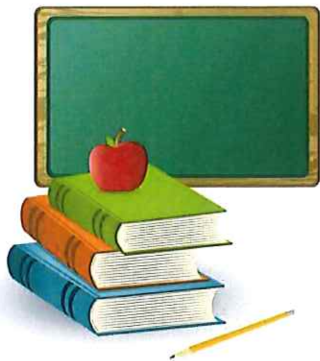

WELCOME TO THE COATESVILLE AREA SCHOOL DISTRICT

A learning community rich in diversity and committed to excellence.

KINDERGARTEN REGISTRATION

For **Kindergarten** children pre-registering for the upcoming school year, spring registration will occur at the student's prospective home school. Children are eligible for admission to kindergarten if they have attained the age of five (5) years on or before September 1st Appointments may be made by contacting your local school's office. At the conclusion of spring registration, any additional kindergarten students will be registered at the District's Central Registration office located in Thorndale.

School staff will be able to schedule appointments, answer your questions and provide information regarding necessary paper work needed for the registration process. Please contact your child's home school at the numbers below:

Caln Elementary	610-383-3760
East Fallowfield Elementary	610-383-3765
Friendship Elementary	610-383-3770
Kings Highway Elementary	610-383-3775
Rainbow Elementary	610-383-3780
Reeceville Elementary	610-383-3785

www.casdschools.org

Your registration is scheduled for:

DATE:______________________________

TIME:______________________________

WITH:______________________________

REGISTRATION CHECKLIST

Please bring the following documents with you on your appointment day to Kindergarten Registration.

- **ALL** of the items listed below must be brought to the school where registering:

    1. Birth certificate
    2. Immunization Records
    3. Lease or Deed (or mortgage book) in Parent's (Guardian's) Name
    4. Early Intervention IEP (Individual Education Plan), Initial ER (Evaluation Report), RR (Reevaluation Report), Initial NOREP (Notice of Recommended Educational Placement/Prior Written Notice) and NOREP (Notice of Recommended Educational Placement)

- **Proof of Residency Checklist:**
  Any **TWO** must be brought to the appointment:

    1. Valid Driver's License with Current Address
    2. Valid Vehicle Owner's Card with Name and Address
    3. Utility Bill within 30 Days with Name and Address
    4. Current and Valid Assistance Paper or Medical Card
    5. Pay Check Stub within 30 Days with Name and Address
    6. Letter from Personnel Director Verifying Address on File

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 does 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) with first dose on or after the 1st birthday or history of the disease

**Usually given as DTP or DTaP or DT or TD*
***Usually given as MMR with the first dose on or after the 1st birthday*

Students in 7th Grade also need the following immunizations:

1 dose of tetanus, diphtheria, acellar pertussis (Tdap) if five (5) years has elapsed since their last tetanus immunization
1 dose of meningococcal 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 ____/____/____ (Month Day Year) **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.) ______________________________

(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 (requires agency letter) ☐ Guardianship (requires affidavit) ☐ Future Resident (requires Affidavit & Sales Agreement or Bldg. Contract) ☐ Non-Resident (requires agency letter)

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

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:**____________________

Please continue to Side 2

COATESVILLE AREA SCHOOL DISTRICT
STUDENT REGISTRATION FORM

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 C. 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 SURVEY[1]

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 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: ______________________________

[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.

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, hear 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

D. CHILD'S HEALTH HISTORY

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

_________	Read Measles	_________	German or "3 Day" Measles
_________	Whooping Cough	_________	Chicken Pox
_________	Rheumatic Fever	_________	Pneumonia

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: ______________________________ ______________

Signature of Parent/Guardian **Date**

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

H511 336 (Rev 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE ______________ 20 ______

NAME OF SCHOOL ______________________________ GRADE ______ HOMEROOM ______

NAME OF CHILD Last First Middle	DATE OF BIRTH	SEX ☐ ☐ M F

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date:__________		
Other __________					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health

☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. ______________
Date

Result of Diagnostic Studies: ______________________________
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes ________ Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify ____________

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

____
Date of Examination

____
Signature of Examiner

____
Print Name of Examiner

____
Address

____
Telephone Number