

STROUDSBURG AREA SCHOOL DISTRICT
STUDENT REGISTRATION OFFICE
1100 West Main Street, Stroudsburg, PA 18360
570-213-3669

INFORMATION NEEDED FOR COMPLETING REGISTRATION

- Parent/Guardian Identification.** One valid form of ID is required with a Stroudsburg Area address, this ID may be a PA Driver's license or PA photo ID. Where the ID possessed does not list a Stroudsburg address, you will need to provide a copy of the submitted change of address application.
- Student's proof of birth:** Original birth certificate or passport. Student must be 5 years old by September 1, 2019. (Student's birthday must be on or before September 1, 2014 to be registered for the 2019-20 Kindergarten class).
- The Property Identification Number (PIN #)** found on the tax bill.
- **A mortgage or lease is mandatory at registration along with two of the following proofs of residency:** current utility bill (phone bill is not accepted), PA vehicle registration, PA vehicle insurance, receipt for payment of municipal or school district taxes, and/or receipt for payment of earned income tax from Berkheimer Associates.
- If the student and the parent/guardian is residing with a Stroudsburg Area School District resident and **does not pay** any utility bills toward the residence, the resident (whose name is on the lease or mortgage and the utility bills), and the parent/guardian must sign and notarize the **Multiple Occupancy certificate** and provide the proper proofs of residency (**reference ** above**).
- If the student and the parent/guardian is residing with a Stroudsburg Area School District resident and **does pay** utility bills toward the residence, the resident (whose name is on the lease or mortgage), must provide a written letter stating that the student and the parent/guardian resides with them at their residence full time. The proper proofs of residency are still required (**reference ** above**).
- When a student does not reside with their parent/guardian but resides with a district resident who financially supports the student, an **Affidavit of Residency certificate** must be completed. The parent/guardian and the district resident must sign and notarize the **Affidavit of Residency certificate** and provide the proper proofs of residency (**reference ** above**).
- Immunization records:** Exemptions from school law for immunizations include: medical reasons and religious beliefs. If your child is exempt from immunizations, your child may be removed from school during a disease outbreak.
- Custody papers**, if applicable.
- Special education documents**, if applicable (i.e. IEP, GIEP, 504, Evaluation reports)

Please make sure that you **COMPLETE THESE FORMS IN ADVANCE AND BRING THEM WITH YOU** at your scheduled time.

If you have any questions or are unable to keep this appointment, please contact the school where you are registering. **During inclement weather**, please call ahead to confirm that your appointment is not delayed or cancelled.

STROUDSBURG AREA SCHOOL DISTRICT - STUDENT REGISTRATION APPLICATION

STUDENT INFORMATION

NAME: _____
LAST _____ FIRST _____ MIDDLE _____ GENDER: Male Female

HISPANIC/LATINO: Yes No ETHNICITY/RACE (circle all that apply): Am Indian/Alaska Native Asian Black/African Am Native Hawaiian/Outer Pacific Is White

DOB: _____ CITY OF BIRTH: _____ STATE OF BIRTH: _____ COUNTRY OF BIRTH: _____

DATE OF PA RESIDENCE: _____ DATE 1ST ENROLLED IN US SCHOOL: _____ GR 09 ENTRY DATE: _____

REPEATING LAST YEAR: Yes No SPECIAL ED: Yes No FOREIGN EXCH: MIGRANT: IMMIGRANT: HOME LANGUAGE: _____

PRESENT ADDRESS: _____
Street _____ City _____ State _____ Zip _____ HOME PHONE: _____

PREVIOUS HOME ADDRESS: _____
Street _____ City _____ State _____ Zip _____ PREVIOUS SCHOOL: _____

PREVIOUS SCHOOL WITHDRAW DATE: _____ GRADE: _____ PREV. SCHOOL ADDRESS: _____

PARENT/GUARDIAN INFORMATION STATUS (Circle One): SINGLE MARRIED SEPARATED DIVORCED GUARDIAN FOSTER

PARENT/GUARDIAN 1: _____ RELATIONSHIP: _____ SPOUSE: _____

ADDRESS SAME AS ABOVE: -or- ADDRESS (H): _____ PHONE (H): _____ (C): _____

EMAIL: _____ EMPLOYER: _____ PHONE (W): _____

PARENT/GUARDIAN 2: _____ RELATIONSHIP: _____ SPOUSE: _____

ADDRESS SAME AS ABOVE: -or- ADDRESS (H): _____ PHONE (H): _____ (C): _____

EMAIL: _____ EMPLOYER: _____ PHONE (W): _____

ADDITIONAL SCHOOL-AGE CHILDREN			
NAME	SCHOOL	AGE	GRADE

Parent/Guardian Signature _____ Date _____

Approved By _____ Date _____

OFFICE USE ONLY

Deed, Lease, Mortgage 1302 Affidavit Act 26
 Utility Bill School Grades/Transcripts Immunization
 Multiple Occupancy Release of Records Birth Certificate
 Custody Decree Foster - Court Letter Health History Language Survey

I.D. Requirement: PA Driver's License or PA Photo ID (REQUIRED)
 (Additional): PA Vehicle Registration Receipt Municipal/School Taxes
 PA Vehicle Insurance Receipt Berkleimer's Associates

Academic Yr: _____ Grade: _____ Bldg: _____ Trans: _____
 1st day of enrollment: _____ Pin #: _____
 SASD Student ID: _____ PA Secure ID: _____

EMERGENCY CONTACT INFORMATION – Who shall be the local contacts if the parent/guardian cannot be reached?

LOCAL CONTACT 1: _____
LAST NAME FIRST NAME RELATIONSHIP: _____
ADDRESS: _____
CITY STATE ZIP PHONE NUMBER: _____

LOCAL CONTACT 2: _____
LAST NAME FIRST NAME RELATIONSHIP: _____
ADDRESS: _____
CITY STATE ZIP PHONE NUMBER: _____

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SPECIAL EDUCATION SERVICES – Check ALL the services that your child is currently receiving:

- Individualized Education Plan (Special Education Services)
- Gifted Individualized Education Plan (Gifted Education Services)
- Section 504/Chapter 15 Service Agreement (Special Accommodations for Health/Physical needs)
- ESL (English as a Second Language)
- Speech/Language Support
- Early Intervention Program
- Math Support (Title Math)
- Reading Support (Title Reading)
- SST or IST (Student or Instructional Support Team)

Stroudsburg 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 the identification.

School District: Stroudsburg Area School District

Name of Child: _____ **Date:** _____

Address: _____ **Grade:** _____

School: _____

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 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.

BLDG # _____
School Yr: _____
Grade: _____

**STROUDSBURG AREA SCHOOL DISTRICT
TRANSPORTATION DEPARTMENT**

STUDENT NAME: _____ STUDENT ID #: _____
(FIRST) (LAST)

MAILING ADDRESS: _____ PHYSICAL ADDRESS: _____

PARENT/GUARDIAN 1: _____ RELATIONSHIP: _____
(H): _____ (C): _____ (W): _____

PARENT/GUARDIAN 2: _____ RELATIONSHIP: _____
(H): _____ (C): _____ (W): _____

DIRECTIONS TO HOME:

YOU ARE ONLY ALLOWED ONE BUS TO SCHOOL AND ONE BUS HOME:

If your child will be picked up or delivered to a babysitter, daycare, etc.- someplace OTHER THAN THE HOME ADDRESS, please complete the following in addition to the above.

Babysitter/Relative/Neighbor/Other Pick Up _____ Drop Off _____ Both _____
Name _____ Phone _____
Location: _____

Daycare Pick Up _____ Drop Off _____ Both _____
Name _____ Phone _____
Location: _____

I have decided to Parent Transport and will not need school transportation. To School _____ From School _____ Both _____

STOP AND READ THIS VERY IMPORTANT MESSAGE if you have a Kindergarten student

On the reverse side of this form – is your Dean’s List – you will list the designated adults permitted to receive your Kindergarten child at his/her bus stop. Please note: those listed

MUST BE 18 YEARS OF AGE OR OLDER

with no exceptions.

STROUDSBURG AREA SCHOOL DISTRICT
STUDENT HEALTH HISTORY

Student Name: _____

Date of Birth: _____

Please check the appropriate box of any conditions that apply and give a brief explanation in the space provided at the bottom of this form. List all current health conditions.

- | | |
|--|--|
| <input type="checkbox"/> NO KNOWN HEALTH PROBLEMS | <input type="checkbox"/> Head injury/Concussion |
| <input type="checkbox"/> Allergy – SEVERE
<input type="checkbox"/> Requires EPIPEN/medication | <input type="checkbox"/> Hearing impairment, list hearing aids if needed |
| <input type="checkbox"/> Allergy – List type and symptoms below | <input type="checkbox"/> Heart Disease/Cardiovascular condition, explain below |
| <input type="checkbox"/> Arthritis – List below | <input type="checkbox"/> Migraines/physician diagnosed, list medication below |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Attention Deficit Disorder – ADD/ADHD
List medication below | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Muscular – Skeletal condition |
| <input type="checkbox"/> Blood Disorder/Anemia/Hemophilia | <input type="checkbox"/> Neurological condition |
| <input type="checkbox"/> Cancer – List type | <input type="checkbox"/> Nosebleeds – Severe |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Orthopedic Impairment |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Seizure Disorder, list medications, describe symptoms |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Speech impairment |
| <input type="checkbox"/> Eating disorders/physician diagnosed | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Other health problems, not listed |
| <input type="checkbox"/> Gastrointestinal condition, list below | |
| <input type="checkbox"/> Growth Disorder, list below | |
| <input type="checkbox"/> Headaches | |

All medication given at school (prescribed or over the counter) and/or the student is carrying an inhaler/EpiPen requires a physician's note (forms are available on the Stroudsburg Area School District website).

EXPLANATION:

Medication taken at home: _____

Medication required during school hours: _____

Parent/Guardian Signature: _____ Date: _____

STROUDSBURG AREA SCHOOL DISTRICT

**Parent Permission for Mandated Examinations in Compliance with
Pennsylvania School Health Act**

Student Name _____ Grade _____

Dental Exams required for Kindergarten, grade 3 and 7.

Please check one.

_____ I grant permission for my child to be examined by the school dentist. You will be notified of the date of the dental exam.

_____ I do not grant permission for my child to be examined by the school dentist. I will have my child examined by his/her family dentist and will send the report to the school nurse by April 1st.

Physical Exams required for Kindergarten, grade 6 and 11.

Please check one or more.

_____ I grant permission for my child to be examined by the school doctor. The exam will include height and weight, blood pressure, pulse, scoliosis check, neuromuscular check, external genital exam (male's only), oral exam, heart and lung sounds, and a review of immunizations. You will be notified of the date of the physical exam.

_____ I wish to be present with my child for the school physical exam.

_____ I do not grant permission for my child to be examined by the school doctor. I will have my child examined by his/her family doctor and will send the report to the school nurse by April 1st.

*****As per School Board Policy #209, all mandated dental, physical and scoliosis exams must be submitted to the school nurse prior to April 1st. If the mandated document(s) are not received by April 1st, the student will be excluded from school on May 1st until all mandated documents are received.**

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date