

# YORK SUBURBAN SCHOOL DISTRICT Registration Form - Student Information

Last Name: _____	First: _____	Middle: _____	Suffix: _____
Nick Name: _____	Birth Date: _____	Gender: _____	Grade: _____
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> American Indian
<input type="checkbox"/> Asian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Multi-Ethnic
Does your student have ...	<input type="checkbox"/> An IEP	<input type="checkbox"/> A 504 Plan	Please provide if available

## Transportation Request

(Check all that apply)

<input type="checkbox"/> Parent Will Transport	<input type="checkbox"/> Bus To School	<input type="checkbox"/> Bus From School
To School From: <input type="checkbox"/> Home	<input type="checkbox"/> Child Care Center	<input type="checkbox"/> In-Home Child Care
From School To: <input type="checkbox"/> Home	<input type="checkbox"/> Child Care Center	<input type="checkbox"/> In-Home Child Care

Name of Child Care Provider or Address of Home Care Provider (District will only provide transportation within the busing zone of assigned building)

## Primary Residence

Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ Household Telephone Number: \_\_\_\_\_

Primary Telephone Numbers: \_\_\_\_\_  
 Used for all automated calls including emergency, school delays, cancellations and activity reminders.

Emergency Numbers: \_\_\_\_\_  
 Used for high priority automated calls including early dismissal, school emergencies, absences without notice.

Name (Please list all people at this residence)	Birth Date	Relationship	Is Guardian
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

## Secondary Residence

Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ Household Telephone Number: \_\_\_\_\_

Primary Telephone Numbers: \_\_\_\_\_  
 Emergency Numbers: \_\_\_\_\_

Receive District Mail  
 Yes  No

Name (Please list all people at this residence)	Birth Date	Relationship	Is Guardian
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

## Parent/Guardian Contact Information (Provide name and relationship in name box)

Name (Relationship): _____	Cell Telephone: _____	<input type="checkbox"/> Unlisted
Email: _____ <input type="checkbox"/> Email Info	Work Telephone: _____	<input type="checkbox"/> Unlisted
Name (Relationship): _____	Cell Telephone: _____	<input type="checkbox"/> Unlisted
Email: _____ <input type="checkbox"/> Email Info	Work Telephone: _____	<input type="checkbox"/> Unlisted

# YORK SUBURBAN SCHOOL DISTRICT Registration Form - Student Information

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Nick Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

## Emergency Information (Non-Guardian Contacts)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Hospital: \_\_\_\_\_  Permission To Transport To Hospital  
Sensitivity to Drugs: \_\_\_\_\_  
Specific Health Problems: \_\_\_\_\_

## Previous School Information

Attended a previous school  
School District: \_\_\_\_\_ Building Attended: \_\_\_\_\_  
Primary Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_  
School Official/Counselor: \_\_\_\_\_  
 Attended school in PA Entry Date into PA School: \_\_\_\_\_  
 Born in the USA Date First Attended a US School: \_\_\_\_\_ Entry Date Into US: \_\_\_\_\_

With the following parent/guardian signature, I state the above information to be true.

\_\_\_\_\_  
Parent/Guardian Name Parent/Guardian Signature Date

## **OFFICE USE ONLY:**

Building of Attendance: \_\_\_\_\_  
Student Number: \_\_\_\_\_ Student Name: \_\_\_\_\_  
Entry Code: E or R Entry Date: \_\_\_\_\_ Grade: \_\_\_\_\_  
HR Teacher: \_\_\_\_\_ Room #: \_\_\_\_\_  
Guidance Counselor: \_\_\_\_\_  
Disability/Exceptionality Code: \_\_\_\_\_  
\_\_\_\_\_  
District Start Date School Start Date PAsecureID

## Transportation

Bus Stop Name: \_\_\_\_\_ Bus Number: \_\_\_\_\_

## Residency

Non Resident: \_\_\_\_\_ Tuition: \_\_\_\_\_ Foster: \_\_\_\_\_ Placment Papers: \_\_\_\_\_

# YORK SUBURBAN SCHOOL DISTRICT Student Health History

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_  
Gender: \_\_\_\_\_

**Please check the illnesses or conditions your child has had. Include dates and important details.**

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies - Food         | <input type="checkbox"/> Heart Disease         |
| <input type="checkbox"/> Allergies - Insect Bites | <input type="checkbox"/> Hernia                |
| <input type="checkbox"/> Allergies - Medications  | <input type="checkbox"/> Head Injury           |
| <input type="checkbox"/> Allergies - Other        | <input type="checkbox"/> Orthopedic Problems   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Pneumonia             |
| <input type="checkbox"/> Chickenpox               | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Scarlet Fever         |
| <input type="checkbox"/> Ear Infections           | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Emotional Problems       | <input type="checkbox"/> Skin Conditions       |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Speech Defect         |
| <input type="checkbox"/> Hearing Problems         | <input type="checkbox"/> Urinary Tract Problem |
| <input type="checkbox"/> Other                    | <input type="checkbox"/> Vision Problems       |

## PARENT PERMISSION FOR STANDARD MEDICATIONS AT SCHOOL

I give permission for the school nurse or other designated person to administer the following medications to my child during school hours as per standing orders from the school physician: (**Cross off** any medications you do not want your child to receive)

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> Generic Tylenol                    | <input checked="" type="checkbox"/> Generic Motrin / Advil | <input checked="" type="checkbox"/> Generic Benadryl |
| <input checked="" type="checkbox"/> Calamine Lotion or similar product | <input checked="" type="checkbox"/> Cola syrup             | <input checked="" type="checkbox"/> Generic Mylanta  |

If I feel my child needs non-prescription cough drops, I will send them in for my child to carry and take as needed.

**I understand that all other medications (even those sold over the counter) may only be administered at school only if the school receives a written order from the child's physician and a written request from the parent / guardian.**

**YORK SUBURBAN SCHOOL DISTRICT**  
**Student Health History**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender: \_\_\_\_\_

Is your child currently under medical treatment?  Yes  No

Explain

Please list all medications your child is currently taking.

Please list any operations, serious injuries, illnesses, or other existing physical conditions.

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital: \_\_\_\_\_  Permission To Transport To Hospital

Covered by insurance

**Birth Information (For children grades K-1)**

Birth Weight: \_\_\_\_\_  Breathing Problems At Birth

Were there any abnormal conditions noted at the child's birth?

Were there any complications during the mother's pregnancy, labor, or delivery?

**VERIFICATION OF YOUR CHILD'S IMMUNIZATIONS IS REQUIRED. PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD FROM YOUR HEALTH CARE PROVIDER. THANK YOU!**

Parent/Guardian Name

Parent/Guardian Signature

Date

# YORK SUBURBAN SCHOOL DISTRICT

## Home Language Survey

Student Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

What is/was the student's first language?

Does the student speak a language(s) other than English?  Yes  No  
(Do not include languages learned in school.)

If yes, specify the language(s)

What language(s) is/are spoken in your home?

Has the student attended any United States school in any 3 years during his/her lifetime?  Yes  No

If yes, complete the following:

Name of School

State

Dates Attended

_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Name

Parent/Guardian Signature

Date

\*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.

# YORK SUBURBAN SCHOOL DISTRICT

## New Student Parental Input

Student Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_

What are your child's strengths?

What are your child's weaknesses?

Please circle the number which best describes your child in the following areas:

	frequently		sometimes		never
Is overly active	1 -----	2 -----	3 -----	4 -----	5
Has difficulty separating from Mom/Dad	1 -----	2 -----	3 -----	4 -----	5
Becomes upset/cries when plans change	1 -----	2 -----	3 -----	4 -----	5
Is shy/timid around others	1 -----	2 -----	3 -----	4 -----	5
Has difficulty sharing/taking turns	1 -----	2 -----	3 -----	4 -----	5
Has problems getting along with other children	1 -----	2 -----	3 -----	4 -----	5

Please describe recent family events or changes (death, divorce/separation, new sibling, moving):

Does your child enjoy books?

Yes     No

Do you read to your child?

Yes     No

How often? \_\_\_\_\_

Please use this space to list any other information you would like the teacher to know

**Permission to Release Student Information**  
**PLEASE FORWARD THIS FORM OR A COPY WITH THE STUDENT RECORDS**

1. Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 has enrolled in the York Suburban School District on \_\_\_\_\_ . PAsecureID: \_\_\_\_\_

2. I hereby give permission for \_\_\_\_\_ to release the following information to **York Suburban School District** for the above-named student. It is my understanding that all information will be utilized only by professional personnel to aid my child in his/her educational program.

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Records including withdrawal grades | <input type="checkbox"/> Psychological/Psychiatric evaluations    |
| <input type="checkbox"/> Grading system explanation                   | <input type="checkbox"/> Comprehensive Evaluation Report (CER/ER) |
| <input type="checkbox"/> Attendance Records                           | <input type="checkbox"/> Multi-Disciplinary Evaluation (MDE)      |
| <input type="checkbox"/> Disciplinary Records                         | <input type="checkbox"/> Individualized Educational Program (IEP) |
| <input type="checkbox"/> Immunization Records                         | <input type="checkbox"/> NORA/NOREP                               |
| <input type="checkbox"/> Health and Dental Records                    | <input type="checkbox"/> Other                                    |
| <input type="checkbox"/> School Violence Report (if applicable)       |   |

Parent/Guardian Name

Parent/Guardian Signature

Date

*(According to the Final-Regulations-Family Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools.)*

**The above information is to be sent to:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Guidance Office<br>Attn: Denise Stayman<br>York Suburban High School<br>1800 Hollywood Drive<br>York, PA 17403<br>Phone: 717-885-1272<br>Fax: 717-885-1273 | <input type="checkbox"/> Guidance Office<br>Attn: Judy Everett<br>York Suburban Middle School<br>455 Sundale Drive<br>York, PA 17402<br>Phone: 717-885-1262<br>Fax: 717-885-1263 | <input type="checkbox"/> Valley View Elementary School<br>Attn: Peggy Dunty<br>850 Southern Road<br>York, PA 17403<br>Phone: 717-885-1220<br>Fax: 717-885-1221 |
| <input type="checkbox"/> East York Elementary School<br>Attn: Gayle Rudacille<br>701 Erlen Drive<br>York, PA 17402<br>Phone: 717-885-1240<br>Fax: 717-885-1241                      | <input type="checkbox"/> Indian Rock Elementary School<br>Attn: Patty Shaffer<br>1500 Indian Rock Dam Road<br>York, PA 17403<br>Phone: 717-885-1250<br>Fax: 717-885-1251         | <input type="checkbox"/> Yorkshire Elementary School<br>Attn: Karen Sides<br>295 Mills Street<br>York, PA 17402<br>Phone: 717-885-1230<br>Fax: 717-885-1231    |

\_\_\_\_\_  
 (Signature of School Official)

YORK SUBURBAN SCHOOL DISTRICT

SWORN STATEMENT

LEGAL AUTHORITY - Section 1304-A Sworn Statement - (A) 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 or is presently 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. The registration shall include the name of the school from which the student was expelled or suspended for the above-listed reasons with the dates of expulsion or suspension and shall be maintained as part of the student's disciplinary record. (B) Any willful false statement made under this section shall be a misdemeanor of the third degree.

I, \_\_\_\_\_, do hereby swear or affirm that I am the parent or guardian of \_\_\_\_\_ who is registering as a student in the York Suburban School District. I further swear or affirm that \_\_\_\_\_ (circle one) has / has not ever been suspended or expelled from any public or private school for an act or offense involving weapons, alcohol or drugs, for the willful infliction of injury to another person, or for any act of violence committed on school property.

If the student has been suspended or expelled for any of these offenses, it is your obligation to provide information relative to the date, the name and location of the school and the charges on which the suspension or expulsion was based. The information should be provided on the reverse of this form or by way of other official documentation attached to this form.

Signature of Parent/Guardian

Witness

Printed Name of Parent/Guardian

Street Address

City, State, Zip

Phone Number

