

WELCOME TO THE COATESVILLE AREA SCHOOL DISTRICT

A learning community rich in diversity and committed to excellence.

CENTRAL REGISTRATION Grades K-12

The Coatesville Area School District has a central registration system for students enrolling in the district in grades K-12. Children are eligible for admission to kindergarten if they have attained the age of five (5) years on or before September 1st or for First Grade if they have attained the age of six (6) years on or before September 1st in the school year for which they are being registered.

For Kindergarten children pre-registering for the next school year, spring registration will occur at the student's prospective home school each year. Appointments may be made by contacting your local school's office. At the conclusion of spring registration, any additional kindergarten students must be registered at the Central Registration office. Students in grades 1-12 will always be registered through the Central Registration office.

The staff at our Central Registration office will be able to schedule appointments, answer your questions and provide information regarding necessary paper work needed for the registration process. Please contact the office at:

DISTRICT ADMINISTRATION BUILDING/CENTRAL REGISTRATION

3030 C. G. Zinn Road

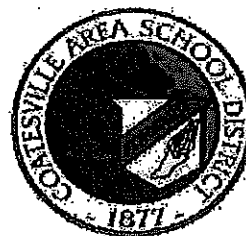
Thorndale, PA 19372

610-466-2400

www.casdschools.org

Please call to make an appointment as walk-ins are not permitted.

<p>Your registration is scheduled for:</p> <p>DATE: _____</p> <p>TIME: _____</p> <p>WITH: _____</p>



REGISTRATION CHECKLIST

FOR OFFICE USE ONLY	Time: _____	Initials: _____	Entry Code: E1 E2 E3 R3 R4 R5 R6 R7 R8
To: _____	Residency Code: R RA NRF		
Student Name: _____	Previous District: _____		
CASD ID: _____	Previous School: _____		
Registration Date: _____	Grade: _____	Transportation Notified: Y N Start Date: _____	
School Assigned: _____	US Enrollment Date: _____		
School Appointment Date: _____	PA Enrollment Date: _____		
Birth Certificate # _____	IEP Noted: Y N SE Depart. Date Notified: _____		

Parent Use Only

- Bring Registration Form
- Bring Proof of Age
- Bring Immunization Records
- Bring Proof of Residency
- Bring Recent Report Card/Transcript
- Bring Special Education Files (if applicable)
- Home Language Survey
- Parental Registration Statement
- Authorization for Release of Records
- Authorization for Immunization Release
- Medical Emergency/Health History

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- Medical Emergency/Health History

Doc Needed: _____

Documents eMailed/Faxed to School: _____
 Parents: _____

PA STATE REQUIRED DOCUMENTS FOR ALL CHILDREN

All applications for registration of students **must** contain the following:

1. Proof of Age [24 P.S. §13-1304; Policy 201]

- Original or certified birth certificate or;
- Passport or;
- Original or certified baptismal certificate, if date of birth is indicated.

2. Immunization Records [24 P.S. §13-1303a; Policy 201]

- Certificate of immunization.

Students who are not immunized as required by the Pennsylvania Department of Health, or who are not medically or religiously exempt *may not be admitted to school.*

3. Proof of Residency* [24 P.S. §13-1302; Policy 202]

Application for registration must be accompanied by one (1) proof of residency from List 'A' and two (2) proofs of residency from List 'B'.

List A (one (1) of the following)

1. Fully executed current residential lease and/or;
2. Recorded deed and/or;
3. Mortgage settlement document(s) or mortgage payment book.

AND

List B (two (2) of the following)

1. Valid Pennsylvania driver's license with current address and/or;
2. Valid vehicle owner's card with current address and/or;
3. Utility bill (provided within 30 days if newly moved) and/or;
4. Valid Pennsylvania identification card and/or
5. Check stub from wages, public assistance or social security issued within the past 30 days and/or
6. Letter from employer verifying address on employment records.

If you reside with another family in the Coatesville Area School District, please complete a Multiple Occupancy Form which must be notarized.

4. Parent Registration Statement [24 P.S. §13-1304a; Policy 218.1]

1. Parent Registration Statement attesting to whether the student has been or suspended or expelled for offenses involving drugs or alcohol, weapons or violence.

The above mandated documents shall be completed and filed with the school district *prior to* any child being accepted as a pupil.

School Children Immunizations

Pennsylvania School Immunization Requirements

Authority: 28 Pa. Code § 23(C)

All Students need the following immunizations to attend school:

- 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 dose of varicella (chickenpox) with first dose on or after 1st birthday or history of disease

**Usually given as DTP or DTaP or DT or TD*

*** Usually given as MMR with first dose on or after 1st birthday*

Students in 7th Grade also need the following immunizations:

- 1 dose of tetanus, diphtheria, acellar pertussis (Tdap) if 5 years has elapsed since last tetanus immunization
- 1 dose of meningoccal conjugate vaccine (MCV)

Proof of immunization means a written record showing the dates (month, day, year) your child was immunized.

The only exceptions to the school laws for immunization are medical reasons and religious beliefs. If your child is exempt from immunizations, your child may be removed from school during a disease outbreak.

COATESVILLE AREA SCHOOL DISTRICT

Central Registration Office

3030 C. G. Zinn Road, Thorndale, PA 19372

School: _____

Bus Number: _____

Registrar's Initials _____

STUDENT REGISTRATION FORM

For Office Use Only: Student # _____ PA State ID#: _____ Registration Date: _____
Entry Code: _____ District Enrollment Date: _____ State Enrollment Date: _____ US Enrollment Date: _____

START HERE -- PLEASE PRINT

Student's Legal Name _____ (Last) (First) (Middle)

Home Address: _____ (House Number) (Street or Road Name) (Apartment or Unit Number)

City: _____ State: PA Zip: _____ Home Phone _____ Unlisted? _____

Mailing address: (if different from above) _____

City: _____ State: PA Zip: _____

Birth Date ____/____/____ Gender: M F Student is: (check one) US Citizen Immigrant Migrant

Grade: (Circle one) K 01 02 03 04 05 06 07 08 09 10 11 12 Other: _____

Ethnicity: (check one) Hispanic/Latino Yes No

Race: (check one or more) White Black/African American Asian Am Indian/Alaskan Native Native Hawaiian/ Pacific Islander

Student Resides at the Address Above with: Both Parents Father Only Mother Only Step Father Step Mother

Guardian (relationship to student) _____

Grandmother Grandfather Aunt Uncle Sister Brother Foster Parent

Father (Mr. Dr.) _____
(Or check one if applicable) ____ Jr. ____ Sr. ____ II ____ III ____ IV
Or Guardian (Dr. Mr.) _____
Home Phone: _____
Cell Phone: _____ Check if Primary #
Employer: _____
Work Phone: _____
Address: (only if different from student) _____
City: _____ State: _____ Zip: _____
Address above to also receive district mailings ____ Yes ____ No
E-Mail address: _____

Mother (Ms. Mrs. Dr.) _____
Or Guardian (Ms. Mrs. Dr.) _____
Home Phone: _____
Cell Phone: _____ Check if Primary #
Employer: _____
Work Phone: _____
Address: (only if different from student) _____
City: _____ State: _____ Zip: _____
Address above to also receive district mailings ____ Yes ____ No
E-Mail address: _____

Type of Residency: (Check one) Resident Foster Child Guardianship Future Resident Non-Resident
(requires agency letter) (requires affidavit) (requires Affidavit & Sales Agreement or Bldg. Contract) (requires agency letter)

Multi-Occupancy Resident Foreign Exchange Homeless: Yes No Residing in shelter: Yes No
(requires Multiple Occupancy Form) (Prior Approval Required)

Placing Agency Name _____ Phone # _____ Contact: _____

Does the student have any health related problems that require attention? ____ Yes ____ No

If yes, what is the nature of the problem? _____

Has the student been identified for any of the following services? Special Ed ESL Gifted 504 Other _____

Language Spoken in the Home: _____ Country of Origin: _____

**COATESVILLE AREA SCHOOL DISTRICT
STUDENT REGISTRATION FORM**

Side 2 of 2

Emergency Contact Information: (Please list others who can be contacted by the school during the day)	
Contact Name: _____	Contact Name: _____
Relationship: _____	Relationship: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

Birth Certificate # _____ Birth City/State _____ Birth Country _____

FORMER SCHOOL INFORMATION:

Former School District: _____

Last School Attended: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Last Grade: _____ Last Date Attended: _____

PLEASE LIST ANY BROTHERS OR SISTERS RESIDING AT THE SAME ADDRESS:

Name (Last Name, First Name)	Date of Birth	Gender (Circle one)	Grade	School Attending
_____	_____	Male or Female _____	_____	_____
_____	_____	Male or Female _____	_____	_____
_____	_____	Male or Female _____	_____	_____
_____	_____	Male or Female _____	_____	_____
_____	_____	Male or Female _____	_____	_____

Signature of Parent/Guardian

Date

The Coatesville Area School District shall provide equal opportunities for education to all persons regardless of their race, religion, color, ancestry, national origin, sex, handicap or disability as provided by the Pennsylvania Fair Educational Opportunities Act, 24 P.S. §5002 et seq., the Pennsylvania Human Relations Act, 42. For information regarding civil rights, grievance procedures, or services, activities and facilities that are accessible to and usable by handicapped persons, contact the Director of Pupil Services, 3030 G. G. Zinn Road, Thorndale, PA 19372. Phone: 610 466-2400.

Office Use:

Data Entry Date: _____

Entered By: _____

Send copy of Registration Form to: Home School, Transportation and Special Education (when applicable)



HOME LANGUAGE SURVEY¹

The Office of Civil Rights (OCR) requires that all Local Education Agencies (LEA's) 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 initial step in the identification process.

School District: _____ **Date:** _____

School: _____

Student's Name: _____ **Grade:** _____

1. What is/was the student's first language? _____

2. 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): _____

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

4. Has the student attended any United States school in any Yes No

3 years during his/her lifetime?

If yes, complete the following:

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

Person completing this form: _____

(if other than parent/guardian)

Parent/Guardian signature: _____

¹ The local education agency (LEA) has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the LEA 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 LEA 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 LEA in the future.



COATESVILLE AREA SCHOOL DISTRICT

Administration Building
3030 C.G. Zimm Road
Thorndale, PA. 19372

"Excellence in Education"

PARENTAL REGISTRATION STATEMENT

Student Name: _____

Date of Birth: _____ Grade: _____

Parent or Guardian Name: _____

Address: _____

Telephone Number - Home: _____ Work: _____

The SAFE SCHOOLS section of the Pennsylvania School Code §13-1304-a states in part "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 of offense involving weapons, alcohol or drugs, or for the wilful infliction of injury to another person or for any act of violence committed on school property."

Please complete the following:

AFFIRMATION

I, the undersigned, do hereby swear or affirm that my child *was* _____ *was not* _____ previously suspended or expelled, or *is* _____ *is not* _____ 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 wilful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

Dates of suspension or expulsion:

(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) _____

Signature of Parent or Guardian

Date

Any wilful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

Coatesville Area School District Release/Exchange of Information Form

Student Name (Last, First) _____

Date of Birth _____

Grade _____

In order to provide and receive information with another person/organization regarding the student named above, Coatesville Area School District requires the permission of the student's parent/guardian.

By signing this form, you are giving permission for information about your child to be exchanged between Coatesville Area School District and the person/organization listed below:

Person(s)/ Organization: _____

Phone: _____ Fax: _____

Types of information to be released from the person/organization listed above to Coatesville Area School District:

- | | |
|---|---|
| <input type="checkbox"/> Educational Records (Grades, attendance, etc.) | <input type="checkbox"/> Psychological Report(s) |
| <input type="checkbox"/> Medical/Neurological Information | <input type="checkbox"/> Speech/Hearing Information |
| <input type="checkbox"/> Psychiatric Information/Report(s) | <input type="checkbox"/> IEP/Special Education Reports/Records |
| <input type="checkbox"/> Summary of Services Received | <input type="checkbox"/> Treatment Summary or Treatment Updates |
| <input type="checkbox"/> Other (specify): _____ | |

I certify that I am the parent, legal guardian, or appointed educational surrogate of the student named above. I hereby give permission for the exchange of information as requested. I am aware of my legal rights regarding the release of personally identifiable information, including my right to withdraw permission at any time and to get copies of the information released upon written request. I understand that this permission is valid only for the purpose stated above.

Parent/Guardian's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

This consent is valid from _____ to _____ (maximum 1 year)

Office Use Only:

PLEASE FORWARD RECORDS TO:

Attach address
label here



COATESVILLE AREA SCHOOL DISTRICT

Administration Building
3030 C. G. Zinn Road, Thorndale, PA 19372

AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

Release of confidential information regarding:

Student Name: _____ Date of Birth: _____ Grade: _____

Name of Last School Attended: _____

Last School's Phone: _____ Last School's Fax: _____

Last School's Complete Mailing Address: _____

Please fax this form and immunization records to:

COATESVILLE AREA SCHOOL DISTRICT

Attn: Central Registration

Fax: ~~610-383-4061~~ 1-610-672-9940

Should there be any questions, please contact Central Registration at 610-466-2400

I understand that I have the right to review those records before they are disclosed or used. I understand that I may revoke this consent, in writing; at any time except, to extent action has been taken. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. This information has been disclosed to the above person, organization, or agency from records whose confidentiality is protected by Pennsylvania Law and/or Federal Public Law 93-282 and is in compliance with person, organization, or agency from making any further disclosure of this information with prior written consent. I understand that any disclosure of this information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Parent/Guardian Signature

Date

This consent is valid from _____ to _____ (maximum 1 year)

Signature of School Official

Date

Note: Pursuant to the provisions of the Family Educational Rights and Private Act 20 USC 1232g(b)(1)(A), parental permission is not required to release or transfer student records to officials of other schools or school systems in which the student seeks or intends to enroll, upon the condition that the student's parents be notified of the transfer, receive a copy of the record if desired, and have an opportunity for a hearing to challenge the content of the record.

STUDENT NAME _____

DATE OF BIRTH _____

DATE FORM COMPLETED _____

INFORMATION FOR MEDICAL EMERGENCIES

PARENT/GUARDIAN:

Mother Name _____

Home Address _____

Home Phone Number _____

Work Place _____

Work Phone Number _____

Father Name _____

Home Address _____

Home Phone Number _____

Work Place _____

Work Phone Number _____

Grandparent (or other relative name) _____

Home Address _____

Home Phone Number _____

Work Place _____

Work Phone Number _____

PERSON LOOKING AFTER CHILD AFTER SCHOOL:

Name _____

Address _____

Phone Number _____

DOCTOR

DENTIST

Name _____

Phone Number _____

SPECIAL HEALTH NEEDS (Circle Yes or No)

Has the pupil ever had any serious illness or operation? YES NO

What? _____ When? _____

Is the pupil going to a hospital, clinic or doctor now for treatment of a condition? YES NO

What for? _____ When? _____

Apart from vitamins, is the pupil taking any medication at this time? YES NO

Name of Medication _____ When? _____

What time during school hours? _____

What for? _____

Is the pupil allergic to anything, such as foods, plants, insects, medication? YES NO

What? _____

Has the pupil ever had any convulsions? YES NO

When? _____ How frequently? _____

Treatment _____

Does the pupil need a special diet or have any food problems? YES NO

Give details _____

Does the pupil have any special health needs, restrictions or activities or problems the school should know? YES NO

Has the pupil had any other illnesses, accidents, broken bones? YES NO

When? _____ What was the problem? _____

Has the pupil ever been seen by a dentist? YES NO

When? _____ Name of Dentist _____

Signature of Mother/Guardian

Date

Signature of Father/Guardian

Date

STUDENT NAME: _____

STUDENT HEALTH HISTORY (ENTRY)

A. Pre-Natal History (circle Yes or No)

1. Did the mother have any major illness during pregnancy? Yes No
2. Did the mother take any medication or drugs (other than iron or vitamins during pregnancy)? Yes No
3. Did the baby come on time? Yes No

B. Developmental History

1. What was the baby's weight?
2. Did the baby have any trouble while in the hospital? Yes No
3. Did the baby have any special problems in the first six months? Yes No
4. At what age did the child sit alone without support?
5. At what age did the child walk alone without support?
6. At what age did the child begin to say two or three words together?
7. Can the child use the toilet without help? Yes No
8. If the child wet the bed, at what age did they stop?

C. Family Health History

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had: Allergy: food/medication/environment, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision/hearing/learning problems, anemia, other inherited or family diseases.
2. Family Members (note any special relationship such as step-parent, adopted, foster child)

Relationship	Age	Name	State of Health	Occupation
Mother				
Father				
Brothers				
Sisters				

3. Have any family members died? (not including miscarriages) Yes No
4. How many people live in the same house as the child?
5. Are there any family problems such as housing, employment, food, etc. Yes No

HEALTH HISTORY - CONTINUED

D. CHILD'S HEALTH HISTORY

1. Check any of the following illnesses the child has had:

- | | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

- | | | |
|--|-----|----|
| 2. Has the child had more than six colds or throat infections, with a fever, a year? | Yes | No |
| 3. Has the child had any trouble with ears or hearing? | Yes | No |
| 4. Has the child had any trouble with eyes or seeing? | Yes | No |
| 5. Has the child had any trouble with teeth? | Yes | No |
| 6. Has the child ever had a convulsion (fit or seizure)? | Yes | No |
| 7. Has the child ever had a fainting spell? | Yes | No |
| 8. Does the child complain of headaches? | Yes | No |
| 9. Has a doctor ever said the child had a heart murmur? | Yes | No |
| 10. Does the child have trouble keeping up with other children? | Yes | No |
| 11. Do any foods disagree with the child? | Yes | No |
| 12. Does the child often have diarrhea? | Yes | No |
| 13. Has constipation ever been much of a problem for this child? | Yes | No |
| 14. Has the child ever had worms or parasites? | Yes | No |
| 15. Have you ever seen blood in the child's stools (bowel movements)? | Yes | No |
| 16. Has the child ever had yellow jaundice or trouble with the liver? | Yes | No |
| 17. Does the child complain of belly aches? | Yes | No |
| 18. Does the child have any problems with urination? | Yes | No |
| 19. Does the child have any skin problems? | Yes | No |
| 20. Has the child ever had eczema or allergy? | Yes | No |
| 21. Has the child ever had asthma or wheezing? | Yes | No |
| 22. Has the child ever had an allergy or reaction to any medication or injections? | Yes | No |
| What medication or injection? _____ | | |
| 23. Does the child seem to have trouble breathing through the nose? | Yes | No |
| 24. Does the child snore at night? | Yes | No |
| 25. Has the child ever complained of pain in the arms or legs? | Yes | No |
| 26. Has the child ever had swelling of any joints or limping? | Yes | No |
| 27. Has there ever been any trouble with the child's blood? | Yes | No |
| 28. Has the child ever eaten paint or plaster or anything else which is not food? | Yes | No |
| 29. Has the child ever been treated for lead poisoning? | Yes | No |
| 30. Does the child have any trouble sleeping? | Yes | No |
| 31. How does the child go to sleep at night? (routine) ... _____ | | |
| 32. Has the child ever had a skin test to TB? | Yes | No |
| Where the results normal? _____ | | |

33. What does the child usually eat for:

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____

Health History obtained from: _____ Date _____

Signature of Parent/Guardian