New Student Registration Checklist

The following will need to be brought in upon registering your student:

- ☐ Birth Certificate of student
- ☐ Proof of Residency (two of the following):
  - Valid PA Driver's License
  - Current Lease/Copy of Deed/Mortgage
  - Statement/Current Tax Bill/Copy of Closing
  - Utilities Bill/Cell Phone Bill/Bank Statement
- ☐ Immunization Record of student
- ☐ Court Order/Custody Agreement (if applicable)
- ☐ Parent Photo ID

The following documents will need to be filled out and returned upon registering your student:

- ☐ Registration Form
- ☐ Parental Registration Statement
- ☐ Authorization to Release Student Records Form
- ☐ Student Residency Questionnaire
- ☐ Physical Exam Form
- ☐ Dental Exam Form
- ☐ Mandated School Health Records
- ☐ Home Language Survey
- ☐ Household Income Form
- ☐ Emergency Dismissal Form
- ☐ Emergency Card
- ☐ Transportation Form
- ☐ Parent Signature Form

Union City Area School District
Registration Form

Student Demographic Information:

Student ID:_____

Date of Registration/District Entry: _____ Grade Going Into: _____

Student's Full Name: _____

Full Address: _____

Home Phone Number: _____ Date of Birth: _____ Place of Birth: _____

Gender: ☐ MALE ☐ FEMALE Ethnicity: Is the student Hispanic or Latino? ☐ NO ☐ YES

Race: ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian

Family Doctor: _____ Phone Number: _____

Academic Information:

Does the student have a current IEP: ☐ NO ☐ YES If yes, circle one: Learning Support / Life Skill / Speech

Is student on a 504 Plan: ☐ NO ☐ YES

Is student enrolled in a gifted program: ☐ NO ☐ YES

Last School Attended: _____ Last Grade Completed: _____

Has the student repeated a grade or failed courses: ☐ NO ☐ YES
If yes, what grade or courses: _____

Has the student been suspended or expelled: ☐ NO ☐ YES
If yes, what is the reason and date: _____

Parent/Guardian Information:

Student lives with: _____ MOTHER _____ FATHER ____OTHER

Is there a court order or custody agreement: ☐ NO ☐ YES

Name of Father: _____ Date of Birth: _____

Employer & Occupation: _____ Work Number: _____

Cell Phone Number: _____ Email Address: _____

Name of Mother: _____ Date of Birth: _____

Employer & Occupation: _____ Work Number: _____

Cell Phone Number: _____ Email Address: _____

Guardian/Custodial Parent: _____ Date of Birth: _____

Employer & Occupation: _____ Work Number: _____

Cell Phone Number: _____ Email Address: _____

Other Residents (list all occupants residing at residence):

Full Name	Date of Birth	Gender	Relationship	School Attending	Grade
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Emergency Contact Information:

Name: _____ **Relationship to Student:** _____

Phone Number: _____ **Phone Number:** _____

Name: _____ **Relationship to Student:** _____

Phone Number: _____ **Phone Number:** _____

Name: _____ **Relationship to Student:** _____

Phone Number: _____ **Phone Number:** _____

Union City Area School District

www.ucasd.org

107 Concord Street
Union City, Pennsylvania 16438

(814) 438-3804
Fax: (814) 438-2030

PARENTAL REGISTRATION STATEMENT

Student Name: _____

Date of Birth: _____ Grade: _____

Address: _____

Parent or Guardian Name: _____

Telephone Number: _____

Is this student currently on probation? ☐ YES or ☐ NO

If yes, please list county and state probation department: _____

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 I am the parent/guardian, or other person having lawful charge of the above-named student, and that he/she is a lawful resident of the Union City Area School District. I also swear or affirm that my child:

Was ☐ /was not ☐ ***previously*** suspended; or, was ☐ /was not ☐ ***previously*** expelled

Is ☐ /is not ☐ ***presently*** suspended; or, is ☐ /is not ☐ ***presently*** 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 or is suspended/expelled: _____

Date(s) of suspension: _____ Date(s) of expulsion: _____

Reason for suspension/expulsion:

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

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

Updated 9/2018

Union City Area School District

www.ucasd.org

107 Concord Street
Union City, Pennsylvania 16438

(814) 438-3804
Fax: (814) 438-2030

Authorization to Release Student Records Form

Student Name: _____

Date of Birth: _____

Previous School: _____

School Telephone: _____

Grade: _____

PIMS Requirement: Please provide original state entry date:_____

We have registered the above named student at Union City Area School District. Please release all educational records including:

- **Academic records including any career ready evidence**
- **Discipline records**
- **Standardized test scores**
- **Birth certificate**
- **Health and immunization records**
- **Special education records**
- **An interpretation of your school's marking system**
- **Any other information which may better help us understand this student**

Please fax K-5th **814-438-1085** or 6th-12th **814-438-8463** or mail the records to the address listed below:

Union City Area MS/HS
105 Concord St
Union City, PA 16438
Attn: Guidance Office

OR

Union City Area Elementary School
91 Miles St
Union City, PA 16438
Attn: Guidance Office

DISCLOSURE OF PUPIL'S RECORDS: FEDERAL LAW 99.31 "NO PARENT SIGNATURE REQUIRED FOR EDUCATION RECORDS SENT TO ANOTHER EDUCATIONAL AGENCY."

Thank you for your attention to this request.

Sincerely,

Deanne Carr
Administrative Assistant

Parent/Guardian Signature: _____ Date: _____

Union City Area School District

107 Concord Street
Union City, Pennsylvania 16438

www.ucasd.org **(814) 438-3804**

Student Residency Questionnaire

Dear Parent or Guardian,

The McKinney-Vento Act, as amended by the No Child Left Behind Act of 2001, defines homelessness and outlines the rights of homeless students. Your response to the following questions will help our staff determine what residency documents are necessary for enrollment of your child(ren).

Student name: _____ Birth date: _____

Person completing this form: _____

Relationship to child: _____

Check the box that applies

_____	In an emergency or transitional shelter
_____	In a park, public space, abandoned building, substandard housing, or similar building
_____	In a motel, hotel, campsite, or car due to lack of alternative accommodations
_____	Sharing housing due to loss of housing, economic hardship, or similar reason
_____	Other places not designed for, or ordinarily used as a regular sleeping accommodation for a person
_____	None of these apply

Contact number for person completing this form: _____

Address where student is currently living: _____

_____

The student lives with:
(check all that apply)

- ☐ Parent(s) or legal guardian
- ☐ Relative
- ☐ Friends or other adult(s)
- ☐ Alone
- ☐ Other: _____

School student attended last: _____

Address of school: _____

Telephone number of school: _____

Contact person at the school: _____

Does the student have an IEP or a Chapter 15/504 agreement?

- ☐ No
- ☐ Yes, please explain: _____

The staff person assisting you with registration will contact the homelessness coordinator to review the information provided. If homelessness is verified, additional information will be needed to complete enrollment.

Signature of Parent/Legal Guardian: _____ Date: _____

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

_____
No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

NOTICE OF MANDATED SCHOOL HEALTH SERVICES

Dear Parent/Guardian:

The health of children is very important if they are to succeed in school. Therefore, to safeguard children in our district, we begin preventative examinations when the child enters school. The State of Pennsylvania, in cooperation with the school nurse and local doctors and dentists, will provide the following tests at various intervals throughout their school years.

1.	Vision Screening	Every grade, PK - 12
2.	Hearing Screening	Grades PK, K, 1, 2, 3, 7, 11
3.	Physical Exam	Grades PK/K (upon entry), 6, 11
4.	Scoliosis Screening	Grades 6, 7
5.	Height and Weight	Every grade, PK - 12
6.	Dental Exam	Grades PK/K (upon entry), 3, 7

Referrals will be made when standard normal results are not met.

Please Note:

Every child of school age attending or who should be attending a public or non-public school within the Commonwealth must receive the above listed services provided by the local public school district. The local school district is reimbursed by the Pennsylvania Department of Health for mandated services provided to children in public and non-public schools.

If permission is NOT granted for the above Pennsylvania State Mandated testing, the parent/guardian is responsible for scheduling these tests with the appropriate caregiver. **Additionally, the tests must then be provided to the school nurse for the student's health record.**

Please give permission for your child to receive these screening tests by signing this form below. This form will be placed in the student's permanent health record. It will remain in effect from Pre-K through Grade 12. You can indicate your preference for private physical or dental exams on the student's Emergency Information card each year.

I have read the notice of Mandated School Health Services and understand that my child

_____ (student name) will receive these mandated health services if not completed by a private dentist/physician.

Parent/Guardian Signature _____ Date _____

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

Household Income Data Collection – Union City Area School District

Household Last Name: _____ Phone: _____ E-mail: _____

PART I: Fill in the following information for children living in your household

1.					
2.					
3.					
4.					
5.					
6.					

PART II: Fill in the following for Household Size and Household Income

Based on your household size, check the appropriate box if your total annual household income is within the range displayed for Category 1 or Category 2. **Do not check an income in both categories.**

For help in determining your household size and total annual household income, please see instructions on the back of this form.

Household Size	Total Annual Household Income Is Within This Range	Total Annual Household Income Is Within This Range
1	☐ $0-$15,782	☐ $15,783-$22,459
2	☐ $0-$21,398	☐ $21,399-$30,451
3	☐ $0-$27,014	☐ $27,015-$38,443
4	☐ $0-$32,630	☐ $32,631-$46,435
5	☐ $0-$38,246	☐ $38,247-$54,427
6	☐ $0-$43,862	☐ $44,863-$62,419
7	☐ $0-$49,478	☐ $49,479-$70,411
8	☐ $0-$55,094	☐ $55,095-$78,403

If household size is greater than 8, list household size and total annual income below:

Household Size:_____ Total Annual Income: $_____

If your total annual household income exceeds the ranges above, check here: ☐

PART III: Signature

I certify (promise) that the information provided on this form is true and that I included all income. I understand that the school may receive state and federal funds based on the information I provide and that the information could be subject to review.

_____ _____ _____

Parent or Guardian Signature Date Print Name of Parent or Guardian

Question you may be asking: Why does Union City Area School District need this information when all students receive free breakfasts and lunches?

Answer: This data is needed to report to the PA Department of Education for the School Performance documentation.

Who should I include in "Household Size"?

You must include yourself and all people living in your household, related or not (for example, children, grandparents, other relatives, or friends) who share income and expenses. If you live with other people who are economically independent (for example, who do not share income with your children, and who pay a pro-rated share of expenses), do *not* include them.

What is included in "Annual Household Income"? Annual Household Income includes the following:

- **Gross earnings from work:** Use your gross income, not your take-home pay. Gross income is the amount earned before taxes and other deductions. This information can be found on your pay stub or if you are unsure, your supervisor can provide this information. Net income should only be reported for self-owned business, farm, or rental income.

- **Welfare, Child Support, Alimony:** Include the amount each person living in your household receives from these sources.

- **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits:** Include the amount each person living in your household receives from these sources.

- **All Other Income:** Include worker's compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income received. Do not include income from WIC, federal education benefits and foster payments received by your household.

- **Military Housing Allowances and Combat Pay:** Include off-base housing allowances. *Do not* include Military Privatized Housing Initiative or combat pay.

- **Overtime Pay:** Include overtime pay ONLY if you receive it on a regular basis.

How do I report annual household income for pay received on a monthly, twice a month, every two weeks, or weekly basis?

- Determine each source of household income based on above definitions. Households that receive income at different time intervals must annualize their income as follows:
  - If paid monthly, multiply total pay by 12
  - If paid twice per month, multiply total pay by 24
  - If paid bi-weekly (every two weeks), multiply total pay by 26
  - If paid weekly, multiply total pay by 52

- Add annualized pay together to determine the total annual household income and check the box on the other side of this form if it is within either of the ranges displayed for your household size.

- If your household size exceeds the size on the chart, list household size and total annual household income in the space provided.

If your income changes, include the wages/salary that you regularly receive. For example, if you normally make $1,000 each month, but you missed some work last month and made $900, put down that you made $1,000 per month. Only include overtime pay if you receive it on a regular basis. If you have lost your job or had your hours or wages reduced, enter zero or your current reduced income.

For additional information on Household Size and Household Income, please see the Eligibility Manual for School Meals on the U.S. Department of Agriculture Guidance and Resource Web page at http://www.fns.usda.gov/cnd/guidance/default.htm.

Union City Area School District School Year _____

EMERGENCY INFORMATION and ANNUAL PARENT PERMISSION CARD

STUDENT'S NAME _____ **GRADE** _____ **BIRTHDATE** ___/___/___ **HOME PHONE** _____

ADDRESS _____ **ZIP CODE** _____ ☐ **check here if address/phone number is different from previous year**

STUDENT LIVES WITH: ☐ Mother ☐ Father ☐ Other (Name and Relationship) _____

MOTHER'S FULL NAME _____ WORK PHONE _____ CELL PH. _____

FATHER'S FULL NAME _____ WORK PHONE _____ CELL PH. _____

GUARDIAN'S NAME (IF APPLICABLE) _____ WORK PHONE _____ CELL PH. _____

PARENTS' HOME E-MAIL ADDRESS _____ *(Please print legibly)* MEDICAL INSURANCE CO. _____

POLICY # _____ GROUP # _____

PHYSICIAN _____ OFFICE # _____ HOSPITAL _____

DENTIST _____ OFFICE # _____

Please list below two people who will assume responsibility for the care of your child if you cannot be reached or if school is dismissed early due to weather or other special circumstances:

NAME _____	NAME _____
HOME PHONE _____	HOME PHONE _____
CELL# _____ WORK# _____	CELL# _____ WORK# _____
RELATIONSHIP TO STUDENT _____	RELATIONSHIP TO STUDENT _____

PLEASE NOTIFY SCHOOL NURSE IMMEDIATELY OF ANY CHANGES **(OVER)**

➤ Does your child have a special health or physical limitation that the school nurse or teacher should be aware of?

☐ No ☐ Yes Explain: _____

➤ List any medication that your child takes:

Medication:	Medication:	Medication:
Dosage:	Dosage:	Dosage:

➤ Does your child have a severe allergy? (Bee/insect sting, medication, food, other) ☐ No ☐ Yes

If yes, please specify: _____

Is any special treatment required for this allergy? ☐ No ☐ Yes

If yes, what treatment is necessary? _____

➤ Health Services Mandates by State Law (please check appropiate box)

Physical Exam (Grades K, 6, 11) ☐ By own doctor ☐ By School Doctor

Dental Exam (Grades K, 3, 7) ☐ By own dentist ☐ By School Dentist

NOTE: If you chose your own doctor/dentist, the exam forms must be completed and returned to the school by December 31. Other services such as growth, vision, hearing and scoliosis screenings will be provided to students as mandated by state law.

In case of accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on the reverse side of this card and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are deemed necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

04/17

UNION CITY AREA SCHOOL DISTRICT
Emergency Dismissal Form

Please complete the following Emergency Dismissal Form to ensure we at the school are informed where your child will go on ***unscheduled early dismissal days***. An unscheduled early dismissal may be the result of inclement weather or other emergencies.

Name of Student: _____ Grade: _____

Please establish and clearly communicate a plan with your child so they are aware of where they are to go if they are sent home early due to an emergency dismissal from school. ***Please do not request that your child ride another bus home as part of your plan.*** In emergency dismissals, buses will make their regularly scheduled stops. In your plan, make sure your child knows what to do when they get off the bus.

Briefly explain the plan:

_____

_____

_____

_____

_____

If your child does not ride the bus, please list the names and phone numbers of two individuals who are permitted to pick up your child.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____

Print Parent/Guardian Signature: _____

Home phone: _____ Work phone: _____ Other: _____

UNION CITY AREA SCHOOL DISTRICT
Transportation Form

ELEMENTARY SCHOOL
91 MILES ST.
UNION CITY, PA. 16438

MIDDLE/HIGH SCHOOL
105 CONCORD ST.
UNION CITY, PA. 16438

Dear Parents/Guardians:

In order to update our bus route information, please provide us with the following information for your child(ren). **Please refer to the transportation policy found in the school handbook, and return this form to the appropriate school office as soon as possible.** If you have any further concerns, please call the Elementary School Office at 438-7611 Ext. 3407, or the Middle School/High School Office at 438-7673 Ext. 5400.

Student name _____ Grade: _____

Student name _____ Grade: _____

Student name _____ Grade: _____

Student name _____ Grade: _____

Current address:

_____

Phone Numbers: _____

Pick up address

Home: ___yes ___no

Sitter current address: _____

Sitter phone number: _____

Parent transport to school: ___yes ___no

Drop off address

Home: ___yes ___no

Sitter current address: _____

Sitter phone number: _____

Parent transport home: ___yes ___no

We look forward to seeing your children on their first day at our school.

Sincerely,

Matthew W. Bennett
Superintendent of Schools

UNION CITY
AREA SCHOOL DISTRICT
SIGNATURE/PERMISSION FORM

Student's Name _____

Beginning of Day Teacher Name _____ Grade: _____

Parents/Guardians are asked to sign below and return to your child's first Period/Block (Middle/High School) or Elementary Teacher.

1.) Parent/Student School District Handbook

I have read the Union City Area School District Parent/Student Handbook and I am aware and understand the rules, policies, and programs stated therein. I am aware there are new policies included in this handbook. Handbooks are also available on the District Website at www.ucasd.org.

_____ _____ _____

Parent/Guardian Signature Student Signature Grade

2.) Videotaping/Photographing

My child may be videotaped/photographed during school activities. The images may be used in newsletters, the Union City Area School District Website, and local media outlets.

_____ _____ _____

Parent/Guardian Signature Student Signature Grade

3.) Blackboard Connect System

I wish to be informed of school cancellations, delays, emergencies, and other activities via the Blackboard Connect System.

_____ _____ _____

Parent/Guardian Signature Phone Number Alternate Number

Check if you would like to also receive text messages

☐

UNION CITY
AREA SCHOOL DISTRICT
SIGNATURE/PERMISSION FORM

4.) Standing Medication Orders

I consent to the use of the listed over the counter medications for my child. They will only be administered as needed. Dosing may not exceed the manufacturer's recommended dosage.

Parent/Guardian Signature	Student Signature	Date

I have reviewed the listed medications and have listed any medications that I do not want my child to receive below.

5.) Fluoride Tablet Consent (Elementary Students Only)

By signing below, I give consent for my child to participate in the fluoride program at the Union City Elementary School.

Parent/Guardian Signature	Teacher/Grade	Date

6.) Medication Administration Consent Form Request

Please check the box below if you would like a Medication Administration Consent form sent home for your child to be given medication by a licensed prescriber during the school day.

☐

7.) No Internet Access

We do not have internet access at home, we are requesting all district forms be printed and sent home as hard copies.

Parent/Guardian Signature	Student Signature	Date