



HAMBURG AREA SCHOOL DISTRICT

701 Windsor Street, Hamburg, PA 19526-0401
Telephone 610-562-2241
Fax 610-562-2634

Dear Parent/Guardian:

If your child is 5 years old on or before September 1, 2020, he/she is eligible to register for kindergarten. Please refer to the Hamburg Area School District website to sign up for a time slot: www.hasdhawks.org

Early registration will take place March 18 (Perry Elementary Center) or March 17 (Tilden Elementary Center).

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 _____

SIBLINGS	NAME/GRADE	BIRTH DATE	() MALE	() FEMALE
_____	_____	_____	() 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
<u>New Address</u>	<u>Former Address if in HASD</u>		
_____	_____		
_____	_____		
_____	_____		

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.

- | | |
|---|---|
| <ul style="list-style-type: none"> _____ Agreement of Property sale/lease _____ Property deed _____ Statement of home owner's insurance _____ Bills or receipts showing new address _____ Bank statement showing address | <ul style="list-style-type: none"> _____ 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



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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any specific illness or health problems? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc.)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are emergency medications required for allergies? If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or as needed)? List _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child need to take medication during school hours? List _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child need a special diet or have intolerance to any food? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing, speech, or developmental delays (glasses, ear tubes, hearing aids)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, or major illness (specify problem)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child any head injury or diagnosed concussion? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any special health needs or problems the school should know about? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any behavioral, psychological concerns, or is under the care of a therapist? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the mother have any illness during pregnancy? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the mother take any medicines or drugs (other than vitamins or iron) during pregnancy? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the mother or family under unusual strain during pregnancy? Cause _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the mother hospitalized? Reason _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Was it a difficult delivery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the baby have any problems at the time of birth? If yes, describe the problem _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____	Encephalitis _____	Pneumonia _____
Allergy _____	Epilepsy _____	Rheumatic Fever _____
Asthma _____	Hepatitis (type) _____	Rubella _____
Autism _____	Heart disease _____	Scarlet fever _____
Chicken pox _____	Heart murmur _____	Tonsillitis _____
Concussion _____	Hernia _____	Tuberculosis _____
Dental concerns _____	Influenza _____	Transfusions (blood) _____
Diabetes (type) _____	Lead Poisoning _____	Whooping cough _____
Eczema _____	Measles _____	Other _____
Emotional/Behavior Concern _____	Meningitis _____	
	Mumps _____	

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	____ Ear infections	____ Frequent headaches
____ Sore throats	____ Frequent stomach aches	____ Poor Speech
____ Nosebleeds	____ Wears glasses	____ Speech Therapy
____ Persistent cough	____ Wetting/soiling during the day	____ Vision problems
____ Ear tubes: Date inserted _____	Still in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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/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 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