

2011-2012 Kindergarten or First Grade Registration

Site based registration dates are 8:00 AM – 5:00 PM as follows:

Monday, February 28, 2011	Penn Lincoln and Washington-Jefferson
Tuesday, March 1, 2011	Baker, Ebner, Juniata Gap
Wednesday, March 2, 2011	Logan and Wright
Thursday, March 3, 2011	McAuliffe Heights, Juniata, Pleasant Valley

Please note that children living in the former Irving School attendance area are now in the Juniata Gap attendance area.

WHAT THE PARENT NEEDS TO BRING – (THE PARENT OR LEGAL GUARDIAN MUST REGISTER THE CHILD)

- A. Proof of age is required by State Law and this must be presented at time of registration. An official certificate of birth is preferred. If this is not available, please bring a hospital certificate, baptismal certificate or the ORIGINAL notarized statement indicating name, date of birth, and place of birth.
- B. If an adult other than the parent is registering the child, a copy of the guardianship papers or a sworn affidavit must be presented at registration. This copy will be kept by the school district. CHILDREN WILL NOT BE REGISTERED WITHOUT PROPER AUTHORIZED FORMS.
- C. Social security numbers can be taken but we cannot mandate them to be given and we cannot hold a student back from registration if a parent doesn't have the social security number or doesn't want to give it.

D. It is MANDATORY that all children starting school have their immunizations of:

*Diphtheria and Tetanus (4 or more doses of DPT, Td, or DT, or any combination of these with the last dose given after the age of four (4) years).

*Poliomyelitis (3 doses of oral vaccine or 4 doses of inactivated vaccine).

*Measles, Rubella, and Mumps (two doses of measles vaccine preferably given as a second dose of Measles, Mumps, and Rubella (MMR). The Measles, Rubella and Mumps inoculations must be given at age 12 months or older.

*Hepatitis B vaccine (three properly spaced doses)

*Chickenpox vaccine (2 doses as per Dept. of Health requirement) or date of disease

Please contact the Pa. Dept. of Health, Cricket Field Plaza, at 946-7300. Immunizations are given there by appointment only or contact your child's pediatrician.

PARENTS MUST BRING THE CHILD'S SHOT RECORD WITH THEM AT THE TIME OF REGISTRATION

E. Any person who wishes to send their child to a school outside their home attendance school must provide a letter at the time of registration (or immediately after) stating the reason for this request. Preference will be given to families residing in the home attendance school area before special requests are approved.

**IT IS ACKNOWLEDGED AND AGREED THAT ANY NAME OR ADDRESS
INFORMATION PROVIDED ON THIS FORM MAY BE SHARED AND DISCLOSED
WITH ANY MUNICIPAL, COUNTY, STATE, OR FEDERAL AGENCY.**

ALTOONA AREA SCHOOL DISTRICT

STUDENT REGISTRATION FORM

Date: _____

STUDENT INFORMATION:

(1) Last _____ **First** _____ **Middle** _____

Home Address _____

Grade Level Entering _____ Date of Birth _____ S.S.N. _____

Male ___ Female ___ Phone Number _____ Unlisted? ___ Yes ___ No

Has the student previously registered with AASD? _____ If yes, where? _____

Does the student have an IEP for speech, OT, PT, or any other Special Education area? _____

Student Race (optional): ___ Hispanic ___ Asian/Pacific Islander ___ White/Non-Hispanic
___ American Indian/Alaskan Native ___ Black/African American/Non-Hispanic

(2) Last _____ **First** _____ **Middle** _____

Home Address _____

Grade Level Entering _____ Date of Birth _____ S.S.N. _____

Male ___ Female ___ Phone Number _____ Unlisted? ___ Yes ___ No

Has the student previously registered with AASD? _____ If yes, where? _____

Does the student have an IEP for speech, OT, PT, or any other Special Education area? _____

Student Race (optional): ___ Hispanic ___ Asian/Pacific Islander ___ White/Non-Hispanic
___ American Indian/Alaskan Native ___ Black/African American/Non-Hispanic

(3) Last _____ **First** _____ **Middle** _____

Home Address _____

Grade Level Entering _____ Date of Birth _____ S.S.N. _____

Male ___ Female ___ Phone Number _____ Unlisted? ___ Yes ___ No

Has the student previously registered with AASD? _____ If yes, where? _____

Does the student have an IEP for speech, OT, PT, or any other Special Education area? _____

Student Race (optional): ___ Hispanic ___ Asian/Pacific Islander ___ White/Non-Hispanic
___ American Indian/Alaskan Native ___ Black/African American/Non-Hispanic

PARENT INFORMATION

(1) Parents are:

Married Widowed Divorced Separated Unmarried

(2) Student(s) live with:

Both parents Natural Mother only Natural Father only
 Guardian Step Parent

(3) Father's Name: First _____ (M) _____ Last _____

Place of employment: _____ Occupation _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Address (if different than student's): _____

(4) Mother's Name: First _____ (M) _____ Last _____

Mother's Maiden Name: _____

Place of employment: _____ Occupation _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Address (if different than student's): _____

(5) Guardian's Name: First _____ (M) _____ Last _____

Place of employment: _____ Occupation _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Address (if different than student's): _____

(6) Step Parent's Name: First _____ (M) _____ Last _____

Place of employment: _____ Occupation _____

Home Phone _____ Work Phone _____ Cell/Pager _____

Address (if different than student's): _____

(7) Do you have custody papers? No Yes

(If yes, the official papers must be duplicated in the school office.)

(8) Emergency number and person to contact if parent is not at home:

Phone No. _____ Name _____

Relationship to student(s) _____

Complete the following information for brothers and/or sisters not already listed:

BROTHER(S):

Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____

SISTER(S):

Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____
Last _____ First _____ Middle _____ Date of Birth _____

This form was completed by:

Print Full Name: _____

Signature: _____

Date: _____

E-Mail Address: _____

Registering For: _____ **School**

Home attendance school (if different from above): _____

COMPLETE FOR KINDERGARTEN REGISTRATION ONLY:

Would you be interested in sending your child to a kindergarten readiness camp in June? ____ Yes ____ No

Is the child attending preschool or a daycare center? ____ No ____ Yes, where: _____

Has the child attended first grade in another school district? ____ No ____ Yes

If yes, where: _____

ALTOONA AREA SCHOOL DISTRICT - ACT 26 QUESTIONNAIRE

STUDENT NAME: _____

PARENTS/GUARDIANS ARE REQUIRED, BY PENNSYLVANIA STATE LAW, TO RESPOND TO THE FOLLOWING STATEMENTS:

Please check either "YES" or "NO" next to each statement.

- (1) Yes No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for an act or offense involving weapons, defined as any type of firearm, cutting tool, nunchaku, or implement capable of inflicting serious bodily injury.
- (2) Yes No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for an act or offense involving weapons, defined as any type of firearm, cutting tool, nunchaku, or implement capable of inflicting serious bodily injury.
- (3) Yes No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for an act or offense involving drugs or alcohol.
- (4) Yes No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for an act or offense involving drugs or alcohol.
- (5) Yes No My son/daughter has been suspended from a public or private school system, anywhere in the United States, for the willful infliction of injury to another person and/or any act of violence committed on school property.
- (6) Yes No My son/daughter has been expelled from a public or private school system, anywhere in the United States, for the willful infliction of injury to another person and/or any act of violence committed on school property.

IF ANY OF THE ABOVE STATEMENTS ARE MARKED "YES", INDICATE THE QUESTION NUMBER, THE APPROXIMATE DATE OF SUSPENSION/EXPULSION, AND A BRIEF EXPLANATION OF THE INCIDENT WHICH LED TO THE SUSPENSION/EXPULSION.

I/WE UNDERSTAND THAT ANY WILLFUL FALSE STATEMENT MADE TO ANY OF THE SIX QUESTIONS ABOVE WOULD BE A MISDEMEANOR OF THE THIRD DEGREE, PUNISHABLE PURSUANT TO 24 PS 13-1304-A. I/WE ALSO UNDERSTAND THAT ANY FALSE STATEMENTS HEREIN ARE MADE SUBJECT TO THE PENALTIES OF THE 18 PA C.S. 4904 RELATING TO UNSWORN FALSIFICATIONS TO AUTHORITIES.

PARENT/GUARDIAN _____ DATE _____

HOME LANGUAGE SURVEY*

ALTOONA AREA SCHOOL DISTRICT

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 identification.

School District: Altoona Area School District

Name of Child: _____

Date: _____

Address: _____

Grade: _____

School: _____

1. What is/was the student's first language? _____

2. 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):

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 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.

ALTOONA AREA SCHOOL DISTRICT

District Attendance Office
1415 Sixth Avenue
Altoona, PA 16602
814-946-8230

Kindergarten children DO NOT report on the first day of school. Sometime around the middle of August, you will be notified by mail when to go into the school for your appointment. The appointment usually takes place during the first couple of days that school is in session. The teacher will tell you to bring your child to school.

PLEASE NOTIFY THE BUILDING WHERE YOUR CHILD WILL BE ATTENDING KINDERGARTEN IMMEDIATELY IF YOU DO ANY OF THE FOLLOWING:

- Move out of the city
- Move to another address in the city
- Change any information that was obtained at registration
- Decide not to send your child to kindergarten

**ALTOONA AREA SCHOOL DISTRICT
Student Health Services
STUDENT HEALTH HISTORY**

Child's Full Name: _____
Last
First
Middle
Birthday: ____/____/____
Month
Day
Year

Address: _____
Telephone#: _____
Place of Birth: _____

Father's Name: _____
 Mother's Name: _____
 Guardian's Name: _____
Occupation: _____
Occupation: _____
Occupation: _____

Give names and birth date of other children in the family:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents are: Married Single Divorced Separated Widowed
 Child is living with: Mother Father Both Guardian (Name please): _____
 If living with guardian, what is relationship to the child? _____
 Have any members of the immediate family died? (Do not include miscarriages.) Yes No
 How many people live in the same household as the child? _____
 Are there any problems such as housing, employment, food, etc...? _____
 Has this child attended: Headstart Pre-School (where) _____

Child's Physician: _____ Child's Dentist: _____

Does your child have any special health needs or problems that will require attention or assistance in school?

Does your child need a special diet or have any food problems? (Give details): _____

Is there any reason why your child should not participate in physical education classes? (Give details) _____

Is your child taking any medications other than vitamins, regularly? Give name of medication/s and reason. _____

Is your child presently being treated for any health problems? (Give details): _____

MEDICAL HISTORY: (Check any of the following your child has had and appropriate age.)

- | | |
|---|--|
| <input type="checkbox"/> Chickenpox _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Measles (Regular) _____ | <input type="checkbox"/> Seizures (Epilepsy) _____ |
| <input type="checkbox"/> Rubella (German Measles) _____ | <input type="checkbox"/> Convulsion (High Fever) _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Head Injury _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Eye Surgery _____ |
| <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Tubes in ears _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Tonsils removed _____ |
| <input type="checkbox"/> Lead Poisoning (Highest Level) _____ | |

Does your child have complete bowel and bladder control? _____

Has your child ever been hospitalized or had an operation? (If Yes, When, where, for what?) _____

Has your child had any serious illness, accident, or broken bones? (If Yes, when, where, what?) _____

---CONTINUED ON REVERSE SIDE---

**ALTOONA AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
PHYSICAL EXAMINATION**

Dear Parent/Guardian:

The Pennsylvania School Law requires all school age children to have periodic physical examinations as follows: kindergarten or grade one, grade six and grade eleven. Transfer students, as well as students with incomplete health records, shall be required to have a physical examination as the need arises.

I am recommending the examination is completed by your family physician since he/she can best evaluate your child's health. The private physician's report form needs to be completed by your family physician and returned to the school nurse by:

Completed private examination forms must be returned prior to the date the school examinations are scheduled or your child will be scheduled for a medical examination at school. If you wish to be present for the examination, please submit your request in writing before the scheduled physical exam.

If you have any questions regarding this health program requirement, please contact me at _____ or email me at _____.

Sincerely,

School Nurse

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD			DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last	First	Middle		

ADDRESS _____

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

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES				
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

- MEDICAL EXEMPTION** The physical condition of the abovenamed child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____ Date _____.

Result of Diagnostic Studies: _____ Date _____.

Preventive Anti-Tuberculosis - Chemotherapy ordered. No Yes _____ Date _____

Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

**ALTOONA AREA SCHOOL DISTRICT
STUDENT HEALTH SERVICES
DENTAL EXAMINATION**

Dear Parent or Guardian:

Pennsylvania School Law requires a dental examination on all children entering school, kindergarten or 1st grade, 3rd grade and 7th grade. The examination may be done in school or by your family dentist.

We recommend your family dentist do this examination since he/she can best evaluate your child's dental health and assist you in obtaining the necessary treatments and corrections.

Please return the dental forms by _____, 20_____.

According to STATE LAW, if a private dentist's form is not returned, the examination will be scheduled and done by the school dentist. If you wish to be present while the examination occurs, please submit your request in writing prior to the scheduled date.

School Dental Examination Scheduled: _____

Respectfully,

School Nurse

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS _____

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

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	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

**ALTOONA AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
IMMUNIZATION REQUEST**

Dear Parent/Guardian:

The immunization record that was submitted at the time of registration indicates your child needs one or more immunizations to complete the Pennsylvania State requirements. ***It is recommended that you have the following highlighted immunizations completed prior to the start of school.*** Please contact your Physician or the State Health Center at 946-7300 for an appointment as soon as possible.

Immunizations needed:

DtaP

1st dose, 2nd dose, 3rd dose, 4th dose, 5th dose

Polio

1st dose, 2nd dose, 3rd dose, 4th dose

MMR

1st dose, 2nd dose

Hepatitis B

1st dose, 2nd dose, 3rd dose

Varicella

(Chickenpox) 1st dose _____
or History of Chickenpox disease (date/age) _____

It is common to receive these immunizations during your child's well check-up exam around age five. Please ensure that the school your child is attending receives a copy of the updated immunizations that were given.

Respectfully,

School Nurse

Preschool Survey

The Learning Express Preschool 2914 W. Chestnut Ave. Altoona, PA 16601 946-8465

Dear Parents:

The Altoona Area School District and The Learning Express Preschool are conducting a survey regarding Preschool services. Families of children registering for kindergarten are asked to fill out this survey and return it at kindergarten registration.

Child's Name: _____ School: _____

Parent(s) Name: _____

Address: _____

Phone: _____

Please check off all that apply to your family.

My child attended _____ Preschool before kindergarten.

My child attended _____ Daycare or went to a private sitter instead of a separate preschool.

My child was involved in Early Intervention Birth to Three through Easter Seals, Home Nursing and North Star Support Services.

My child was involved with Preschool Early Intervention through The Learning Express or the Appalachia Intermediate Unit 08.

My child did not attend preschool, or only attended preschool for a short time.

Reasons my child did not attend preschool:

My family could not find free/low-cost preschool, and could not afford preschool.

Preschool(s) that I called were full or had a waiting list.

I did not know of any preschools in the area.

Transportation – I did not have a way to get my child to and from preschool.

I did not feel my child was ready for preschool.

I did not feel it was necessary for my child to go to preschool before kindergarten.

Other reasons: _____

If you would like to be called about this survey:

Please call me—I have questions about this survey.

Please call me—I have younger children at home and would like information about preschools in the area.

Please call me – I have concerns about my younger child's readiness for preschool.

ALTOONA AREA SCHOOL DISTRICT

CONFIDENTIAL INFORMATION FOR COUNSELORS – (KINDERGARTEN/FIRST GRADE STUDENTS ENROLLING FOR THE FIRST TIME)

Date: _____

For School Year: _____

Child's Name: _____

Parent(s) Name: _____

School: _____

(1) Do you have any concerns about your child's behavior, discipline or development?
No ___ Yes ___ (If yes, please explain below.)

(2) Has your child received help from any community agency or resource? If Yes, check all that apply and complete the information for "Other", if applicable.

___ Family Resource Center

___ Altoona Hospital - Mental Health Center

___ Canal Ways

___ WRAP Around

___ Blair County Children & Youth Services

___ Learning Express

___ Early Intervention

___ Easter Seals

___ Headstart

___ Other (specify) _____

(3) Do you believe that these concerns will influence your child's learning?
No ___ Yes ___ (If yes, please explain below.)

(4) Would you like to talk with a school counselor about your child?

No ___ Yes ___ (If yes, daytime phone number: _____)

**ALTOONA AREA SCHOOL DISTRICT
GUARDIANSHIP PACKET**

Parent(s) **DO NOT** live in the Altoona Area School District

Information from an applicant who is requesting resident school privileges (under Section 1302 of the Pennsylvania School Code) for a student(s) **(NOT HIS/HER OWN)** kept in his/her home.

I/WE UNDERSTAND THAT ANY WILLFUL FALSE STATEMENT MADE TO ANY OF THE QUESTIONS WOULD BE MISDEMEANORS OF THE THIRD DEGREE, PUNISHABLE PURSUANT TO 24 PS 13-1304-A.

I/WE ALSO UNDERSTAND THAT ANY FALSE STATEMENTS HEREIN ARE MADE SUBJECT TO THE PENALTIES OF 18 PA C.S. 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

By signing this, I fully understand the consequences of this packet:

Signature

Date

**ALTOONA AREA SCHOOL DISTRICT
GUARDIANSHIP PACKET**

Parent(s) **DO NOT** live in the Altoona Area School District

Information from an applicant who is requesting resident school privileges (under Section 1302 of the Pennsylvania School Code) for a student(s) (**NOT HIS/HER OWN**) kept in his/her home.

In order to be given consideration the applicant must:

- A. Complete and sign **Part I** of the questionnaire.
- B. Have the parent(s) of the student(s) complete and sign **Part II** of the questionnaire.
- C. Return the completed questionnaire and affidavit to the **Student Registration Office or the Home School.**

The admission of a student(s) by the school authorities will be tentative and subject to final approval of the Superintendent or his/her designees. Altoona Area School District reserves the right to verify any and all information contained within the Guardianship Packet with law enforcement agencies. By executing this form, the applicant and student authorize Altoona Area School District to retrieve any information necessary in making a determination with respect to enrollment applications. By submitting this request, the parent(s), guardians and student hereby waive the right to privacy guaranteed by FERPA so that the District can gather the information necessary to make the enrollment decision.

PART I – APPLICANT INFORMATION

- 1. Name of Applicant: _____
Spouse of Applicant (if applicable): _____
Home Address: _____

Home Telephone No.: _____
Work Telephone No.: _____

- 2. Name of Student: _____
Date of Birth: _____
Grade of Student: _____
Last School Attended: _____

- 3. The date student(s) began residing in the Applicant's home: _____

- 4. Are you related to the student(s)? YES _____ NO _____

- 5. How are you related to the student(s)? _____

6. Please explain why the student(s) is(are) residing with you and not with the parent(s).

7. Is the father living? YES _____ NO _____

NAME: _____

HIS ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

8. Is the mother living? YES _____ NO _____

NAME: _____

HER ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

9. Will the **parent(s)** contribute anything for the student's support:

MONEY	YES _____	NO _____
FOOD, CLOTHING	YES _____	NO _____
HEALTH INSURANCE	YES _____	NO _____

10. Will you receive welfare, public assistance or any other form of aid or payment for this child?

YES _____

NO _____

11. Will the **parent(s)** claim the student(s) as a dependent(s) for income tax reporting purposes? **(The School District reserves the right to review your income tax return.)**

YES _____ NO _____ If **NO**, who will claim? _____

12. What is the anticipated length of time that the applicant plans to keep the student(s)?

13. Will the student(s) customarily return to the parent(s) during vacations?

YES _____

NO _____

14. Will the student(s) continuously sleep overnight at the applicant's residence?

YES _____

NO _____

ALTOONA AREA SCHOOL DISTRICT RESERVES THE RIGHT TO REVOKE ADMISSION IF THE APPLICATION CONTAINS FALSE INFORMATION ON WHICH THE SCHOOL DISTRICT RELIED IN MAKING ITS DECISION TO ENROLL THE STUDENT.

(FOR ADMINISTRATIVE USE ONLY)

Applicant Interviewed by: _____ Date: _____

Action Recommended: _____

Final Administrative Action: **APPROVED** _____ **DENIED** _____

Signature: _____ Date: _____

COMMENTS:

ALTOONA AREA SCHOOL DISTRICT
Certification of Applicant – Part I

*I certify that I am a **legal resident** of the Altoona Area School District and that I have paid all my taxes for the last 12 months. I further certify that the information submitted in response to the above questions is correct and that I will submit the necessary affidavit (sworn statement) in support of this application after carefully reading it and finding that it is consistent with the facts. I UNDERSTAND THAT IF THE INFORMATION FURNISHED IS **UNTRUE**, I WILL BE LIABLE FOR THE PERSONAL TUITION PAYMENTS in accordance with School District Policy #5003R.*

I understand that any willful false statement made to any of the questions would be a misdemeanor of the third degree, punishable pursuant to 24 PS 13-1304-A. I also understand that any false statements herein are made subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities.

Date: _____ Signature of Applicant: _____

Telephone Number: _____ Address: _____

Verification of Parent(s) – Part II

*I/We certify that I/we have read the above information in Part I submitted by the applicant and also the affidavit necessary to be submitted by the applicant and find that the information contained therein is correct and the I/we give my(our) permission for **[Name of Student(s)]** _____ to be placed under the responsibility of the above applicant as though said student(s) was his or her own, agreeing that he or she assumes all personal obligation for the said student(s) relative to the school requirements and with the understanding that it is his or her intention of supporting the student(s) continuously and not merely throughout the school term.*

I/We understand that any willful false statement made to any of the questions would be misdemeanors of the third degree, punishable pursuant to 24 PS 13-1304-A. I/We also understand that any false statements herein are made subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities.

Date: _____ Signature of Father: _____

Signature of Mother: _____

Telephone Number: _____ Address: _____

ALTOONA AREA SCHOOL DISTRICT

AFFIDAVIT OF GUARDIAN

COMMONWEALTH OF PENNSYLVANIA)
) **SS:**
COUNTY OF BLAIR)

Before me, the undersigned Notary Public, this day personally appeared

_____, residing at _____

to me known, who being duly sworn according to law, depose(s) and say(s) the following:

I (we) am (are) keeping and supporting _____, gratis, and that I (we) will be responsible for this person for school attendance and all personal requirements, and that I (we) intend to so keep and support this individual continuously and not merely throughout the school term. In addition, I (we) fully understand that the School District may make an independent investigation to make certain that the guardianship I (we) am (are) claiming is a legitimate one.

GUARDIAN

GUARDIAN

Subscribed and sworn to before me this _____ day of _____, 20____.

NOTARY PUBLIC

My Commission Expires:

Student Birth Information:

Name: _____

Date of Birth: _____

Place of Birth: _____