GETTYSBURG AREA SCHOOL DISTRICT
A Great Place To Learn

Gettysburg Area School District
900 Biglerville Road
Gettysburg PA 17325
(717)334-6254

KINDERGARTEN REGISTRATION PROCEDURES

Welcome to the Gettysburg Area School District.

Gettysburg Area School District uses an emergency response system for notifications. The School District Notification System is a system used to communicate important updates to parents about school closings, delays, early dismissals, emergencies, or other urgent or timely information. It is essential that your contact information on file with the school district be accurate so that you receive these communications. These notifications will be done using telephone calls, emails and text messages depending on the type of information contained in the message. For emergencies all contact numbers and email addresses will be utilized, while the main home number will be used for all other notifications.

In order to establish and verify your residence within the Gettysburg Area School District, a few documents need to be completed and approved. All procedures are in accordance with Sections 1301 and 1302 of the Pennsylvania School Code and Regulations 11.11 and 11.19 which authorize the Gettysburg Area School District to request proof of residence or guardianship prior to admission to our school programs.

Only the biological parent/adoptive parent or court appointed guardian may enroll a student into GASD and the parent/guardian must come into the office in person to complete the enrollment process. If a resident of the District requests that a student be enrolled whose parent(s) live outside the District, an Affidavit must be completed by both the resident of the District and the natural parent(s). If the natural parent is not able to appear in person, then their signature must be notarized.

Registration packets can be picked up in advance or printed from our Website. The forms may also be mailed to you. To have a packet mailed to you, please call 717-334-6254, press 5, then EXT 1229.

Kindergarten Registration is completed at the District Administration Building, 900 Biglerville Road, Gettysburg. Hours: March 13, 2018 – 9 am to 5 pm; March 14, 2018 – noon to 8 pm. CHILD MUST BE 5 BEFORE SEPTEMBER 1ST. For those families who need to register after those dates, they will need to make an appointment at one of the Elementary Buildings to complete the process.

Please use this checklist to make sure you have all necessary documents for registration and bring the completed packet with checklist at registration.

WHAT TO BRING WHEN YOU REGISTER YOUR CHILD

→**Proof of Residency in the Gettysburg Area School District** May be any of the following indicating an address within the Gettysburg Area School District: deed, lease, sales/mortgage agreement, current utility bill, property tax bill, driver's license, or automobile registration. If you are currently displaced from housing, please let us know. Your child may be eligible for additional services through the McKinney-Vento Assistance Act. We will ask you to complete a Residence Questionnaire.

→**Photo ID of Parent and Proof of Guardianship**: Legal custody agreement, if applicable. A copy will be placed in the student's file.

→ **Proof of Child's Age:** Original birth certificate of student, Baptismal certificate or hospital record letter, passport

→**Record of Immunizations**: State law requires that a complete record of immunizations be provided. You can get a copy of your child's health records from the school you are leaving. Shot records are also available from your doctor's office. Physicals are required for students entering kindergarten, 6th and 11th grades.

→**Name, address and phone number of the previous school** (including the city and state) in order to obtain records.

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ADMINISTRATIVE GUIDELINES: Entrance to School

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

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.

All efforts will be made to help students in the classroom. If we find that a student is having trouble with these health habits the parent will be contacted by the school nurse and plan of correction will be developed. It is the parent's responsibility that this plan is followed and that the problem is corrected. Actions for correction may include but are not limited to, collaboration with the parents, guidance and administrative personnel, and a consultation with the student's physician to rule out a medical problem.

Adherence to these guidelines will ensure a safe and healthy environment in which all children can learn.

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NEW STUDENT REGISTRATION

STUDENT INFORMATION

Student Legal Last Name	Legal First Name	Middle Name	Suffix	Gender

Birth Date	Birth City/State/Country	Grade Entering	Home Language

Ethnic Category (check one)	Ethnic Group: (check all that apply)
□ Hispanic or Latino □ Not Hispanic or Latino	□American Indian □Asian □Black □Hispanic □Native Hawaiian/Pacific Islander □White □other (specify)

Date your child first attended a PA public school (mo/yr): Date your child first attended a school in the USA (mo/yr):	Has your child ever attended Head Start? □Yes □No

CUSTODIAL PARENT/GUARDIAN INFORMATION: Names(s) of person(s) with **whom the student is living**

Student is living with:

□Both Parents	□Mother Only	□ Father Only	□ Self	□ Agency(specify) _____
□Guardian	□Mother/*Stepfather	□Father/*Stepmother	□ Foster	□ Other ((i.e. houseparent, case worker) _____

* Stepparent indicates legal marriage; please check "Other" for non-married

Parent Last Name	First Name, Suffix	Relationship	Cell/Mobile Phone ( )	Work Phone w/ Ext ( )

Last Name	First Name, Suffix	Relationship	Cell/Mobile Phone ( )	Work Phone w/ Ext. ( )

Parent/Guardian Home Address & Mailing Address (if P.O. Box)	Home Phone ( )

City	State/Zip	

Email address(s)

Employer (Parent 1)	Employer (Parent 2)

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CHILD'S NAME:_____

NONCUSTODIAL PARENT/GUARDIAN INFORMATION: Name of parent and/or guardian **OTHER** than those listed under Primary Household Information

Relationship: □ Mother □ Father □ Guardian □ Other (specify) _____

Last Name	First Name	Home Phone ( )	Work Phone w/ Ext. ( )
Email address			Cell/Mobile Phone ( )
Parent/Guardian Home Address & Mailing Address (if PO Box)		City	State/Zip
Employer	City		

SIBLING INFORMATION

Name	Date of Birth	Grade & Building (if applicable)	Lives with student □Yes □No
Name	Date of Birth	Grade & Building (if applicable)	Lives with student □Yes □No
Name	Date of Birth	Grade & Building (if applicable)	Lives with student □Yes □No
Name	Date of Birth	Grade & Building (if applicable)	Lives with student □Yes □No

If student does not live with both natural parents:

Is there a Formal Custody Agreement?	□Yes □No
If Yes to above, have you provided copy of custody papers to district?	□Yes □No
Should this parent/guardian receive school mailings regarding this student?	□Yes □No
Can this parent/guardian pick student up at school?	□Yes □No

_____ _____

Signature of Parent or Legal Guardian ***Date***

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CHILD'S NAME:_____

EMERGENCY CONTACT INFORMATION: Please list two or more persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. We attempt to contact parents first.

Name	Address	Relationship To Student	Daytime Phone
Name	Address	Relationship To Student	Daytime Phone
Name	Address	Relationship To Student	Daytime Phone

BABYSITTER/DAY CARE INFORMATION

Name	Address	Daytime Phone

TRANSPORTATION

Will the student use district transportation?			
In the morning:	□Yes □No	In the Afternoon:	□Yes □No
If yes, please indicate the following: (If other than home address, please include name and phone number.)			
AM PICK UP location			
PM DROP OFF location			

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SPECIAL SERVICES CHECKLIST

Student's Name	**Birth Date**
Parent/Guardian Name	**Grade**

In order for us to best serve your child please complete the following where applicable.

Do any of the following apply to this student from his/her previous school? Please check all that apply.

□ Student has an IEP	□ Student is Deaf/ Hard of Hearing
□ Student received Speech/Language Services	□ Student is Blind /Visually Impaired
□ Student received Occupational Therapy	□ Individual Health Plan
□ Student received Physical Therapy	□ Head Start
□ Early Intervention Services/LIU Preschool	□ Other (please list)

District Use Only		
School:	**Date Registered:**	**Date of Entry:**
Student Grade:	**PA Secure ID #**	**Local Student ID #**
Birth Verification Document: **□ Birth Cert. □ Other**	**Proof of Residency Document:**	**Proof of Guardianship:** **Affidavit required** □Yes □No
IEP Attached: □	**Other Documents:**	

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HEALTH HISTORY-New Student

Student Name: _____ Date of Birth: _____ □ Male □ Female

MEDICAL HISTORY: PLEASE CHECK APPROPRIATE BOX. IF YES, PLEASE GIVE DATES AND PROVIDE COMMENTS

Are any of these conditions considered "Life Threatening"? □ Yes □ No
If yes, please notify the school nurse for further instruction to protect your child at school.

YES	NO		YES	NO	
□	□	**ADD/ADHD (if yes, does your child take medication?)** □ Yes □No If yes, what type? _____	□	□	Genitourinary
□	□	**ALLERGY (bee sting, food, other)** EPI Pen/other medication (circle) ***Is there a Life Threatening Food Allergy*** **□ Yes □No**	□	□	Hearing Problems or Ear Tubes
□	□	**ASTHMA** Inhaler/Oral Medication (circle)	□	□	Hypertension
□	□	**DIABETES** Oral/Pump/Injection (circle)	□	□	Head Injury (Please detail in comment section)
□	□	**SEIZURE DISORDER** List medication _____	□	□	Malignancies
□	□	Birth Defects/Developmental	□	□	Nose Bleeds
□	□	Bleeding Disorders/Anemia	□	□	Orthopedic
□	□	Cardiovascular Condition/ Heart Murmur	□	□	Psychiatric
□	□	Chicken Pox (Age ____ Date____)	□	□	Sickle Cell Disease
□	□	Cystic Fibrosis	□	□	Vision /Color Deficit
□	□	Eating/Weight Disorder	□	□	Arthritis/Rheumatic Disease
□	□	Gastrointestinal	□	□	Cerebral Palsy
□	□	Spina Bifida	□	□	Tourette's Syndrome

Comments

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HEALTH HISTORY (Continued) New Student/Kindergarten

Student Name:_____ Date of Birth: _____

A. PREGNANCY AND BIRTH

1. Child born at:_____ City_____ State _____
2. How many weeks gestation? _____(Full term 40 weeks); Birth Weight: _____lb. _____oz.

3. Any complications or information you wish to share? _____

_____

B. EARLY CHILDHOOD

1. Any illnesses, head injury or medical conditions at birth or within the baby's first year? □Yes □No
If yes, describe:_____

C. DEVELOPMENTAL

1. Sat up at _____months Crawled at _____months Walked at _____months
2. Spoke at _____months Spoke in Sentences/phrases at _____months
3. Toilet Trained: For urine at _____ months For bowels at _____months
Any patterns of bedwetting or "accidents" since then? _____

D. BEHAVIOR AND PERSONALITY

1. Activity Level: □Excessive □Average □Fairly Inactive
2. Clumsiness noted: □Yes □ No Coordinated: □Yes □No Tires Easily: □Yes □No
Rarely Tires: □Yes □No
3. Disposition: Outgoing: □Yes □No Shy: □ Yes □No Average: □ Yes □No
Anxious: □ Yes □No
4. Impulsive: □ Yes □No Thinks Before Acts: □ Yes □No Reserved: □ Yes □No
5. Attention Span: □ Average □Short □ Long
6. Discipline Needed: □Seldom □Frequently □Average
7. Sleep Habits: Still Naps? □ Yes □No Sleeps through the Night? □ Yes □No In his/her own bed? □ Yes □No
Nightmares? □ Yes □No Frequency _____ Usual Bedtime_____ Gets Up At _____

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Student Name:_____ Date of Birth: _____

State immunization law requires all children prior to entering school for the first time to have the vaccines listed below. In order to comply with the law, the district requires an accurate immunization record of all children entering school.

IMMUNIZATION RECORD

Attach a copy of Immunization Record

All students in grades indicated will need the following immunizations to start school:

4 DTP or TD (Diptheria/Tetanus/Pertussin) with one vaccine on or after the 4th birthday (K-12)
1 Tdap (Boostrix or Adacel) (Gr 7)
4 Polio (with one vaccine on or after the 4th birthday (K-12)
2 MMR (Measles/Mumps/Rubella) (K-12)
3 Hepatitis B (Properly spaced) (K-12)
2 Varicella (chickenpox) or date of chickenpox disease (K-12)
2 Menactra (Meningitis) (one in Gr 7 and one in Gr 12)

Reviewed by School Nurse:_____
Complete_____ Incomplete_____

I have been notified that state law requires my child to have a **physical** and **dental examination** to enter school. I understand that if the completed private physician and private dentist forms are not received from the previous Pennsylvania school or I do not return them, my child will be examined by a school physician and/or dentist and may be transported to another building for this examination.

Parent/Guardian Signature_____ ***Date***_____

Child's Doctor	Address	Phone
Child's Dentist	Address	Phone

Do you wish to schedule a conference with the school nurse to discuss any of the information in the Health History?
□ Yes □No

Routine in case of major illness or accident: <u>In all cases the welfare of the child will be the first consideration</u>.
1) Parent will be contacted
2) If this fails, family doctor may be called
3) In event neither the parents nor the family doctor can be contacted 911 will be called, if necessary and/or the student will be taken to the nearest hospital .

If any parent does not agree with this procedure he/she must notify the school and submit a written alternate plan for the care of his/her child.

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KINDERGARTEN QUESTIONNAIRE

Child's Name: _____

Name to be used in school: _____

Address: _____

Phone: _____

We recognize that parents are knowledgeable experts when it comes to understanding their child. We ask the following questions about characteristics and experiences that are particularly important to early school success.

1. Which, if any, of these experiences has your child had? (List name and location)

□ Pre-school: _____

□ Day Care: _____

□ Babysitter(s): _____

2. Check places your child has visited:

□ Grocery Store	□ Farm	□ Factory	□ Ocean/Beach	□ Museum	□ Circus
□ Airport	□ Zoo	□ Fair/Carnival	□ Mountains	□ Library	

3. I usually read to my child: □ every day □ once a week □ on special occasions

4. Additional information or comments that will assist us with caring for and educating your child.

_____

_____

_____

_____

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PROGRAMS FOR LIMITED ENGLISH PROFICIENCY STUDENTS
Student Home Language Survey

Student's Name_____ Grade _____ Birth Date _____

The US Office of Civil Rights requires that schools identify possible English Language Learner students during enrollment. This Home Language Survey will be used as a tool to determine if your child is eligible for language support services (ELL). If a language other than English is used by your or your child and your child meets the Limited English proficient definition, the school may give your child an English Language Proficiency Assessment. The school will share the results of the assessment with you.

1. What language(s) are spoken at home?_____

2. What language(s) do you use the most to speak to your child?_____

3. What language(s) does your child use the most at home?_____

4. What languages(s) did your child learn when he/she first began to talk?_____

5. In what language would you prefer to receive information from the school? _____

6. Has the student attended any United States school(s)? YES □ NO □

If yes, please complete the following:

Name of School	**State**	**Dates Attended**
_____	_____	_____

_____
Print Parent/Guardian Name

_____ _____
Parent/Guardian Signature ***Date***

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STUDENT /FAMILY RESIDENCE QUESTIONNAIRE

Your child may be eligible for additional educational services through Title I Part A, Title I part C-Migrant and/or Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Presently, are you and/or your family living in any of the following situations? Check all that apply.

- ☐ Staying in a shelter (family shelter, domestic violence shelter, youth shelter) or FEMA trailer
- ☐ Waiting for foster care placement
- ☐ Sharing the housing of others due to loss of housing, economic hardship, or similar reason
- ☐ Living in a car, park, campground, abandoned building or other inadequate accommodations
- ☐ Temporarily living in a motel or hotel due to loss of housing, economic hardship or similar reason
- ☐ Living alone as a minor student without an adult (unaccompanied youth)

If you checked any box above, please complete the remainder of this form and submit it to school personnel. If you did not check any box above, you do not need to complete the remainder of this form.

2. If you checked any box above, please list **all** children currently living with you. ONLY **ONE** FORM NEEDED PER FAMILY

First	M. I.	Last	M/F	Birth Date	Grade	School Name

The undersigned parent/guardian certifies that the information provided above is accurate.

_____

Print Parent /Guardian Name **Signature** Date

_____

(Area code) Phone Number Street Address City

Your children have the right to:

- Continue to attend school in the school attended before you became displaced (school of origin)
- Receive transportation to the school of origin
- Enroll in school without giving a permanent address and attend classes while the school arranges for a school transfer, immunization records or other documents required for enrollment.
- Receive the same special programs and services, if needed, as provided to all other children served in these programs
- Have enrollment disputes quickly addressed

The McKinney Vento Homeless Education Assistance Act ensures the educational rights above for the students who are experiencing homelessness. The McKinney Vento School Liaison for Gettysburg Area School District is the Coordinator of Educational Services and can be reached at 717-334-6254 (ext 1207). If you wish to have a copy of this document, please ask the staff person helping you today.

Printed name of staff member assisting with this process: _____

NORTHWEST TRI-COUNTY INTERMEDIATE UNIT
252 Waterford Street, Edinboro, Pennsylvania 16412-2315
PHONE 814-734-5610
1-800-677-5610
TTD 814-734-1098
http://www.iu5.org

Upon completion, send to deke_showman@iu5.org.

Pennsylvania Migrant Education Program
School Referral Form

This form is to determine if your children (ages 0 to 21) can qualify for the Pennsylvania Migrant Education Program and the FREE additional educational services provided by the program. We will contact you based on your responses.
ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

Parent or Guardian Name_____Date _____

Address_____

Telephone Number_____

Names of your Children:_____

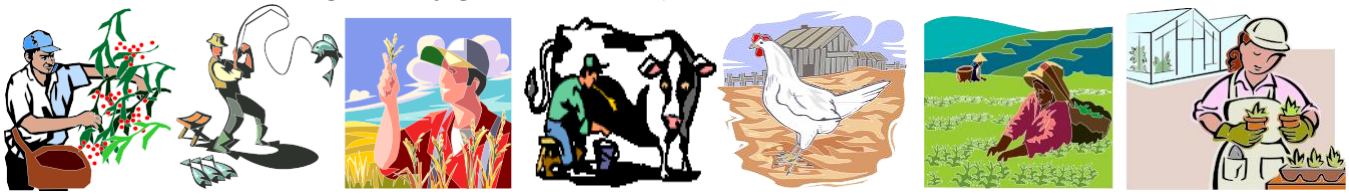
_____

Please answer "yes" or "no" if it applies to you.

(1) Has anyone in your household moved from another country, town or school district within the past 3 years?____**Yes** _____**No**

(2) Has anyone in your household worked or looked for work at the following occupations within the last three (3) years?_____**Yes** _____**No**

☐ Any agricultural or farm work (such as hay, dairy, fruit or vegetable crops, poultry, fish farming, nursery/greenhouse, other)?



☐ Work related to logging, timber growing or harvesting? Work at a food processing plant, such as vegetable or poultry processing plants, packing apples, vegetables, pork or beef?

If your children qualify for the Migrant Education Program, they will be offered FREE supportive educational services that may include after school tutoring, summer school programs, pre-college activities and referrals to other agencies that help you and your children. Your children will also receive free lunch in school. Sus niños también recibirán almuerzo gratis en la escuela.