rmead@gasd-pa.org

Lincoln Nurse:
Phone: 717-334-6254,
opt 4 ext. 7127
Email: ksites@gasd-pa.org

**Scan QR code
for Health
Service Forms**





Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____

Today's date _____

Date of birth _____

Age at time of exam _____

Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

Adapted in part from the **Pre-participation Physical Evaluation History Form**; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD ☐ DO ☐ PAC ☐ CRNP ☐

HEALTH CARE PROVIDERS: *Please photocopy immunization history from student's record – OR – insert information below.*

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date: _____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH**PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
_____ Last	_____ First	_____ Middle		☐ M ☐ F		

ADDRESS

No. and Street	City or Post Office	Borough/Township	County	State	Zip
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REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment?

Yes ☐No ☐

Treatment Completed

Yes ☐No ☐_____
Date of Dental Examination_____
Signature of Dental Examiner_____
Print Name of Dental Examiner_____
Address