West Greene School District
Enrollment Checklist

Please check each box once form is completed and sign and the bottom of form.

- ☐ Parental Registration Statement
- ☐ Birth Certificate
- ☐ Proof of Residency
- ☐ Request for Records
- ☐ Policy Review Agreement
- ☐ Student Registration Form
- ☐ Request for Administration of Medication
- ☐ Request for Self-Administration of Medication
- ☐ Transportation Request Form
- ☐ Home Language Survey
- ☐ Student Residency Questionnaire
- ☐ Notification/Permission Form
- ☐ Emergency Card Information
- ☐ Free/Reduced Lunch Application

_____ _____

Parent/Guardian Signature Date

West Greene School District
Parental Registration Statement

Student Name: _____

Date of Birth: _____/_____/_____

Parent/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 of 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 or offense involving weapons, alcohol or drugs, of for the willful infliction of injury to another person or for any act of violence committed on the 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 the school from which the 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:

_____

West Greene School District
Record Release Form

Previous School District: _____

School District Information: _____
(Address)

_____
(Phone Number) (Fax Number)

Send Records to:

___ West Greene Elementary Center
1350 Hargus Creek Road
Waynesburg, PA 15370
Ph: (724)499-5183 Fax: (724)499-5085

___ West Greene Middle-Senior High
1352 Hargus Creek Road
Waynesburg, PA 15370
Ph: (724)499-5183 Fax: (724)499-5492

Records Requested for:

Student:_____ Birthdate: _____ Grade:_____

Student:_____ Birthdate: _____ Grade:_____

Student:_____ Birthdate: _____ Grade:_____

Student:_____ Birthdate: _____ Grade:_____

Please send **ALL** of the following school records:

PA Secure ID _____ Grade 9 Entry Date _____ (if applicable)

_____ Transcript

_____ Academic Test Results

_____ Psychiatric Evaluation

_____ Discipline Record

_____ Health and Dental Records

_____ Attendance Records

_____ Psychological Testing

_____ IEP, ER (CER), NOREP (NORA)

_____ Other

Parent/Guardian authorization is given for the transfer of all my child's records to West Greene School District.

_____
(Parent/Guardian Signature)

West Greene School District
Policy Review Checklist

Please review all district policies including those listed here:

- ☐ **Policy 204**
- ☐ **Policy 209**
- ☐ **Policy 221**
- ☐ **Policy 237**
- ☐ **Policy 249**
- ☐ **Policy 815**

All other policies can be found on the district website.

Parent/Guardian Signature

Date

West Greene Elementary Center (K-6) _____

West Greene Middle School (7-8) _____

West Greene High School (9-12) _____

PA SECURE ID _____

GRADE 9 ENTRY DATE _____

DOES CHILD HAVE AN: IEP, GIEP, 504, ESL

STUDENT NUMBER_____

West Greene School District
Student Registration Form

DATE ENTERED: _____/_____/_____ NAME: _____
(last name) (first name) (m)

Place of Birth: _____ Date of Birth: _____/_____/_____ Sex: ( ) M ( ) F

Grade Currently Enrolled:_____ Homeroom Teacher and Number: _____

Please Check One: ___ Am. Indian ___Asian ___Black ___Native Hawaiian ___White ___ Hispanic ___ Multi Racial

HAVE YOU EVER ATTENDED SCHOOL IN THE WGSD? Y ( ) N ( ) SCHOOL:_____

Name of Former School: _____

Address of Former School:_____
(street) (city) (state) (zip)

How long if less than a year?_____ School Attended:_____

Living with: Mother_____ Father_____ Both_____ Guardian_____ Foster_____ Other_____

Father's Name_____ Employer_____Ph:____/____-_____

Step Mother_____ Employer_____Ph:____/____-_____

Mother's Name_____ Employer_____Ph:____/____-_____

Step Father_____ Employer_____Ph:____/____-_____

Present Address:_____
(street) (city) (state) (zip)

Phone: _____/_____-_____ Cell: _____/_____-_____ Alt. Ph.: : _____/_____-_____

Person you are living with (if other than Parents):_____

Please list any other children living in the household age birth to 18:_____ _____

Verification of Residency:
___Copy of dated rent receipt, if applicable
___Copy of current utility bill listing date and address
___Copy of current paid tax receipt

___Other, please identify_____

ADMISSION APPROVED BY: _____

West Greene School District
REQUEST FOR ADMINISTRATION OF MEDICATION

Dear Doctor:

The parents have requested that the school supervise the administration of prescribed medication to their child during the school day. It is the policy of the West Greene School District to request that prescribed medication be given before or after school hours whenever possible. Any medication which has not been prescribed by the physician, regardless of whether it may be purchased over-the-counter will **not** be administered by the West Greene School District.

If it is essential that the student receive the medication during school hours, please complete the following information and sign this form. Attach additional sheets if necessary. Thank you for you cooperation.

Sincerely,

_____
School Nurse Signature

Student Name_____ DOB ____/____/____
Parent/Guardian Name _____
Diagnosis_____

Name of Medication_____Dosage_____
How to be Administered_____

Time Schedule for Administration_____
Duration of Medication Administration_____
Can the Student Self-Administer this Medication ( ) Yes ( ) No

Possible Side Effects or Contraindications_____

Any Curtailment of School Activities_____
Other medication prescribed by physician that student is taking outside of school hours_____

Other medication prescribed for student, of which physician is aware_____

Please include a brief statement as to how this medication has to be administered while the student is in school:
_____
_____

Physician Signature_____ Date_____

Physician Phone Number____/____-_____
Physician Address_____
_____

West Greene School District

PARENT REQUEST & AUTHORIZATION FOR THE ADMINISTERING AND/OR SUPERVISION OF THE SELF-ADMINISTRATION OF MEDICATION

I (We), the parent(s) of the student listed below, hereby request and authorize the West Greene School District to administer and/or supervise the self-administration of the medication listed below. I (We) have included with this Parental Consent Form, the Physician's signed Request and Authorization Form. No medication will be administered to any student unless both forms are received by the School District.

Student Name_____ Age_____Date of Birth_____

Mother's Full Name_____

Address_____

Home Phone Number_____ Work Phone Number _____ex._____

Father's Full Name_____

Address_____

Home Phone Number_____ Work Phone Number _____ex._____
Name of Medication being prescribed_____ Dosage_____

How to be administered_____

Time Schedule for administration_____ Duration of medication administration_____

Name of Physician prescribing medicine _____Physician Phone_____

Names of other Physicians or Health Care Practitioners providing treatment to your child_____

Other medication prescribed or suggested for use by your child_____

Other medication currently taken by your child, whether prescription or non-prescription medication, and regardless of when and where taken._____

I (We) acknowledge that the individual responsible for administration, or supervision of self-administration, of medication for my child may not, in accordance with the terms of this Policy, in every instance be the school nurse.

I (We) acknowledge that in complying with this Request for Authorization for Administration of Medication, and in accordance with the current physician's order, I (we) are releasing and indemnifying the School District, its officers, agents and employees, from any and all liability resulting from administration of the medication, or supervision of my child's self-administration of the medication, PROVIDED, HOWEVER, that the parent(s) of a "protected handicapped student" as that term is defined within the Pennsylvania Department Regulations found at 22 PA Code Chapter 15, shall not be required to acknowledge or execute such a Release or Indemnification Agreement..

Parent(s) Signature_____ Date_____

West Greene School District
Transportation Request Form

It is necessary for the following information be completed for transportation to begin.

Name of Student_____Date_____
Student ID No._____ Homeroom No._____
Date of Birth_____ Age_____ Grade_____

Parent/Guardian_____
Street Address_____
City_____ State_____ Zip_____
Phone Numbers: Home _____Cell _____
Work _____ ex. _____

Emergency Contact_____
Street Address_____
City_____ State _____Zip_____
Phone Numbers: Home _____Cell _____
Work _____ ex. _____

Physical location of student pickup:
_____

Pickup to begin: (date) _____

Please fax completed form to:

Pioneer Garage
(724) 499-5011 Fax
(724) 499-5004 Phone

School District Use Only

Faxed to Bus Garage _____

Transportation Contractor Use Only

Bus Contractor Authorization_____

Information Needed by School from Transportation Contractor

Student's Bus # **Driver** **Student Pick Up Time:** **am**

West Greene School District
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 has selected the Home Language Survey as the method for the identification.

School:_____**Date:**_____

Student's Name: _____**Grade:**_____

Sex: ( ) M ( ) F **Home Phone:**_____

1. **What is/was the student's first language?** _____
   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): _____
2. **What language(s) is/are spoken in your home?** _____

3. **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 AVTS 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.

West Greene School District
Student Residency Questionnaire

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name: _____ Birth Date: _____

   Person completing form: _____Relationship to child: _____

2. In what type of setting is the student living now? Check one box below:

SECTION A	SECTION B
☐ In an emergency or transitional shelter ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations ☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings ☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings CONTINUE to Question 3 if you checked any box in SECTION A	☐ None of the choices in Section A apply.  If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.

3. Contact number for person completing the form: _____

   Address where student is now living: _____

4. The student lives with:
   Check all that apply
   - ☐ Parent(s) or legal guardian
   - ☐ Relative, friend(s), or other adult(s)
   - ☐ Alone
   - ☐ Other: _____

5. Name Adress and phone number of school last attended: _____

   _____

6. Does the student have an IEP or a Chapter 15/504 agreement?
   - ☐ NO
   - ☐ YES. Please explain: _____

   Signature of Parent/Legal Guardian: _____Date: _____

West Greene School District

Notification/Permission Form

Dear Parents/Guardians:

During the school year, students are often involved in activities that go beyond the classroom and the usual day-to-day instructional process. Please review the activities listed below. Sign this form at the bottom and return it as requested. Indicate any area of concern by signing the specific area(s). Please realize that this list may not include all activities that may arise during the year. If you have any other areas of concern, please contact your child's principal.

Student's Name	**Grade**	**Date**

PERMISSION TO PARTICIPATE IN THESE ACTIVITIES/EVENTS

Academic group testing per State and Local regulations/practices.

☐ I do not give permission _____

Participation in educational research studies (with student anonymity) as approved by school officials.

☐ I do not give permission _____

Individual/Group Pictures in Yearbooks and other school publications, including videos.

☐ I do not give permission _____

School Academic/Activity photographs in news articles for newspapers.

☐ I do not give permission _____

Included in general interest/news television reports.

☐ I do not give permission _____

Events/Parties, which relate to cultural observances such as Thanksgiving, holidays, cultural awareness months, etc.

☐ I do not give permission _____

Access to Internet within school-use guidelines.

☐ I do not give permission _____

Participation in Fund Raising Activities:

☐ I do not give permission _____

Educational field trip sponsored by the school district supervised by the teacher(s) with prior notification of date, destination, and anticipated return.

☐ I do not give permission _____

Medical condition sponsors should be aware of: _____

Other:_____

PLEASE SIGN AND RETURN _____ _____

PARENT/GUARDIAN SIGNATURE DATE

West Greene School District

Student Emergency Record Card

Name: _____ Date of Birth: ____/____/_____
(Last) (First)

Student # _____ Grade:_____ Building: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Father: _____ Work Phone: _____

Mother: _____ Work Phone: _____

Student lives with: Mother Father Both

Email Address:_____

When neither parent can be contacted, please contact the following:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Relationship to student _____ Relationship to student _____

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN: If neither parent can be contacted in case of serious illness or injury, I hereby authorize representatives of the WEST GREENE SCHOOL DISTRICT to act as my agent to secure emergency medical treatment for _____, a minor child for whom I am responsible, at WASHINGTON HOSPITAL OF GREENE COUNTY (or nearest hospital) when in the opinion of the school representatives such emergency medical treatment is deemed appropriate during the time when the student is attending, going to, or leaving school, I hereby agree to hold the WEST GREENE SCHOOL DISTRICT and its representatives harmless for exercising its judgment and authorize them to sign any required emergency hospital treatment forms on my behalf. I also agree to assume responsibility for any charges incurred as a result of such treatment.

Name any special health problem (s):

_____

List any medications to which the above named child is allergic:

_____

Name of family physician: _____Phone: _____

Parent/Guardian Signature: _____ Date: _____