HAMBURG AREA SCHOOL DISTRICT
701 Windsor Street, Hamburg, PA 19526-0401
Telephone 610-562-2241
Fax 610-562-2634

A Great place to live and learn

Dear Parent/Guardian:

Welcome to the Hamburg Area School District. Enclosed in this packet are forms to be filled out for Kindergarten registration. **Please refer to the Hamburg Area School District website to sign up for a time slot April 2 (Perry Elementary Center) or April 3 (Tilden Elementary Center) for the registration process.**

Please read these forms carefully and be sure to include the items that are listed on this letter.

1. A copy of the child (ren)'s birth certificate,
2. **A** copy of the child (ren)'s immunizations that are **complete and up to date**
3. **Two** proofs of residency for the parent that include **your name and address.** Example: Driver's licenses, utility bill, vehicle registration, lease agreement.

Please choose a time slot on the website for Kindergarten Registration, print out and complete this packet, and bring all necessary forms listed above to the appointment. **If you do not have the above information with you at the time of your appointment the registration process will not be completed.**

PLEASE NOTE: Prior to the first day of Kindergarten, your student must have:
4 doses of tetanus, diphtheria, and acellular pertussis
4 doses polio
2 doses measles, mumps and rubella
3 doses hepatitis B
Every student in **any grade must have 2 varicella shots** if **they haven't had the disease.**

We look forward to having you and your family in our community and in our district. We strive to help your child(ren) achieve academic success. Please feel free to access our website **at: www.hasdhawks.org** for more information.

Sincerely,
LisaD Welgo
liswel@hasdhawks.org
Central Registration Secretary
610-562-2241 ex. 1736

HAMBURG AREA SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Date of Registration _____

Child's Name_____Gender _____ Grade Entering_____
Last First Middle

Address _____City_____ Zip Code_____Boro/ Township_____

Birth Date _____/_____/_____ State/Country of Birth _____Home Telephone _____

Child resides with: ( ) Both Parents ( ) Father ( ) Mother ( ) Step-Parent: Name:_____
( ) Other _____

Hispanic/Latino Ethnicity: ( ) Yes ( ) No

Ethnicity of Child: ( ) White ( ) Pacific Islander ( ) American Indian ( ) Asian ( ) African American ( ) Multi-Racial

Father's
Name:_____
Last First MI

Address:_____

_____

Home#:_____Work#_____

Cell#_____Email:_____

Active Military:_____Yes_____No Branch_____

Mother's
Name:_____
Last First MI

Address:_____

_____

Home#:_____Work#_____

Cell#_____Email:_____

Mother's Maiden
Name_____
Active Military:_____Yes_____No Branch_____

Name of former school:
_____Address:_____

Does the Student have an IEP or any special learning needs? Yes_____ NO_____

	NAME/GRADE	BIRTH DATE		
SIBLINGS	_____	_____	( ) MALE	( ) FEMALE
	_____	_____	( ) MALE	( ) FEMALE
	_____	_____	( ) MALE	( ) FEMALE
	_____	_____	( ) MALE	( ) FEMALE

Emergency Contact Sheet

The following contacts will be used if the parent or guardian cannot be reached during the day, (i.e. grandparent, neighbor, or other). Please list in order of priority.

Students Name: _____

(1) Name:_____ Relationship to Student_____

Phone Number_____ Alternate Number_____

Student may be released to this contact in the case of an emergency. Yes ___ No ___

(2) Name:_____ Relationship to Student_____

Phone Number_____ Alternate Number_____

Student may be released to this contact in the case of an emergency. Yes ___ No ___

(3) Name:_____ Relationship to Student_____

Phone Number_____ Alternate Number_____

Student may be released to this contact in the case of an emergency. Yes ___ No ___

(4) Name:_____ Relationship to Student_____

Phone Number_____ Alternate Number_____

Student may be released to this contact in the case of an emergency. Yes ___ No ___

(5) Name:_____ Relationship to Student_____

Phone Number_____ Alternate Number_____

Student may be released to this contact in the case of an emergency. Yes ___ No ___

Signature: _____ Date: _____

** Please notify school if these contact should be changed or removed.

HAMBURG AREA SCHOOL DISTRICT
VERIFICATION OF IDENTITY AND RESIDENCY

Student Name	DOB	Grade	Building

New Address	Former Address if in HASD

PROOF OF IDENTITY: A copy shall be maintained in the student records file.

_____ Original or certified copy of Birth Certificate
_____ Other (please circle): adoption decree, passport, Certificate of Birth Abroad, court order or similar legal instrument specifying student's name, sex, date of birth, and parents' names.

PROOF OF RESIDENCY

Under the authority of Sections 1301 and 1302 of the Pennsylvania School Code, you are requested to submit **two (2) or more** of the following. These documents will be used to verify the residency of a **Regular Resident, Multiple Occupancy Resident**, and **Custodial Resident**. This proof of residency must be submitted **before** the enrollment of a student can occur.

_____ Agreement of Property sale/lease
_____ Property deed
_____ Statement of home owner's insurance
_____ Bills or receipts showing new address
_____ Bank statement showing address
_____ Vehicle registration card or application for change of address
_____ TV cable or satellite activation/billing statement; current electric and phone bill bearing new address
_____ Driver's license or driver's application for change of address
_____ Property tax receipt
_____ Pay stub from employer

Change of address card from the post office **cannot be accepted

The above-checked items have been presented to me as acceptable proofs of residence.

_____ _____
Signature of Registrar Date

I, the undersigned, the parent/guardian enrolling the above-referenced child, presented the documents as indicated by the above-checked items in fulfillment of my obligations to enroll the said child for free school privileges and attest that each is a true and correct document and I recognize the following pursuant to laws regarding unsworn statements:

That the documentation presented for the purposes of enrollment for free school privileges are subject to investigation and verification, and should it be determined that the above are not a true representation of fact, either now or in the future, I shall then be liable to reimburse the school district at the then current annual tuition rate for improper attendance of each ineligible child in the Hamburg Area School District.

_____ _____
Signature of Parent/Guardian Date

Revised October 2009

HAMBURG AREA SCHOOL DISTRICT
CHILD CUSTODY INFORMATION

1. Child's Name _____Grade_____Building_____
   PLEASE PRINT

2. Name of custodial parent(s) with whom the child resides:

   _____

   _____ _____
   Address Telephone #

3. List the name(s) of any other person(s) whom you authorize to have access to your child's school records or to represent you in discussions regarding your child.

   _____

The following information (4-8) is needed only if your child does not reside with both natural parents due to separation or divorce. The parent with whom the child resides will be considered the custodial parent, however, the non-custodial parent has access to the child's records in the absence of a court order forbidding it. **It is the responsibility of the custodial parent to provide the school with any limiting court order.**

4. Name of non-custodial parent:

   _____

   _____ _____
   Address Telephone #

5. Do you, as custodial parent, have LEGAL custody through a court order? _____ yes _____ no (If yes, a copy of the court order MUST be supplied to the school office to be kept on file.) If pending, the date to be finalized: _____

6. If there is a court order, **does it limit the non-custodial parent access to school records?** _____ yes _____ no (If yes, a copy of the court order MUST be checked by school officials.)

7. May the child be released from school to the non-custodial parent? _____ yes _____ no (If no, a copy of the court order MUST be checked by school officials.)

8. Please provide any additional information (on the back of this sheet) regarding custody of which the school should be aware.

_____ _____
Date Signature of Custodial Parent

(Please return to the school office or your child's teacher.)

HAMBURG AREA SCHOOL DISTRICT
CONFIDENTIAL HEALTH HISTORY

To Parent or Guardian:
In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you, which will be helpful in meeting your child's health needs. The information provided will be kept in your child's school health record.
I give my permission for release of information on this form for confidential use in meeting my child's health and educational needs.

_____ _____
Signature of Parent/Guardian Date

Child's Full Name_____ ☐ Female ☐ Male
Last First Middle

Birth Date_____ Place of Birth_____

Home Address_____

Phone Number_____

Father/Guardian Name_____ Mother/Guardian_____

Please check answers to the following questions in columns on the left.
Explain all "yes" answers in the space provided below.

Yes	No	
☐	☐	Does your child have any specific illness or health problems?_____
☐	☐	Does your child have any allergies (food, insects, medication, etc.)?_____
☐	☐	Are emergency medications required for allergies? If yes, what?_____
☐	☐	Does your child take any medications (daily or as needed)? List_____
☐	☐	Does your child need to take medication during school hours? List_____
☐	☐	Does your child need a special diet or have intolerance to any food?_____
☐	☐	Does your child have any problems with vision, hearing, speech, or developmental delays (glasses, ear tubes, hearing aids)?_____
☐	☐	Has your child had any hospitalization, operation, or major illness (specify problem)?_____
☐	☐	Has your child had any significant injury or accident (specify problem)?_____
☐	☐	Has your child any head injury or diagnosed concussion?_____
☐	☐	Does your child have any special health needs or problems the school should know about?_____
☐	☐	Does your child have any behavioral, psychological concerns, or is under the care of a therapist?_____
☐	☐	Does your child have any restrictions on play or physical activities?_____

Please explain all "yes" answers here or on the back of this sheet. Include year and/or child's age at the time of illness/injury.

STUDENT HEALTH/DEVELOPMENTAL HISTORY

History of Pregnancy and Birth

Please check answers to the following questions in columns on the left.

Yes	No	
☐	☐	Did the mother have any illness during pregnancy?_____
☐	☐	Did the mother take any medicines or drugs (other than vitamins or iron) during pregnancy? What? _____ _____
☐	☐	Was the mother or family under unusual strain during pregnancy? Cause_____
☐	☐	Was the mother hospitalized? Reason_____
☐	☐	Was it a difficult delivery?
☐	☐	Did the baby have any problems at the time of birth? If yes, describe the problem_____
☐	☐	As an infant, was there any significant illness or injury?_____

Weeks Gestation (full term is 40 weeks)_____ Birth Weight_____

Early Childhood History

Approximate age your child was:

Sitting without support_____ Crawling_____ Walking without support_____

Single words developed_____ Short sentences developed_____ Toilet trained_____

Please check and indicate dates if your child has had any of the following:

Anemia_____
Allergy_____
Asthma_____
Autism_____
Chicken pox_____
Concussion_____
Dental concerns_____
Diabetes (type)_____
Eczema_____
Emotional/Behavior Concern_____
Encephalitis_____
Epilepsy_____
Hepatitis (type)_____
Heart disease_____
Heart murmur_____
Hernia_____
Influenza_____
Lead Poisoning_____
Measles_____
Meningitis_____
Mumps_____
Pneumonia_____
Rheumatic Fever_____
Rubella_____
Scarlet fever_____
Tonsillitis_____
Tuberculosis_____
Transfusions (blood)_____
Whooping cough_____
Other_____

Does the child need prophylactic antibiotics for dental work and/or surgery? ☐ Yes ☐ No

Check if any of the following apply to your child:

_____ Frequent colds
_____ Sore throats
_____ Nosebleeds
_____ Persistent cough
_____ Ear tubes: Date inserted_____ Still in place? ☐ Yes ☐ No
_____ Ear infections
_____ Frequent stomach aches
_____ Wears glasses
_____ Wetting/soiling during the day
_____ Frequent headaches
_____ Poor Speech
_____ Speech Therapy
_____ Vision problems

Additional health information you want to share:_____

_____

HAMBURG AREA SCHOOL DISTRICT
PERMISSION FOR EXAMINATIONS AND SCREENINGS

THE NATURE AND PURPOSE OF THIS HEALTH RECORD _____

Name of Student

I understand that the information I give to the School nurse is important for the school staff to understand and help the health and education of my child.

I understand that the information will be kept confidential by the School Health staff, and will be shared with other professionals in the school and in other institutions only when the School Nurse and/or the School Physician believe that it is in the best interests of my child's health and education.

Copies of this health record will be sent to other agencies who request it only with my written consent.

Signature of Parent/Guardian _____

PERMISSION FOR EXAMINATIONS AND SCREENINGS

I give permission for my child to receive medical and dental examinations and screenings as provided by the School Health Services of the Hamburg Area School District.

I understand that state law requires:

*Physical examination
*Dental examination
Screenings for:
- Growth (Body Mass Index, height, and weight) – Grades K - 12
- Vision – Grade K – 12
- Hearing – Grades K - 3, 7, 11
- Scoliosis – Grades 6, 7

*Parents are encouraged to have physical and dental examinations completed by the child's primary care physician/dentist.

I understand that the Hamburg Area School District has obtained approval from the Pennsylvania Department of Health to provide expanded health services.

I understand that I will be informed of any abnormal results of the examinations and screenings given to my child.

I give permission for the following: *(if not done by private provider)

Health History/Health Record
*Physical examination
*Dental examination
Screenings for:
- Growth
- Vision
- Hearing
- Scoliosis

Signature of Parent/Guardian _____

HAMBURG AREA SCHOOL DISTRICT
HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/chatter 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 this identification.

School:_____ **Date:**_____

Student Name_____ **Grade:**_____

1. **What is/was the student's first language?**_____
2. **What language (s) is/are spoken in your home?**_____
3. **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):._____
4. 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	Date	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person completing this form (If other than parent/guardian):_____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited 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 student 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.

Dear Parents/Guardians,

Please take a few minutes to share your child's preschool experience with us:

Did your child attend preschool? Yes _____ No _____

If yes, name of preschool _____

How many times a week? _____

How many hours a week? _____

How many years/months? _____

_____
Child's Name

_____
Parent/Guardian Name

_____
Date