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: _____ County: _____

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

107 Concord Street
Union City, Pennsylvania 16438

www.ucasd.org
438-3804
(814)

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 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

BLACKBOARD CONNECT: Voice notification to keep you informed!

In an effort to enhance communications between the family, the school, and the community, the school district will be using a phone broadcast system in order to provide parents timely notifications of emergencies, delays, closings, and other activities. For those that choose to participate, announcements will be sent to your family's primary phone number on file at school. Please update the **PRIMARY PHONE** information below. Families that wish to include an additional phone number may do so also by including that information on the form below. If any of this information changes during the school year please notify your child's school office as soon as possible.

If for any reason, however, you choose not to participate and would like your primary phone number removed from the call list, please indicate below and return the form. By declining, you will not receive the phone broadcast messages.

As always, however, radio and TV broadcasts will continue to be an important source of information for families. BLACKBOARD CONNECT is simply another method of getting important information to you.

----------**Cut Here and Return Completed Form**----------

_____ (place "X" Here") Yes, I want to receive phone broadcast notifications of emergencies, closings, and delays.

_____ (place "X" Here) No, I do not want to receive phone broadcast notifications.

Childs's Last Name	**First Name**	**Grade**	**Home Phone Number**	**2nd Contact Number (optional)**

Parent Name: _____ Date: _____

UNION CITY AREA SCHOOL DISTRICT
2022-2023 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 the first day of school, Tuesday, August 30, 2022.

Sincerely,

Dr. Melissa L. Tomcho
Elementary Principal

Mr. Adam L. Shrout
Middle School Principal

Mr. Daniel N. Keefer
High School Principal

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 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_____