

**BUTLER AREA SCHOOL
DISTRICT**

2019-2020

1ST – 12TH GRADE

ENROLLMENT PACKET

CURRENT DATE

/ /

BUTLER AREA SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

(PRESS FIRMLY)

- NON-RESIDENT
- EMANCIPATED

STUDENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	SEX <input type="radio"/> Male <input type="radio"/> Female
STREET ADDRESS (HOUSE NUMBER, STREET NAME)			CITY, STATE, ZIP CODE		ETHNICITY <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic
MAILING ADDRESS (IF P.O. BOX)			PHONE NUMBER () -		<input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> White
DATE OF BIRTH		PLACE OF BIRTH		BIRTH DATE AUTHORITY	
MONTH	DAY	YEAR	CITY OF BIRTH	STATE OF BIRTH	COUNTRY OF BIRTH
					BIRTH CERTIFICATE # OTHER

In the following fields, place the date the CHILD moved into PA and the U.S. respectively.

- ★ If child resided in PA since birth, place child's birth date in "Date Moved to PA" and "Date Moved into U.S."
- ★ If child resided in U.S. since birth, place child's birth date in "Dated moved into U.S."
- ★ If child moved multiple times in/out of PA and/or U.S., use MOST CURRENT move dates.

DATE MOVED INTO PA			DATE MOVED INTO U.S.			TOTAL YEARS IN U.S. SCHOOLS
MONTH	DAY	YEAR	MONTH	DAY	YEAR	

DATE CHILD ENTERED 9 th GRADE			PREVIOUS SCHOOL ATTENDED	ADDRESS OF SCHOOL	DATES ATTENDED
MONTH	DAY	YEAR	<input type="radio"/> Child has not entered Grade 9.		

NATURAL PARENT/LEGAL GUARDIAN INFORMATION

Relationship to Student: FATHER MOTHER STEP-PARENT FOSTER PARENT OTHER (SPECIFY) _____

FIRST NAME	LAST NAME	HOME PHONE NUMBER () -
RESIDENCE <input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> LEASE <input type="checkbox"/> OTHER	STREET ADDRESS (HOUSE NUMBER, STREET NAME)	CITY, STATE, ZIP CODE
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER () -

Relationship to Student: FATHER MOTHER STEP-PARENT FOSTER PARENT OTHER (SPECIFY) _____

FIRST NAME	LAST NAME	HOME PHONE NUMBER () -
RESIDENCE <input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> LEASE <input type="checkbox"/> OTHER	STREET ADDRESS (HOUSE NUMBER, STREET NAME)	CITY, STATE, ZIP CODE
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER () -

CHILDREN IN HOUSEHOLD NOT LISTED ABOVE

Last Name	First Name	*REL	Sex	MO	BIRTHDATE DAY	YR	School	Grade

Relationship: B - BROTHER S - SISTER A - AUNT U - UNCLE C - COUSIN N - NO RELATIONSHIP O - OTHER

OFFICIAL USE ONLY

TRANSPORTATION

ASSIGNMENT

BUS #	BUS STOP LOCATION:	PICK-UP TIME	BUILDING	GRADE	HOMEROOM	START DATE
		: AM PM				

Please print clearly all data requested below and return this form to the school as soon as possible. Parents should list emergency contact person(s) who live near the school, have transportation, and have local phone numbers. The safety of your child may depend on the accuracy of this data.

STUDENT / PARENT / GUARDIAN PERSONAL DATA			
Student Name: (Last)	(MI)	Birth Date:	Grade: Room: Teacher:
Address:	City / Zip:	Phone # :	
Father / Guardian:	Home Phone:	Work Phone:	Cell / Pager:
Address (If different):		Email:	
Mother / Guardian:	Home Phone:	Work Phone:	Cell / Pager:
Address (If different):		Email:	
PHYSICIAN EMERGENCY DATA			
Family Physician:		Office # :	
Family Dentist:		Office #:	
Please note student medical problems. (If you wish them to be confidential, contact the school nurse):			
EMERGENCY DATA CONTACT - MUST LIVE LOCALLY			
Please list below person(s) we may contact in an emergency when parents/guardians are unavailable. These persons must be authorized to pick up the student as a temporary designated custodian in the event of evacuation or need to transport the student for medical treatment. List names in the order you would like us to make contact.			
1. Name:	Phone:	3. Name:	Phone:
Address:	Relationship:	Address:	Relationship:
2. Name:	Phone:	4. Name:	Phone:
Address:	Relationship:	Address:	Relationship:
MEDICAL INFORMATION			
Insurance Company Name:			Policy Number:

I have read and understand the Butler Area School District Medication Policy. In case of an emergency requiring immediate medical treatment, if I cannot be reached by phone, I give my permission to transport this student (by ambulance if necessary) to the Butler Memorial Hospital, and I will assume responsibility for the expenses incurred.

Parent / Guardian Signature _____

Date _____



BUTLER AREA SCHOOL DISTRICT

HARRIGER EDUCATIONAL SERVICES CENTER η 110 Campus Lane η Butler, PA 16001

CONSENT FOR RELEASE OF RECORDS

Student Name: _____ D.O.B. _____ Grade _____

School Attends: _____

Parent Name: _____

Parent Address: _____

I hereby authorize Butler Area School District to obtain and/or release information on my child to/from:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

I/We, _____, hereby give consent to have the following records of my
(Parent/Guardian -- PLEASE PRINT NEATLY)
son/daughter transferred to the Butler Area School District.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Administrative Records
(home address, birth date, grade level completed, attendance record) | <input checked="" type="checkbox"/> PA Secure ID _____ |
| <input checked="" type="checkbox"/> Standardized Achievement Test Scores | <input checked="" type="checkbox"/> Psychological Records (if applicable) |
| <input checked="" type="checkbox"/> Intelligence Aptitude Test Scores | <input checked="" type="checkbox"/> Disciplinary Records |
| <input checked="" type="checkbox"/> Records of Extracurricular Activities | <input checked="" type="checkbox"/> Special Education Records |
| <input checked="" type="checkbox"/> Health Records | <input checked="" type="checkbox"/> Other (Keystone Scores) |

For internal use only

Please send records to:

SCHOOL: _____

BUTLER, PA 16001

Phone: 724-287-8721

Fax: _____

Parent/Guardian Signature

Former Address

Former School of Attendance

SAFE SCHOOLS AFFIDAVIT

CURRENT PHOTO IDENTIFICATION REQUIRED AT
TIME OF NOTARIZATION
SIGN ONLY IN THE PRESENCE OF NOTARY

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF BUTLER
BUTLER, PENNSYLVANIA 16001

Internal Office Use	
Student Grade	_____
Building	_____
School Year	_____

_____ the parent(s)/guardian(s) for

_____ personally appeared before me,
the undersigned authority. The said parent/guardian, who being duly sworn according to the law,
deposes and says that his/her/their son/daughter, who is enrolled or who is seeking enrollment
within the Butler Area School District,

_____ has never been suspended or expelled from any public or private school
within the Commonwealth of Pennsylvania or any other state

_____ has been suspended or expelled from a public or private school within the
Commonwealth of Pennsylvania or another state

For an act or offense involving a weapon, alcohol or drugs, or for the willful infliction of injury to
another person or for an act of violence committed on school property.

***False statements made within this Affidavit shall constitute an offense equal to a misdemeanor in
the third degree.***

This Affidavit is submitted to the Butler Area School District pursuant to Title 24, 1301-A, et seq., of
the Pennsylvania School Code.

Parent/Guardian Signature

Sworn to and subscribed before me,
This _____ day of _____, 20

(Notary)

**BUTLER AREA SCHOOL DISTRICT
110 CAMPUS LANE
BUTLER, PA 16001**

HOME LANGUAGE SURVEY

The Civil Rights Act of 1964, title VI – Language Minority Compliance Procedures, requires that school districts/charter schools identify limited English proficient (LE) students. Pennsylvania Department of Education has selected the Home Language Survey as the method for the identification.

SCHOOL _____ GRADE _____

STUDENT NAME _____ DATE OF BIRTH _____

GENDER: M _____ E _____

HOME PHONE NUMBER () _____

CELL PHONE NUMBER: () _____

ADDRESS: _____

WHAT IS THE STUDENT'S FIRST LANGUAGE?

DOES THE STUDENT SPEAK A LANGUAGE OTHER THAN ENGLISH? (DOES NOT INCLUDE LANGUAGES LEARNED IN SCHOOL)

WHAT LANGUAGE(S) IS/ARE SPOKEN IN YOUR HOME?

NAME OF PERSON COMPLETING THIS FORM (only if other than parent/guardian)

SIGNATURE: _____ DATE: _____
Parent/Guardian

The school district/charter school 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 has the right to ask for the information it needs to identify English Language Learners (ELL's). As part of the responsibility to locate and identify ELL's, the school district/charter school may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enroll in the school district/charter school in the future.

Student Program Information

Check ALL services that your child is currently receiving:

<input type="checkbox"/> Individualized Education Plan
<input type="checkbox"/> Section 504/Chapter 15 Service Agreement
<input type="checkbox"/> Preschool Program
<input type="checkbox"/> ESL (English as a Second Language)
<input type="checkbox"/> Remedial Math (Extra Help)

<input type="checkbox"/> Gifted Individualized Education Plan
<input type="checkbox"/> Early Intervention Program
<input type="checkbox"/> Speech/Language Support
<input type="checkbox"/> IST (Instructional Support Team)
<input type="checkbox"/> Remedial Reading (Extra Help)

Health History
Confidential

TO THE PARENT OR GUARDIAN

The information requested on this form will be of help to the school personnel in determining the health status of your child and in assisting him/her to receive maximum benefits from his/her educational experience.

Student full name _____ Male _____ Female _____ Birthdate _____

Address _____ Phone _____

Place of birth _____

Father's Name (first, middle, last) _____

Mother's Name (first, middle, maiden, last) _____

With whom does child live? _____

List names of siblings:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL

Name of child's doctor or nurse practitioner _____ Phone number _____

In the past 12 months, did you have problems obtaining medical care for your child? Yes _____ No _____

DENTAL

Name of child's dentist _____ phone number _____

Did your child receive a dental exam in the last 12 months? Yes _____ No _____

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes _____ No _____

Do others have difficulty understanding your child? Yes _____ No _____

If yes, please explain _____

Does student have Individualized Education Plan (IEP)? Yes _____ No _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes* _____ No _____

Describe: _____

*If yes, a meeting with the school nurse is required. Medication or treatment orders will need to be completed.

PLEASE COMPLETE BACK OF FORM

Check next to any condition or illness that applies to your child.
 Note: For medication questions, mark the "yes" box only if child is taking medication now.

1. Allergies Food _____ Medicine _____
 Ants Wasps Bee stings
 Environmental allergies List _____ Other allergies List _____
 Specify reaction to allergy or allergen Rash Swelling Hives Trouble Breathing
 Vomiting Diarrhea Local Reaction
 Takes medication for any allergies List medication(s) _____
 Does child need a special diet? Yes No (if yes, school requires a prescription from a doctor.)
2. Arthritis Describe _____
3. Asthma List triggers _____ Diagnosed at age _____
 Takes medication List medication(s) _____
 Under doctor's care now Yes No
4. Other frequent Respiratory Conditions Describe _____
5. Attention Deficit/Hyperactivity Disorder (ADD/ADHD) Medically Diagnosed? _____
 Takes medication List medication(s) _____
6. Blood disorder Sickle cell anemia Anemia Specify _____
7. Cancer Explain _____
8. Chickenpox-illness At age _____
9. Cystic Fibrosis Takes medication List medication(s) _____
10. Dermatological/Skin Condition Describe _____
11. Developmental Delay Explain _____
12. Diabetes (high blood sugar) Type 1 Type 2 Hypoglycemia (low blood sugar)
13. Digestive/Gastrointestinal disorders Explain _____
14. Eating Disorder Explain _____
15. Endocrine Explain _____
16. Gynecological Problems Explain _____
17. Headaches Migraines Under doctor's care for this condition Yes No
 Takes medication List medication(s) _____
18. Head injury/Concussion Month/Year _____ Explain _____
19. Hearing Problems Tubes Uses hearing aid
20. Heart condition Explain _____ Under doctor's care for this condition Yes No
 Physical restrictions Yes No If yes, explain _____
21. High blood pressure (Hypertension)
22. Kidney or bladder disorder Explain _____
23. Muscle/bone/mobility disorder Explain _____
 Physical restrictions Yes No Explain _____ Need a doctor note yearly.
24. Neurological Condition Cerebral Palsy Explain _____
25. Nosebleeds
26. Psychiatric diagnosis _____
 Takes medication List medication(s) _____
27. Seizure Disorder Type _____ How long ago was the last one? _____
 Takes medication List medication(s) _____
28. Sinus Problems Explain _____
29. Surgery Explain _____ Date _____
30. Vision problems Glasses Contacts Explain _____
31. Other Explain _____
32. My child does not have any of the listed conditions or illnesses.

Parent/Guardian Signature _____ Date _____