STO·ROX
SCHOOL DISTRICT

Kindergarten Registration Packet

Our Schools & District Offices

Sto-Rox Primary Center (K-3)
300 Ewing Road
McKees Rocks, PA 15136
412-771-3213, ext. 3000

Sto-Rox Upper Elementary (4-6)
298 Ewing Road
McKees Rocks, PA 15136
412-771-3213, ext. 2000

Sto-Rox Jr./Sr. High School (7-12)
& District Administration
1105 Valley St.
McKees Rocks, PA 15136
412-771-3213, ext. 1000

PLEASE REGISTER AT THE DISTRICT ADMINISTRATION OFFICE UNLESS THERE IS A REGISTRATION EVENT.

Registration Contact

Ashley Vojtecky, Central Registrar
avojtecky@srsd.k12.pa.us
Phone: 412-771-3213, ext. 4100

Sto-Rox School District

Registration Checklist

Sto-Rox District Policy states that students MUST be registered by the SECOND WEEK of school.

- ❑ **Proof of Child's Age** (original birth certificate or certified duplicate copy issued from the Commonwealth of Pennsylvania)
- ❑ **Two** Proofs of Residency
  - ☐ **Lease/Mortgage**
  - ☐ **Utility Bill**
  - ☐ **Current Automobile Registration**
  - ☐ **Driver's License**
  - ☐ **Check Stubs from Wages**
  - ☐ **Court-Ordered Custodial Agreement**
- ❑ Student Information Sheet (Page 3-6)
- ❑ Home Language Survey Form (Page 7)
- ❑ ACHD School Immunization Regulations (Page 8)
- ❑ Health Survey (Page 9-10)
- ❑ Request for Transportation-New Student (Page 11)
- ❑ Request for Alternate Transportation for Childcare Purposes (Page 12-13)
- ❑ Request for Records (If Applicable) (Page 14)
- ❑ Act 26 - Parent Certification Statement (Page 15)

STO•ROX
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***Kindergarten: Child must be Five (5) Years old on or before September 1st of the school year**

***1st Grade: Child must be Six (6) years old on or before January 31 of the school year**

STUDENT INFORMATION (Please Print)

Last Name: ______________________________ First Name: __________________________ Middle Name: ________________

Date of Birth: ____________________ Gender: ❑ Male ❑ Female Grade: _______________

Ethnicity/Race:

❑ Asian ❑ Black or African American ❑ White ❑ American Indian or Alaska Native ❑ Hispanic or Latino

❑ Native Hawaiian/Other Pacific Islander ❑ Multiracial (if checking multiracial, please choose at least two ethnicities)

RESIDENCY

- Home Address (House #, Street Name): ____ Apt #: ____________

  City, State, Zip: ____

The following information will be used for messages from the school/district:

- **Primary Phone : ❑ Home ❑ Cell** ____

- **Primary email address (es) :** ____

Child resides with:

❑ Both Parents ❑ Mother only ❑ Mother and Stepfather ❑ Father only ❑ Father and Stepmother ❑ Guardian(s)

❑ Relative(s) ❑ Foster Parent(s) ❑ Student is court emancipated

CONTACT INFORMATION

If the student resides at the home address with one or both parents:

- Mother's Name: ______________________________________ Email Address: ___________________________________

  Address: ____ City: _______________ State: _______ Zip: _________

  Cell Phone: ____ Work Phone: ____________________________________

- Father's Name: ____ Email Address: __________________________________

  Address: ____ City: _______________ State: _______ Zip: _________

  Cell Phone: ____ Work Phone: ____________________________________

If the student resides at the home address with guardian/foster parent:

- Guardian's Name: ______________________________________ Email Address: __________________________________

  Relationship to student: __________________________________ Cell Phone: ____________________________________

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SCHOOL DISTRICT

STUDENT INFORMATION Page 2

In the event that a parent/guardian cannot be reached, please list two emergency contacts and their relationship to your child:

- Emergency Contact Name:_____________________________________ Relationship:_____________________________

  Phone Number: ______________________________________
- Emergency Contact Name: _____________________________________ Relationship: ____________________________

  Phone Number: ______________________________________

PIMS INFORMATION ***The Pennsylvania Information Management System (PIMS) requires that public schools collect and report data pertaining to birth and state/country entry***

Birth Country ___________________ Date Student Entered the US _________________ Birth City/State ____________________

Date child most recently entered PA (if never left PA then enter date of birth): ____

1. If the student was born in the USA, enter the student's birthdate.
2. If you do not know the first date the student entered the USA, use the date the student first attended ANY school in the USA.

Month/year student initially started school: __________ In what state? ________

Is the student's parent/guardian an active duty member of a branch of the armed forces (Army, Navy, Air Force, Marine Corp, Coast Guard) including full time National Guard? ❏ Yes ❏ No

SERVICES

Does or has your child received any of the following services? (check all that apply)

Has a current IEP? ❏ Yes ❏ No Has had an IEP or GIEP in the past? ❏ Yes ❏ No 504/Chapter 15 agreement? ❏ Yes ❏ No

❏ Hearing ❏ Vision ❏ Speech ❏ ESL/ELL Other: ____

SCHOOL INFORMATION

❏ My child has not previously been enrolled in school. ❏ My child has previously attended Sto-Rox.

❏ My child has attended a non- Sto-Rox school.

Previous School Name: ___________________________________ Phone: ___________________________________

Address of school: _______________________________________ Fax: ______________________________________

Grade level at time of attendance: __________________________ Dates Attended:____________________________

STUDENT INFORMATION Page 3

Please list the names and dates of birth of siblings in your household, grades K-12 **(attending either a public or nonpublic school)**

Name	Date of Birth	Grade	School Attending	Male/ Female	Relationship to Student

Please fill out only if applicable: To address the requirements of the McKinney-Vento Act, the following questions will help the district determine if the student meets eligibility criteria for services provided under the Act.
The student lives with (check one): ❑ parent ❑ an adult who is not a parent/legal guardian ❑ no adult/unaccompanied.
Does the family live with friends or relatives for the time being because of economic hardship (check one): ❑ Yes ❑ No
Does the student stay in any of the following at night: In a shelter, in a motel/hotel (check one): ❑ Yes ❑ No In a location not appropriate for regular habitation: (check one): ❑ Yes ❑ No A space that is not fixed/adequate/or regular (check one) : ❑ Yes ❑ No Substandard House (check one): ❑ Yes

- ❑ No

Doubled up with relatives (check one):

- ❑ Yes
- ❑ No

I certify that the information that I have provided for enrollment into the Sto-Rox School District is true and correct.

I understand that I must be a resident living within the boundaries of the Sto-Rox School District to register my child for school and I have provided the Sto-Rox School District with accurate information pertaining to my residency. If the information is incorrect, I fully understand that I am responsible for reimbursing the District the cost of my child's education. The District reserves the right to investigate residencies in question at any time.

____ ________________________

Signature of Parent/Guardian **Date**

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 Department of Education has selected the Home Language Survey as a method for the identification.

School District: Sto-Rox School District

Student Information (Parent/Guardians should complete this section)

Child's first name: ____

Child's last name: ____

Child's Date of Birth: ____________________

Questions for Parents or Guardians

1.What is/was the student's primary language: _____________________

2.Does the student speak a language other than English? (circle one) Yes No

If yes, please specify the language: ________________

3.What language(s) is/are spoken in your home: _______________

4.Please indicate the number of months the student has been enrolled in U.S. schools : _____ months

____ _________________

Signature of Parent/Guardian Date

*The school district 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 has the right to ask for the information it needs to identify English Learners (ELs). As part of the responsibility to locate and identify ELs, the school district 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 in the future.

ALLEGHENY COUNTY HEALTH DEPARTMENT

SCHOOL IMMUNIZATION REGULATIONS

<u>IMPORTANT</u>
*** Immunizations must be completed before entry into the first day of school or risk exclusion from school. There will be no provisional enrollment. ***

<u>ALL GRADES K-12</u>

- 4 doses of Tetanus, Diphtheria and Acellular Pertussis*
  (1 does on or after 4th birthday)
- 4 doses of Polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)
- 2 doses of Measles, Mumps and Rubella*
- 3 doses of Hepatitis B
- 2 doses of Varicella (chicken pox) or written statement from physician/designee indicating month and year of chicken pox illness or serologic proof of immunity

If your child **<u>does not</u>** have the above immunizations, they have **<u>five (5) days</u> to complete the series or get a doctor's letter with the date to be given.** If not given on this date, the child will be excluded until given or a new plan in place.

If they have multiple immunizations to catch up on, this plan will again need to be written by your physician and followed.

Allegheny County Health Department, 425 First Avenue, Pittsburgh, PA 15219, 4th Floor, Hartley- Rose Building (entrance on Cherry Way). Phone: 412-578-8060.

Walk-in immunization services are available at the Allegheny County Health Dept on Monday, Tuesday, Thursday and Friday from 9:00 a.m. - 4:00 p.m. and on Wednesdays 1:00 p.m.-8:00 p.m.

STO·ROX SCHOOL DISTRICT

HEALTH SURVEY

Student's Name: ____ Date of Birth: ________________________ ❑ Male ❑ Female

Phone: ______________________________ Grade: _________ School: _______________

Physician's name: ____________________________________ Phone: _____________________ Date of last exam:_____________

Dentist's name: _____________________________________ Phone: ______________________ Date of last exam:_____________

Part I: Student Health Status (please use back of form if needed)

Health History (complete the checklist by indicating any past or present conditions and explain below**)**

❑ ADD/ ADHD ❑ Depression ❑ Hearing Impairment ❑ Vision (glasses/contacts)

❑ Arthritis/joints ❑ Developmental delays ❑ Heart problems/cardiac ❑ Other: _______________

❑ Asthma ❑ Diabetes (Type 1 or 2) ❑ Nose bleeds _________________________

❑ Autism ❑ Fainting ❑ Physical Limitations _________________________

❑ Birth defects ❑ Digestive Disorder ❑ Premature at birth _________________________

❑ Blood disorder ❑ Epilepsy/Seizure Disorder ❑ Sickle Cell Disorder _________________________

❑ Bowel problems ❑ Gastrointestinal Disorder ❑ Skin Disorder _________________________

❑ Cancer ❑ Headaches/Migraines ❑ Speech Problems _________________________

Are there any special medical conditions or chronic diseases which require restriction of activity, special accommodations (bathroom needs), or which might affect your child's education? If so please explain:____________________________________

____

Allergies ❑ **YES** (indicate below) ❑ No known allergies

	Name/Type	Reactions	Treatment
❑ Medications	______________________	______________________________	________________________
❑ Environmental	______________________	______________________________	________________________
❑ Food	______________________	______________________________	________________________
❑ Insects	______________________	______________________________	________________________
❑ Other	______________________	______________________________	________________________

Part II: Medications (please use the back of the page if needed)

❑ My child has asthma ❑ Mild ❑ Moderate ❑ Severe Inhaler prescribed? ❑ Yes ❑ No
❑ My child has allergies ❑ Mild ❑ Moderate ❑Severe EpiPen prescribed? ❑ Yes ❑ No
❑ My child is diabetic ❑ Insulin dependent ❑Non-insulin dependent
❑ Is glucometer and/or care needed at school? ❑ Yes ❑ No

❑My child has a seizure disorder Describe type and medications taken: ____

Does your child take any prescribed or over the counter medications? ❑ Yes ❑ No

If yes, list medications, dosage, frequency and reason: ____

____

Health Survey Cont. Part III: School Medication Policy

The law which regulates the administration of medication in the school is the same as that applied to hospitals and other institutions. When possible, medications should be administered at home.

Prescription Medication: Written permission from Physician and Parent are required for your child to receive the medication at school. All medications must be in a prescription container labeled by the pharmacy or in the original container labeled by the manufacturer. It is the parent's responsibility to provide refills of the medications throughout the school year. Students are not allowed to carry the medication to school to give to the nurse. An adult would need to bring the medication to the office. (Appropriate form **signed by a doctor MUST be submitted.**)

Over-the-counter Medication: If it is necessary for your child to receive over-the-counter medication (such as Tylenol, Advil, Benadryl) during the school day, the District DOES NOT supply these medications; they must be provided by the parent in the **original** container. (Appropriate form **signed by the parent** must be submitted.)

Asthma Medication (including hand held inhalers): If it is necessary for your child to receive asthma medication during the school day, the District does NOT supply these medications; they must be provided by the physician in the **original** container. . (Appropriate form **signed by a doctor MUST be submitted.**)

All medications must be stored and dispensed from the nurse's office. These same requirements also apply to over-the-counter medications needed during the school year.

Physicals and Dental Exams

Children entering Kindergarten, Grades 6 and 11 are required to have a physical examination.

Children entering Kindergarten, Grades 3 and 7 are required to have a dental examination.

These procedures may be done either by your family doctor and dentist or by the school doctor and dentist, under the school program.

If you prefer to have your doctor or dentist complete these procedures, special forms can be obtained at the school. These procedures must be completed in the summer prior to entering school or during the school year.

However, these procedures will be done at the school if the private physician or dental form is not completed and returned to the school by the time our school physician and dentist are available to us.

If my child needs immediate medical attention and the school is unable to contact the parent/guardian, Emergency Medical Technicians (EMT's) have my permission to take my child to the emergency room of a local hospital for treatment.

I have read the above information and understand my responsibilities.

____ ____________________

Signature of Parent/Guardian Date

STO-ROX SCHOOL DISTRICT
Transportation Department
298 Ewing Road, McKees Rocks, PA 15136
(P) 412-771-3213 ext 5217 (F) 412-771-0238
Email: slarcade@srsd.k12.pa.us

REQUEST FOR TRANSPORTATION-NEW STUDENT

Today's Date: ____________________________

Student Information:

Last Name: ______________________________ First Name: _________________________ Middle Name:__________________

Date of Birth: ____________________________

Home Address: ____ ______________________ ___________ __________
City State Zip Code

School Attending: (Please circle one)

Sto-Rox Primary School **Sto-Rox Upper Elementary** **Sto-Rox Jr.-Sr. High School**

Check what busing you will need: ❏ **AM only** ❏ **PM only** ❏ **Both AM/PM**

Parent Information:

Name of Parent/Guardian 1: _____________________________ Relationship: _______________ Phone: ___________________

Name of Parent/Guardian 2: _____________________________ Relationship: _______________ Phone: ___________________

IN THE EVENT THAT A PARENT/GUARDIAN CANNOT BE REACHED, please list TWO EMERGENCY contacts and their relationship to your child.

Emergency Contact 1: ___________________________________ Relationship:________________ Phone: _________________

Emergency Contact 2: ___________________________________ Relationship: ________________ Phone: _________________

Parent/Guardian Signature: ____ Date: ___________________

FOR DISTRICT ONLY
AM Bus Number_________________
AM Stop Location________________
Pick Up Time: __________________
Transportation Start Date: _________
Notes:____
____

Date For Received by Transportation Office ___________
PM Bus Number: _____________________
PM Bus Location: _____________________
Drop-Off Time: ________________________

Procedures and Conditions for

Request for Alternate Transportation for Childcare Purposes

Request for Alternate Bus Assignment Due to Childcare Arrangements

In order to have students transported to an alternate site for childcare purposes, it is necessary to complete and submit to the school office the **Request for Alternate Bus Assignment Due to Childcare Arrangements** application. This application must be submitted a minimum of one week prior to when transportation is requested to start.

Approval of the request is contingent on the signature and approval of the building principal and the Director of Administrative Services. The request will be granted only if both the principal and Director of Administrative Services agree and if the conditions listed below are followed and agreed to by the parent/guardian.

1. **Same Bus**
   The student must ride the same bus in the morning all five (5) days from the same location. The student must ride the same bus in the afternoon all five (5) days to the same location. Example: A student may be picked up at a childcare provider on Bus 12 in the morning and taken home on Bus 15 from school to home.

2. **Existing Bus Route**
   The location of the childcare provider must be on an existing bus route and, if possible, close to an existing bus stop. There will be rerouting of a bus to accommodate a childcare request.

3. **Space Availability**
   The assignment of a student to an alternate bus is contingent on the space availability. If the bus route requested is full at the time of the request, the request will be denied. The district will not move stops from one bus to another or reroute buses to accommodate a childcare request.

4. **Same Attendance Area**
   A student may not travel outside their attendance area to go to a childcare provider and receive alternate transportation services by the district. Even though some of the buses may cross attendance boundaries, students will not be eligible for alternate transportation if it is outside their assigned attendance area.

5. **Emergency Closings**
   If the child care provider's facility is closed due to emergency or inclement weather, parents are responsible for providing transportation to and from the school. Students may not use their home school assignment in the event of an emergency. If the Childcare Program closes early, parents must pick up their child(ren) at the regular school dismissal time.

6. **Yearly Request**
   The request for alternate transportation must be for the entire school year. If you change a childcare provider during the school year, you must submit another request for consideration. Up to two (2) changes may be made after the initial request. If subsequent requests are denied, parents must transport their child(ren) to school or the child(ren) must ride the transportation provided from their regular bus assignment. The alternate transportation form must be completed at the beginning of each school year.

STO-ROX SCHOOL DISTRICT
Transportation Department
298 Ewing Road, McKees Rocks, PA 15136
(P) 412-771-3213 ext 5217 (F) 412-771-0238
Email: slarcade@srsd.k12.pa.us

Request for Alternate Bus Assignment Due to Childcare Arrangements

Today's Date: ______________________________

Student Information:

Last Name: __________________________ First Name: ______________________ Middle Name:________________

Date of Birth: ______________Home Address: ____

School Attending: (Please circle one)

Sto-Rox Primary School **Sto-Rox Upper Elementary** **Sto-Rox Jr.-Sr. High School**

Name of Parent/Guardian 1: _________________________ Relationship: _____________ Phone: _________________

Name of Parent/Guardian 2: _________________________ Relationship: _____________ Phone: _________________

CHILD CARE INFORMATION for change in Transportation (Must be 5 days a week Monday-Friday)

❏ AM only **❏ PM only** **❏ Both AM/PM** **❏ ADDRESS CHANGE ONLY**

Daycare Provider: ____ Phone: ______________

Daycare Provider's Address:____

I understand and agree that an alternative bus arrangement for childcare purposes depends on (1) the student may not travel outside the school's attendance area; (2) the site of the childcare provider must be on an existing bus route [there will be no rerouting of buses]; (3) the student must ride the alternate bus five (5) days per week; (4) the assignment of students to an alternate bus is contingent on space availability at the time of the request. Further, I agree that if the childcare provider is closed due to inclement weather and/or emergency situations, I am responsible for transportation to and/or from school. Additionally, I have read and understand the procedures listed on the reverse side of this form.

Parent Signature: ____ Date: ________________

FOR DISTRICT ONLY
AM Bus Number_______________
AM Stop Location_______________
Pick Up Time: _________________
Transportation Start Date: _________

Date For Received by Transportation Office __________
PM Bus Number: ___________________
PM Bus Location: ___________________
Drop-Off Time: _____________________

Notes:____
____

Authorization for Release of Information for School Records

Name of Previous School: ____

____
Address City State Zip

Telephone/Fax Number: ____

Student name:_____________________________ DOB:_________ has been enrolled in grade _____________ at Sto-Rox School District.

Please release the information listed below regarding the student has withdrawn from your school:

Administrative records (name, address, grade, birth certificate, etc.)	Academic records/ report cards/ transcripts	Attendance Records
Confidential records including custody papers	Health and Immunization Records	Discipline Records
Standardized test scores	Specialized Education Services records (ER, IEP, GIEP, NOREP, Speech and Language, etc.)	Other (specify):

Send Records to:

Sto-Rox Primary Center (K-3) 300 Ewing Road McKees Rocks, PA 15136 Fax: 412-771-8641 (Attention: Jasmine Smith)	Sto-Rox Upper Elementary (4-6) 298 Ewing Road McKees Rocks, PA 15136 Fax: 412-771-3848 (Attention: Sophie Shuhilo)	Sto-Rox Jr.-Sr. High School (7-12) 1105 Valley Street McKees Rocks, PA 15136 Fax: 412-771-5193 (Attention: Ashley Vojtecky)

____ _______________________
Signature of Parent/Guardian Date

STO-ROX
SCHOOL DISTRICT

Act 26- PARENT CERTIFICATION STATEMENT

Sworn Statement of Previous Suspension or Expulsion for Admission of ______________________________ as a pupil in the Sto-Rox School District.

I/We __________________________, the parent(s)/guardian(s) in control of whom I/We desire to register with and attend classes in the Sto-Rox School District, hereby swear/affirm that the pupil (circle one) **was**/ or **was not** previously suspended or expelled from any public or private school in the Commonwealth of Pennsylvania or any other state for an act or offense involving weapons, alcohol or drugs, or for an offense involving willful infliction of injury to another person or for any act of violence committed on school property.

Complete the following <u>in the event the above-named student was suspended or expelled</u> **for the above reasons:**

The student, ____, was suspended or expelled from (school) ___________________________on (date) ________________. The expulsion/suspension was effective from (dates) _____________ to __________________. The expulsion/suspension was for the following reasons:

____

____

____

I/We fully understand that any false statement herein would be a violation of Act 26 of 1995 and shall be a misdemeanor of the third degree, and would also constitute a violation of the Pennsylvania crimes code, Title 18, consolidated Pennsylvania statues, 18 PA. C.S.A. 4903 and 4904, as amended and could subject me to a fine of up to $2,000.00 or imprisonment for up to 1 year or both.

____ ______________

Signature of Parent/Guardian Date