JOHNSONBURG AREA HIGH SCHOOL

315 HIGH SCHOOL ROAD, JOHNSONBURG, PENNSYLVANIA 15845 • (814) 965-2556 • (814) 965-2776 (F)

MR. RAYMOND KELLY, PRINCIPAL • MRS. KARA VOLLMER, SUPERVISOR OF SPECIAL EDUCATION • MS. RACHELLE KASTNER, SCHOOL COUNSELOR • MRS. GINA SCHREIBER, ATHLETIC DIRECTOR

RELEASE OF INFORMATION

District/Agency: _____

Address: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

_____ _____

Student Name Grade Level

_____ _____

Parent Signature Date

Please send the records to the attention of:

Rachel Wells or Laura Lynch
FAX: (814) 965-2776 or Email:
rwells@johnsonburgasd.net or
llynch@johnsonburgasd.net

Information Requested:

1. Academic Records (grades, transcripts, test results)
2. Personal Records (birth certificate, proof of age, attendance records)
3. Disciplinary Reports
4. Medical Data/Records **(Please FAX immunizations ASAP.)**
5. Psychological Test Results
6. Confidential Reports (IEP/ER)
7. PIMS Data: **PA Secure ID:**_____
   State Entry Date:
   _____
   Grade 9 Entry Date: _____
8. Exchange of Verbal Information (may include PHI*)
   *PHI = Protected Health Information
9. Record of Extracurricular Activities/PIAA Physical
10. Other relative school info: _____

*Parental permission is no longer required when records are requested by authorized school personnel. Family Educational Rights and Privacy Act (34 CFR § 99.31).

THE JOHNSONBURG AREA SCHOOL DISTRICT IS AN EQUAL RIGHTS AND OPPORTUNITIES DISTRICT. FOR MORE INFORMATION REGARDING CIVIL RIGHTS OR GRIEVANCE PROCEDURES CONTACT THE EOE/ADA DIRECTOR OF THE JOHNSONBURG AREA SCHOOL DISTRICT.

Johnsonburg Area High School Registration Form

Please print.

Student Last Name _____ First _____ Middle Name _____

Street/Mailing Address (include apartment information) _____

City _____ State _____ Zip _____

Sex _____ Birth Date ____/____/____ Birth City and State _____ Grade _____

Cell Phone _____ Home Phone _____

Ethnic Group:
Is the student Hispanic/Latino: Yes No
Even if you answered yes to above, please continue on below:
Check all that apply:

- ☐ Am. Indian/Alaskan Native
- ☐ White
- ☐ Black/African Am.
- ☐ Asian
- ☐ Hispanic
- ☐ Native Hawaiian/other Pacific Islander

Health Information (Check all that apply):

- ☐ Asthma
- ☐ Bee Sting Allergy
- ☐ Diabetes
- ☐ Hearing Problem
- ☐ Seizures
- ☐ Wears Glasses

Takes medicine regularly (list): _____

Mental Health Diagnosis: _____

Other health or personal problems: _____

Previous Schools and Grade Level:

1. _____ School Name _____ City _____ State _____ Grade(s) _____
2. _____ School Name _____ City _____ State _____ Grade(s) _____
3. _____ School Name _____ City _____ State _____ Grade(s) _____
4. _____ School Name _____ City _____ State _____ Grade(s) _____

Has the child been retained? (circle) Yes No
If Yes, which grade (circle): K 1 2 3 4 5 6 7 8 9 10 11 12

Was this student ever enrolled in an out-of-state school? (circle) Yes No
If Yes, which grade and/or dates? _____

Has this student ever attended Johnsonburg Area S.D.? (circle) Yes No
If Yes, When? _____

Has the student ever attended school outside the United States? (circle) Yes No
If Yes, how long? _____

Parent or Guardian Information

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Step_____ ☐ Guardian ☐ Other_____

Any Custodial Restrictions? ☐ Yes ☐ No

If Yes, please explain: ☐ Affidavit ☐ Custody Papers ☐ Foster Child

_____

_____

*If yes, please furnish a copy of the custody papers to the school principal.

If child was placed in your custody by an agency, please give name & address of agency:

_____

_____

_____

Support Services/Special Education (Check ALL that apply)

- ☐ Instructional Support (IST)
- ☐ Assistance Programs (SAP)
- ☐ Title I Reading
- ☐ Title I Math
- ☐ Adapted Physical Education
- ☐ Deaf/Hearing Support
- ☐ Physical Support
- ☐ Learning Support
- ☐ Speech/Language Support
- ☐ Gifted Support
- ☐ Emotional Support
- ☐ Behavior Support
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Vision Support
- ☐ Life Skills Support
- ☐ Autistic Support
- ☐ Other:_____

_____

Father or other Guardian

Name (Last, First) Mr., Mrs., Ms., Miss, Dr. | Address (if different from student) | Relationship to student:

Employer | Home Phone | Work Phone | Cell Phone | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Mother or other Guardian

Name (Last, First) Mr., Mrs., Ms., Miss, Dr. | Address (if different from student) | Relationship to student:

Employer | Home Phone | Work Phone | Cell Phone | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Parent/Guardian Signature: _____ Date _____

Other Household members: (include all adults and children in house)

Female:

Last	First	Birth date	Relationship

Male:

Last	First	Birth date	Relationship

Office Use Only

Student ID# _____
Entry Date _____
Grade _____
Homeroom _____
Locker _____
Entry Code _____

Documents that have been secured:
Birth Certificate _____
Immunizations _____
Court Documents (custody Issue) _____

Birth Certificate #/Baptismal:

JOHNSONBURG AREA HIGH SCHOOL

315 High School Road
Johnsonburg, PA 15845
(814) 965-2556

**Please make any corrections, updates, and/or changes on the back of this form. **

- ☐ Corrections made
- ☐ No changes

STUDENT CONTACT INFORMATION

STUDENTS FULL NAME	GENDER	DATE OF BIRTH	SCHOOL

GUARDIAN INFORMATION

FULL NAME	GENDER	EMAIL	PHONE TYPE	PHONE NUMBER

MOTHER'S/GUARDIAN'S HOME ADDRESS	FATHER'S/GUARDIAN'S HOME ADDRESS
MOTHER'S/GUARDIAN'S MAILING ADDRESS	**FATHER'S/GUARDIAN'S MAILING ADDRESS**

Parent/Guardian Information:
Child Lives with:

- ☐ Both Parents
- ☐ Natural Mother
- ☐ Natural Father
- ☐ Legal Guardians
- ☐ Homeless

Any Custodial Restrictions? If yes, please explain:

_____

_____

If you have not already done so, please provide the school staff with a copy of court order or legal document regarding custody of your child.

EMERGENCY CONTACTS

Please provide a relative, friend, or neighbor we may contact in your absence for advice or directions in caring for your child in case of illness, accident, or emergency. **PLEASE DO NOT LIST A PARENT.**

NAME	GENDER	RELATIONSHIP	PHONE TYPE	PHONE NUMBER

Parent/Guardian signature: _____ Date: _____

Student Name:_____ Grade: _____ Homeroom: _____ Date of Birth: _____

Johnsonburg Area School District Information and Authorization—School Health Services

*The following information must be updated annually in order for school health service providers to administer effective medical attention to your student. Information provided on this form may also be shared for educational purposes, school related activities, and school sponsored outings. *If this form is not completed and returned in a timely manner, no medical services can be provided to your student.

Name of parent/guardian with whom student resides: Custodial Restrictions? (circle one) Yes / No				
Parent/Guardian	Home Phone Number	Cell Phone Number	Employer	Work Phone Number

Please list medical conditions, mental/emotional conditions, physical limitations, and recent surgeries: **OR** ☐ No known medical problems

_____

_____

Did your child sustain any type of head injury over the past year? Yes / No If yes, please give date and event history:_____

_____

Does your child have a **severe allergy**? Yes / No If yes, please specify: _____

Reaction:_____

Needs Epi-Pen at school? Yes / No (Requires a physician order and written parental consent)

Does your child have asthma? Yes / No Typical symptoms:_____

Needs an inhaler at school? Yes / No (Requires a physician order and written parental consent)

Does your child have seizures? Yes / No

Needs emergency medication at school? Yes / No (Requires a physician order and written parental consent)

Name of emergency medication:_____

Reminder: ALL medications will require a physician order and written parental consent, including but not limited to: epi-pens, asthma inhaler, insulin, seizure medications, etc.

Immunizations received this year and date (please provide copy for your child's record):_____

(PLEASE COMPLETE BOTH SIDES)

Student Name:_____ Grade:_____ Homeroom:_____

Please list ALL current medications your child is taking, including medications given at home prescription, OTC, herbs, supplements, etc.) Please write name, dose, time, frequency, and route. Will any medication need to be given at school? Yes / No

_____

_____

_____

Please list other persons we may call for advice or direction in case of serious accident, illness, or disaster warning, in the event we are unable to contact parent/guardian.

Name	Relationship to Student	Home phone	Cell phone	Employer	Work Number

In case of extreme emergency, if the school is unable to contact any of the above persons, your child will be transported to the nearest hospital and I will assume all expenses. I also give permission to make information on this form available to authorized school and transportation personnel. Parent/Guardian signature: _____

I give permission for JASD School Nurses to contact my student's health care providers listed below for any health information regarding medical conditions, immunizations, physical and dental examinations. Parent/Guardian Signature: _____

Please list your student's family physician and dentist.

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____ Phone: _____

Parental permission to give medication: Please initial after EACH individual medication that you authorize school personnel to administer to your student. Medications without an initial will not be administered with the exception of Epinephrine (for suspected life threatening allergic reactions and Narcan (high school only) for suspected drug overdose. Contact the nurse if you wish to opt-out of Epinephrine or Narcan.

Medication	Initial	Medication	Initial	Medication	Initial
Non-aspirin pain reliever/fever reducer (Tylenol-like product)		Throat lozenges, cough drops, or salt water gargle (sore throat or cough)		Gelusil or Tums (upset stomach)	
Caladryl, Calamine, or Neosporin (skin irritations)		Benadryl		Silvadene Cream or First Aid cream (minor burns)	
Orajel					

Signature of Parent/Guardian: _____ Date: _____

Grade 7-12 Health History Form
Johnsonburg Area High School

Date: _____

General Information:

(Print) Last Name: _____ First_____ Middle _____

Sex: ☐ Male ☐ Female

Parent/Guardian Name: _____

Health Care Provider: _____ Phone: _____

Person to notify in case of emergency:

Name: _____

Address: _____

Phone: (home/work) _____

Health History: (check those that apply)

Diseases

____ Chickenpox
____ Measles
____ Mumps
____ Rubella
____ Meningitis
____ Tuberculosis (tb)
____ Lymes

Allergies

____ animals*
____ food*
____ insect stings*
____ medicine/drugs*
____ environment*
____ other*

Chronic/Recurring Illness

____ Headaches
____ Heart defect/disease
____ Seizures
____ Asthma/lung disease
____ Diabetes
____ Anemia/bleeding disorders
____ Back/joint problems
____ Ulcer/colitis
____ Hepatitis/infectious disease
____ Bladder/kidney problems
____ Other _____

Impairments

____ Speech
____ Hearing
____ Sight
____ Other

Does child have an epi-pen ordered for severe allergic reaction? ☐ Yes ☐ No

Please use the space below to provide any important information about any of the above conditions.

_____
_____
_____
_____
_____

Johnsonburg Area School District

315 High School Road
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814-965-2556 • FAX 814-965-2776

Home Language Survey

The office of Civil Rights (OCR) requires that school districts/charter schools/full days 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: Johnsonburg Area **Date:** _____

School: High 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?**
   (Do not include languages learned in school)
   ☐ **Yes** ☐ **No**

   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 AVYS 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.**

JOHNSONBURG AREA SCHOOL DISTRICT AFFIDAVIT

SWORN STATEMENT BY RESIDENT UNDER §13-1302

TO BE COMPLETED BY RESIDENT ONLY

Instructions: Please complete the following statement. If the potential student is living, or will be living, in a household with more than one resident adult who will assume responsibility for the student, all such adult residents ·must complete and sign this statement.

This is a legal document. You may ask to see a copy of 24 P.S. §13-1302 prior to signing this document and consult with an attorney if you have any questions or do not understand any portion of this document.

1. Your Name _____
   Home Address _____
   Home Telephone Number _____ Work Number _____

2. Do you live in the school district and does the child live with you? Yes _____ No _____

3. Child's Full Name _____
   Birth Date _____ Grade _____
   Name & Address of Last School Attended _____
   _____
   Date child began/will begin to reside in your home _____

4. Are you supporting this child gratis (without personal compensation or gain)?
   Yes _____ No _____

5. Will you assume all personal obligations related to school requirements for this child that may include providing for required immunizations, uniforms, fees/fines, citations/fines for truancy, attending parent-teacher conferences, or attending meetings/hearings concerning discipline?
   Yes _____ No _____

6. Do you intend to keep and support the child continuously and not merely through the school term?
   Yes _____ No _____

Through my notarized signature, I/We understand that the school district, pursuant to guidelines issued by the Department of Education and their own written policy, may require other reasonable information to be submitted to confirm this sworn statement.

Signed by resident(s) and notarized _____

STOP - DO NOT SIGN THIS FORM
Please call the District Office to schedule a time to have this form notarized before signature.
Call: 814-965-2536

Taken, sworn and subscribed Before me, this _____ day of _____ 20 _____ SEAL

Per 24 P.S. § 13-1302, a person who knowingly provides false information in the above statement for the purpose of enrolling a child in a school district for which the child is not eligible commits a summary offense and shall, upon conviction for such violation, be sentenced to pay a fine of no more than three hundred dollars ($300) for the benefit of the school district in which the person resides or to perform up to two hundred forty (240) hours of community service, or both. In addition, the person shall pay all court costs and shall be liable to the school district for an amount equal to the cost of tuition calculated in accordance with §2561 during the period of enrollment.

JOHNSONBURG AREA SCHOOL DISTRICT

315 HIGH SCHOOL ROAD, JOHNSONBURG, PENNSYLVANIA 15845 • (814) 965-2536 • (814) 965-5809 (F)

MS. KAREN HABERBERGER

SUPERINTENDENT

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

Telephone Number _____

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an action of offense involving a weapon, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child was_____ was not _____ previously suspended or expelled , or is _____ is not _____ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief..

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

_____

Dates of suspension or expulsion:

_____

(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) _____

I_____ the undersigned Notary Public, state that the person whose signature appears on this document appeared before me and signed this document This____day of _____, 20____.

_____
Parent/Guardian Signature

_____
Date

STOP - DO NOT SIGN THIS FORM Please call the District Office to schedule a time to have this form notarized before signature. Call: 814-965-2536

Any willful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

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