Shade-Central City School District

203 McGregor Avenue
Cairnbrook, PA 15924
Telephone (814) 754-4648 FAX (814) 754-5848
website <www.shade.k12.pa.us>

The mission of the Shade-Central City School District is to support all students to achieve academic success and become positive, productive members of our school, community and society.

New Student Registration

Welcome to the Shade-Central City School District, Home of the Panthers!

When enrolling a student in Shade SD, parents, please remember that it is imperative for you to provide your **child's birth certificate, immunization records, and verification of residency**. Residency may be proven via a current utility bill, lease, or mortgage.

**In order to attend Shade SD schools, a child must reside with parents/guardians and sleep in a home located within Shade SD boundaries unless otherwise stipulated by supporting court documentation. Ownership of or association with a Shade SD property does NOT determine residency.

New enrollment meetings, for students in grades 7-12, take place by contacting the main office throughout the year.

Although not necessary, families **are encouraged to bring records of grades (report card, transcript, etc.) and special education paperwork, if applicable,** to make the enrollment meeting even more effective.

Mr. Troy Carbaugh
Shade JSHS School Counselor

Phone: 814-754-4648
Email: tcarbaugh@shade.k12.pa.us

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***John Krupper**, Superintendent/ Elementary Principal*
***Sean Wechtenhiser**, Junior/Senior High School Principal*
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Enrollment Checklist

Student Name _____ Grade_____

Have you ever been enrolled in Shade Central-City SD before? ____Yes ___NO

(Below will be completed by school)

DOCUMENTS NEEDED:

_____ BIRTH CERTIFICATE

_____ IMMUNIZATION RECORDS

_____ PROOF OF RESIDENCY

RECORDS RECEIVED FROM PRIOR SCHOOL DISTRICT:

_____ ACADEMIC RECORDS

_____ STANDARDIZED TEST SCORES

_____ SPECIAL EDUCATION RECORDS (IF APPICABLE)

APPICABLE? ____Yes ___NO

_____ HEALTH RECORDS

VERIFIED BY_____ DATE_____

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To Whom It May Concern:

According to the Final Regulations-Family Educational Rights and Privacy Act (Buckley Amendment), dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within educational institutions and officials of other schools in the school system in which the student may intend to enroll, may receive a student's records without a written consent for such release.

We would appreciate information on:

Name: _____
Birth Date: _____
Grade: _____

Please send the following information as soon as possible:

_X_Official administrative records (Birth certificate, grade level, name, address, report card grades, attendance records, grading scale, standardized achievement test scores, etc.)
_X_ School/counselor generated tests, such as intelligence and aptitude scores
_X_ Birth Certificate & Social Security Card
_X_ Health records with the immunization card
_X_ Discipline records (PA Act 26 Mandate)
_X_ Exceptional student education records including I.E.P, CER, ER, NORA, etc.
_X_ Driver Education Grade
_X_ PA Secure ID (if applicable)

Sincerely,

Mr. Troy J Carbaugh
School Counseling Department

Please send information to:

Shade Central Jr./Sr. High School
Attn: Mr. Troy J. Carbaugh
School Counseling Department
203 McGregor Avenue
Cairnbrook, PA 15924

SHADE-CENTRAL CITY JUNIOR-SENIOR HIGH SCHOOL

Last First Middle

Student's Name: _____ Grade: _____ DOB: _____

Address: _____ Home Phone: _____

Birth City, State, & County: _____ Years in United States Schools: _____

Mother/Guardian Name: _____ Work Phone: _____ Cell Phone: _____

Father/Guardian Name: _____ Work Phone: _____ Cell Phone: _____

Mother/Guardian email: _____ Father/Guardian email: _____

Person with whom student lives: _____ Relationship: _____

Bus # Morning: _____ Bus # Afternoon: _____ Walker: _____ Drives to school: _____

Ethnicity (circle one): White Hispanic Black Asian/Pacific American Indian Other: _____

The student is (circle one): Adult Emancipated Minor Minor

Adults who are available during school hours to assume care of/transport of your child if you cannot be reached:

#1: Name: _____ Relationship: _____ Phone: _____

#2: Name: _____ Relationship: _____ Phone: _____

Student has permission to drive home/to appointment with parent permission letter (check one): _____ Yes _____ No

Photo Release: Your child's photo may be taken for inclusion in district publications or in local newspaper/magazine articles or in letters relating to school activities. Please check one: _____ YES, I GIVE PERMISSION _____ NO, I DO NOT GIVE PERMISSION

School Year: _____ Parent/Guardian Signature: _____

PARENT/GUARDIAN(S) ARE RESPONSIBLE TO NOTIFY THE SCHOOL OF ANY INFORMATION CHANGE ON THIS CARD

pennsylvania
DEPARTMENT OF EDUCATION

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.

SHADE-CENTRAL CITY SCHOOL DISTRICT
HEALTH SERVICES

AUTHORIZATION FOR DISPENSING MEDICATION IN SCHOOL

Medication will be given during school hours only if needed to maintain an appropriate effect upon the child. Otherwise, medications should be given outside school hours whenever possible. Parent/Guardian must bring medication to school. Students are not permitted to carry medications. This form needs completed for all prescription and over-the-counter medications to be given at school.

THIS PORTION TO BE COMPLETED BY PHYSICIAN

Child's Name: _____

Medication: _____
Name Strength Dose Route Time

Length to be given without a subsequent order: _____

Diagnosis: _____

Side effects of medication: _____

Other recommendations/comments: _____

If prescribing a rescue inhaler or Epipen, may the child carry and self-administer? ☐YES ☐NO

Physician's Signature: _____ Phone: _____ Date: _____

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for Shade-Central City School District personnel to administer the above medication to _____.
Child's Name Birth Date Homeroom Teacher

Please list all medication your child is taking: _____

_____ _____
Parent/Guardian Signature Date

PARENTS/GUARDIANS ARE RESPONSIBLE TO NOTIFY THE SCHOOL NURSE OF ANY CHANGES IN WRITING. A WRITTEN PHYSICIAN'S ORDER IS ALSO NEEDED TO CHANGE ABOVE ORDER INCLUDING FREQUENCY, DOSE, ETC.

Rev. 8/07

NAME OF STUDENT _____ **TEACHER** _____

GRADE LEVEL _____

Are there any custody issues that we should be aware of? ☐ No ☐ Yes, if so please explain.

_____

PHOTO RELEASE: YOUR CHILD'S PHOTO MAY BE TAKEN FOR INCLUSION IN THE DISTRICT PUBLICATIONS OR IN LOCAL NEWSPAPERS OR MAGAZINE ARTICLES OR LETTERS RELATED TO SCHOOL ACTIVITES PLEASE CHECK BELOW.

☐ YES, I GIVE PERMISSION ☐ NO, I DO NOT GIVE MY PERMISSION

HAS YOUR CHILD RECEIVED SPECIAL EDUCATION/SPECIAL CLASSES WITHIN THE LAST YEAR?
IF YES, CHECK THOSE THAT APPLY:

☐ SPEECH ☐ GIFTED SUPPORT ☐ LEARNING SUPPORT/RESOURSE ROOM ☐ TUTORING

☐ EMOTIONAL SUPPORT ☐ COUNSELING ☐ VISION OR HEARING SUPPORT ☐ OT/PT ☐ OTHER

EMERGENCY INFORMATION

NAME	ADDRESS	PHONE CELL PHONE
NAME	ADDRESS	PHONE CELL PHONE
NAME	ADDRESS	PHONE CELL PHONE
NAME	ADDRESS	PHONE CELL PHONE

ANY CHANGES THAT MAY OCCUR ON THE INFORMATION PROVIDED MUST BE REPORTED TO THE OFFICE AS SOON AS POSSIBLE.

_____ _____

(Signature of Parent/Guardian) (Date)

SHADE CENTRAL CITY SCHOOL DISTRICT

Shade Panthers

HEALTH INFORMATION

NAME OF STUDENT _____ **TEACHER** _____ **GRADE LEVEL** _____

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS OF WHICH WE SHOULD BE AWARE OF SUCH AS:

☐ BEE STING ☐ FOOD ALLERGY ☐ SKIN DISORDER ☐ DIABETES ☐ DIETARY RESTRICTIONS
☐ ASTHMA/RESPITORY ☐ WEAR GLASSES/CONTACTS ☐ ORTHOPEDIC PROBLEMS ☐ HEART CONDITION
☐ BLEEDING DISORDER ☐ ADD/ADHD ☐ ANY SERIOUS ILLNESS, ACCIDENTS, INJURIES ☐ SEIZURE DISORDER
☐ EAR PROBLEMS ☐ URINARY/PROBLEMS/BEDWETTING ☐ BOWEL PROBLEMS
☐ OTHERS _____

(If you checked any above please explain)

_____

Has your child ever been admitted to a hospital or had an operation? YES NO
If yes, please explain: _____

_____

DOES YOUR STUDENT TAKE DAILY MEDICATION AT HOME? ☐ YES ☐ NO
WILL MEDICATION BE NEEDED AT SCHOOL? ☐ YES ☐ NO

NAME OF MEDICATION(S) AND REASON FOR TAKING _____

_____

" By law, if student requires prescription medication at school, a consent form must be completed by the prescribing doctor and parent/legal guardian. These forms are readily available from the school nurse."

FAMILY PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

HOSPITAL OF CHOICE _____ PHONE _____

Students needing over the counter medication during school hours may receive the following medication from the nurse with parent permission. Please check yes or no for each medication listed.

YES	NO		YES	NO	
☐	☐	Tylenol	☐	☐	Alcohol 70%
☐	☐	Cough Drops	☐	☐	Hydrogen Peroxide
☐	☐	Chloraseptic Spray	☐	☐	Bactine
☐	☐	Triple Antibiotic Ointment	☐	☐	Benadryl
☐	☐	Caladryl Lotion	☐	☐	Orajel or Anbesol
☐	☐	Aloe Vera Gel	☐	☐	Salt Water Gargles
☐	☐	Eucerin Moisturizing Lotion	☐	☐	Petroleum Jelly
☐	☐	Clear Eyes or Visine	☐	☐	Sunscreen
☐	☐	Contact Lens Relief (rewetting drops)	☐	☐	Narcan
☐	☐	Hydrocortisone Cream 1%	☐	☐	
☐	☐	Tums, Mylanta, or similar	☐	☐	

☐ My child has no known medication allergies
☐ My child is allergic to _____

Do you give your permission for your child to receive first aid and nursing care for illnesses and accidents?
Please check ☐ YES ☐ NO

_____
(Signature of Parent/Guardian) (Date)

PLEASE ATTACH UPDATED COPY OF IMMUNIZATION RECORD TO THIS FORM

PARENTAL/GUARDIAN SIGNATURES (PLEASE READ CAREFULLY AND SIGN)

I understand that information given to the school nurse is for use in understanding and assisting in the health and education of my child. I understand that the information will be kept confidential and will be shared with other professional or school employees only when it is believed that it is in the best interest of my child's health, safety, and ability to learn.

In case of accident or serious illness the school may make any arrangements deemed necessary if the school is unable to reach the emergency contacts listed.

In the event that the parent/guardian cannot be reached, the individuals listed have authorization to pick up my child. In case of serious accident or illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian(s) are responsible for all expenses.

I give my consent for my child to receive first aid and nursing care for illnesses and accidents.

I hereby authorize the school nurse to obtain/release information regarding immunizations, diagnosis, and treatment of health concerns.

Student's Name: _____ School Year: _____

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN(S) IS RESPONSIBLE TO NOTIFY THE SCHOOL NURSE OF ANY INFORMATION CHANGES ON THIS FORM.