CALIFORNIA AREA SCHOOL DISTRICT

CALIFORNIA AREA ELEMENTARY SCHOOL
40 TROJAN WAY, COAL CENTER, PA 15423

TELEPHONE 724-785-5800
FAX: 724-785-5458
WEBSITE: www.calsd.org

RACHEL NAGY
PRINCIPAL

Information Required by School District

Enrollment Information

Required Documents for Enrollment

The following items are required for admission into California Area School District

- Birth Certificate or Documentation of Birth
- Social Security Card/Passport/Visa
- Immunization Records
- Proof of Residency—3 documents are required
- Photo Identification of Parent/Guardian
- Documentation of Custody/Guardianship

Examples:

- Current Real Estate Bill (homeowners)
- Lease Agreement (renters)
- Current paid per Capita Tax Receipt
- Driver's License with Current Address
- Bank Statement with Current Address
- Utility Bills (gas, electric, cable, phone) with Current Address
- Letter from Social Security Office with Current Address
- Letter from Public Assistance Office with Current Address:

Contact for Kindergarten Registration

Shannon Matty
School Secretary
40 Trojan Way
Coal Center, PA 15423
Phone: 724-785-5800 x 2400
Fax: 724-785-5458

How to register your child for Kindergarten

Proof of Your Child's Age: At least one acceptable document to demonstrate your child's age. This includes

- Your child's birth certificate
- Your child's passport
- Your child's baptismal certificate

Proof of Residency: At least three **(3)** documents to demonstrate parent/guardian residency. These include:

- Current utility bill including landline telephone, electric, water, gas, cable, etc. (wireless telephone bills cannot be accepted)
- Current rental/mortgage contract or receipt including deed of sale for property.
- Current paycheck/check stub, work ID badge, if address is included.
- Current driver license/ID issued by the Pennsylvania Department of Transportation.
- Current Pennsylvania motor vehicle registration or title.
- Current Internal Revenue Service tax reporting W-2 form within the last 12 months.
- Receipt for personal property or real estate taxes paid within the past last year.
- Notarized lease agreement.

Custody Agreements (as applicable): If you are not the child's parent, or you have sole custody, bring proof of custody (court order).

Child's Immunization Records: Under the regulations of the Pennsylvania Department of Health, all children entering kindergarten or first grade will be required to provide proof of having received the following immunizations:

- 4 doses of tetanus*
  (1 dose on or after the 4th birthday)
- 4 doses of diphtheria*
  (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox)
  Vaccine or history of disease
  *Usually given as DTP or DTaP or DT or Td
  **Usually given as MMR

pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

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Kindergarten Registration

Student Record Check List

Student Name:_____ **Date:**_____

Birth Date:_____

_____ **Student Demographics** **(Form 3)**

_____ **Home Language** **(Form 1)**

_____ **Parent Access** **(Form 6)**

_____ **Photo ID**

_____ **3 Proofs of Residency**

_____ **Birth Documentation**

_____ **Social Security Number**

_____ **Immunization Record**

_____ **Court Order**

_____ **Guardian** ***(Affidavit required)***

_____ **Foster Care** ***(Affidavit required)***

_____ **Ethnicity**

_____ **Special Services**

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Record of Inspection of Pupil Record

(Should be signed by anyone examining student record)

Name of Student: ____

Date	Examiner	Title	Purpose

California Area School District Form #3
Student Demographics

Name (Last, first, middle) _____ **Generation Code(e.g., Jr., Sr..):** _____

Physical Address: _____ **City** _____ **State PA Zip** _____

Mailing Address: _____ **City** _____ **State PA Zip**_____

Home Phone _____ **Gender** ___ **Date of Birth** _____**SSN#** _____**Grade**_____

Is the student Hispanic or Latino? _____**Yes** _____ **No** **Race: (Please check one or more that apply)**

- ☐ **I-American Indian/Alaskan Native**
- ☐ **A-Asian**
- ☐ **B-Black or African American**
- ☐ **M-Multi-Racial/Ethnic**
- ☐ **P-Native Hawaiian/Other Pacific Islander**
- ☐ **W-White**

Per 24 P.S. §13-1302, a person who knowingly provides false information in the above statement for the purpose of enrolling a child in a school district for which the child is not eligible commits a summary offense and shall, upon conviction for such violation, be sentenced to pay a fine of no more than three hundred dollars ($300) for the benefit of the school district in which the person resides or to perform up to two hundred forty (240) hours of community service, or both. In addition, the person shall pay all court costs and shall be liable to the school district for an amount equal to the cost of tuition calculated in accordance with §2561 during the period of enrollment.

_____ Date_____
Parent/Guardian** By signing this I agree that I have read the above information

Father's (Last, first): _____

Father's Home Phone: _____ **Father's Day Phone:** _____**Father's Cell Phone** _____

Address: (Please fill in if different than student)
Mailing Address: _____ **City:** _____**State** _____ **Zip**_____

Father's Employer_____ _____

Mother's Last, first): _____

Mother's Home Phone: _____ **Mother's Day Phone:** _____**Mother's Cell Phone:** _____

Address: (Please fill in if different than student)
Mailing Address: _____ **City:** _____**State:** _____ **Zip:** _____

Mother's Employer: _____ _____

Guardianship: _____ ___ **Guardian's E-mail:** _____

Step Father: _____ **Step Father's Day Phone:** _____
Step Father's Home Phone: _____ **Step Father's Cell Phone**_____

Step Mother: _____ **Step Mother's Day Phone:** _____
Step Mother's Home Phone: _____ **Step Mother's Cell Phone:** _____

First Emergency Contact:_____ _____
Day Phone: _____ Cell Phone:_____ Relationship to Student:_____

Second Emergency Contact:_____ _____
Day Phone: _____ Cell Phone:_____ Relationship to Student:_____

Third Emergency Contact:_____ _____
Day Phone: _____ Cell Phone:_____ Relationship to Student:_____

Doctor:_____ **Phone:** _____
Dentist:_____ **Phone:**_____

Guardianship

Name:_____ Guardian's Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Affidavit must be on file

Second Mailing

If you would like to share school reports with an alternate custodial parent not living at the listed mailing address, please complete the second mailing information.

Name:_____ **Relationship to student** _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Information required by the state of Pennsylvania

State Entry Date: _____ **Birth Certificate Number:** _____

Initial US Entry Date: _____ **Country of Birth:** _____

City of Birth _____ **State of Birth:** _____

What year did the student enter their first school: _____

What year did the student enter grade 9: _____

2020-2021 California Area School District
CONFIDENTIAL EMERGENCY HEALTH INFORMATION

Name: _____ Birthdate: _____ Sex: M / F (circle)
Last First MI

School: _____ Grade: _____ Teacher: _____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. It is very important to know LIFE THREATENING conditions.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. Medical History: Check the ones that apply to your child and describe under the comment section.

____ Anxiety/Panic Attack
____ Arthritis/Rheumatic Disease
____ Asthma
____ Attention Deficit Disorder
____ Attention Deficit Hyperactivity Disorder
____ Bee Sting allergy
____ Bleeding Disorder & Cooley's Anemia
____ Bowel problem
____ Cardiovascular Condition
____ Cerebral Palsy
____ Color Blindness
____ Diabetes Type 1
____ Diabetes Type 2
____ Eating Disorder
____ Emotional Concerns
____ Epilepsy & Other Seizure Disorders
____ Epi-Pen
____ Headaches
____ Hearing problem
____ Heart Condition
____ Muscle Disorder
____ Neurological Concern
____ Orthopedic problem
____ Sickle Cell Anemia
____ Spina Bifida
____ Tourette's syndrome
____ Vision problems
____ Other _____
____ PE Activity
Limited: _____ Not Limited: _____
Explain: _____

Comments: _____

B. History of mental health problems (explain): _____

C. ALLERGIES: List allergies your child has that cause a problem at school:

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

D. MEDICATION: (Include prescription, over-the-counter and herbal medication.)

	Name	Used to treat	Taken at school?
1.)	_____	_____	Yes ____ No ____
2.)	_____	_____	Yes ____ No ____
3.)	_____	_____	Yes ____ No ____

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent/guardian and physician and kept on file.

E. List any other operations, injuries, hospitalizations, etc. and provide the dates:

_____

F. Does your child wear contact lens? _____ Glasses? _____

Parent/Guardian's Signature: _____ Date: _____

Form # 1

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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 identification.

Student's Name: _____Grade: _____ Date: _____

1. What is/was the student's first language?
   _____
2. Does the student speak a language(s) other than English?
   (Do not include languages learned in school)

   Yes _____ No _____
   If yes, specify the language(s)
   _____
3. What language(s) is/are spoken in your home?
   _____
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	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Parent/Guardian signature: _____

*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.

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PARENT NOTIFICATION

In accordance with school district policy 238, if parents are legally separated or divorced, each parent has equal rights to the access of the child/children and the child's/children's records UNLESS a parent has a court order that indicates which parent has access to the child/children or the child's/children's school records. The school MUST HAVE A COPY OF THE COURT ORDER on file, otherwise, either parent may check the child/children out of the school with proper identification or be given access to the child's or children's school records.

I HAVE READ THE ABOVE STATEMENT OF THE LAW.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

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Consent for Health Screenings

Students in Kindergarten are required by the state to have a physical and dental exam while a member of this class. These exams can be done at the school free of charge or may be completed by your family Physician and Dentist.

Physical Exam

___ I will have my child's physical exam conducted at the school free of charge.

___ I will have my child's physical exam conducted by his/her physician at my expense.

Dental Exam

___ I will have my child's dental exam conducted at the school free of charge.

___ I will have my child's dental exam conducted by his/her dentist at my expense.

Student's Name _____

Parent's Signature _____

Date: _____

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Speech/Language Screening

Date: _____ Date of Birth: _____

Name of Child: _____ Age: _____

School: _____ Phone: _____

Address: _____

_____

Please answer the following questions:

	YES	NO
Is your child's speech difficult to understand?		
Does he/she sound different from other children the same age?		
Was the child late in starting to talk?		
Does he/she have difficulty following directions?		
Can he/she imitate sounds? words? Name pictures/objects?		
Has he/she ever received speech/language services? If yes, please indicate: Facility: _____ Address: _____ _____ Phone: _____		
Please describe your child's speech to include any concerns you may have:		

Parent's Signature: _____

H514.027

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 or Township | County | State | Zip

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

pennsylvania
DEPARTMENT OF HEALTH

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: *Has the student...*	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: *Has the student...*	**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: *Has the student...*	**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: *Has the student...*	**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: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	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: *Has the student...*	**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 _____

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

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
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)					