



# Manheim Central School District

*Preparing Responsible Citizens, Who Are Lifelong Learners*

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Peter J. Aiken, D. Ed – Superintendent

Today's Date
Grade Entering
School Year

## Student Enrollment and Registration Form

For All New and Re-Entering Students  
Please Print Using Ink – Not Pencil

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## STUDENT DEMOGRAPHICS

**Gender:**  MALE /  FEMALE (Check One)

**Last Name (Legal):** \_\_\_\_\_

**First Name (Legal):** \_\_\_\_\_

**Middle Name (Legal):** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_  

Street Address
City
State
Zip

**Mailing Address (if different):** \_\_\_\_\_  

Street Address
City
State
Zip

**Phone Number:** \_\_\_\_\_

Student Date of Birth	Student Place of Birth (City, State, Country)	If Student NOT Born in PA, Please Provide Date When Student Moved to PA

**RESIDENCY (check all that apply):**     Resident     Homeless     Tuition Student – Paid By: \_\_\_\_\_

**FOSTER (1305 - Attach Agency Letter):** \_\_\_\_\_  

Guardian Ad Litem
Phone
  
 Address \_\_\_\_\_

**GUARDIANSHIP TYPE (1302):**     Minor     Emancipated Minor     Adult

**Has Student Ever Attended School in the Manheim Central School District?**  No     Yes - \_\_\_\_\_  
Dates of Attendance

**If Yes to Above, Building:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**ETHNICITY:**     Hispanic or Latino     Not Hispanic or Latino

**RACE:**     White     Black/African American     Asian  
 Native Hawaiian or Pacific Islander     American Indian or Alaskan Native

**Does Student Have Migrant Status?**     No     Yes - Migrant ID Number: \_\_\_\_\_

**Is Student a Foreign Exchange Student?**     No     Yes

**Is Student a Single Parent?**     No     Yes

# SCHOOL ENROLLMENT HISTORY

List All Schools Attended Previously (most recent first):

School District	Name of School	School Address & Phone No.	Grades Attended	Withdraw Date

**US ENROLLMENT DATE:**

What is the first date that your child attended school in the United States? \_\_\_\_\_

**STATE ENROLLMENT DATE:**

What is the first date that your child attended school in Pennsylvania? \_\_\_\_\_

**DISTRICT ENTRY DATE:**

What is the first date that your child attended school in Manheim Central School District? \_\_\_\_\_

**SCHOOL ENTRY DATE:**

What is the first date that your child attended any school (usually kindergarten)? \_\_\_\_\_

I affirm that all the information provided on this student enrollment and registration form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

***FOR OFFICE USE ONLY***

PA Secure ID: \_\_\_\_\_ Student ID: \_\_\_\_\_ School ID: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Resident Code (if resident, leave blank): \_\_\_\_\_

Entry Grade 9 Entry Date: \_\_\_\_\_ Tuition Student Board Approval Date: \_\_\_\_\_

ADMINISTRATOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## 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) 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.

**Last Name (Legal):** \_\_\_\_\_

**First Name (Legal):** \_\_\_\_\_

**Middle Name (Legal):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

1. Is a language other than English spoken in the child's home?       Yes                       No
2. Does the student speak a language(s) other than English?       Yes                       No
3. What is the language that your child first learned to speak? \_\_\_\_\_

**IF ANY ABOVE ANSWER IS "YES," A FAMILY INTERVIEW  
WILL BE CONDUCTED DURING THE REGISTRATION PROCESS**

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

# KINDERGARTEN QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## EVALUATIONS -

Indicate if your child has been evaluated and note when/where:

- VISION       HEARING       SPEECH/LANGUAGE       PSYCHOLOGICAL  
 PHYSICAL/OCCUPATIONAL THERAPY

Notes: \_\_\_\_\_  
\_\_\_\_\_

## AGENCY INVOLVEMENT -

Check all that your child has ever been seen by:

- EASTER SEALS       CLEFT PALATE CLINICS       JUNE SMITH       SCHREIBER PEDIATRIC  
 MH/MR       PHIL HAVEN       IU PRESCHOOL SERVICE       OTHER

If "OTHER," Please List - i.e., CYSTIC FIBROSIS, CEREBRAL PALSY ASSOC., etc.: \_\_\_\_\_  
\_\_\_\_\_

## SELF HELP SKILLS -

Check if your child can:

- ZIPPER       TIE SHOES       BUTTON       DRESS SELF WITHOUT HELP

Does your child have complete bowel control?       YES       NO

Does your child have complete bladder control?       YES       NO

Does your child experience bed wetting?       YES       NO

Does your child care for self at toilet?       YES       NO

Does your child sleep:       LIGHTLY       SOUNDLY       HAS FRIGHTENING DREAMS

## SOCIAL DEVELOPMENT -

Child prefers to play:

- ALONE       WITH ONE CHILD       WITH SEVERAL CHILDREN       WITH ADULTS

Is your child able to follow directions?       YES       NO

Do you read to your child?       YES       NO

Does your child have any difficulty in understanding or using language?       YES       NO

## PERSONALITY DEVELOPMENT -

Check all that apply:

- TRAITS:**       CHEERFUL       SULLEN       ASSERTIVE       EXCITABLE       FRIENDLY  
 SHY       NERVOUS       AGGRESSIVE       IMPULSIVE       COOPERATIVE

- PROBLEMS:**       DESTRUCTIVE       BITES NAILS       DISOBEDIENT       INATTENTIVE  
 CRIES EASILY       OPPOSITIONAL       TEMPER TANTRUMS  
 WORRIES       PROBLEMS SLEEPING

**PHYSICAL DEVELOPMENT -**

**Pregnancy:** Duration - \_\_\_\_\_ Complications - \_\_\_\_\_

**Birth Details:** Natural - \_\_\_\_\_ Instruments - \_\_\_\_\_ Injury - \_\_\_\_\_

**Age of Walking Alone:** \_\_\_\_\_

**Age of Talking:** One or Two Words - \_\_\_\_\_ Sentences - \_\_\_\_\_

**EDUCATIONAL EXPERIENCE -**

<b>TYPE</b>	<b>SCHOOL</b>	<b>YEARS ATTENDED</b>	<b># DAYS / WEEK</b>
<b>Preschool</b>			
<b>Nursery School</b>			
<b>Day Care</b>			
<b>Babysitter</b>			

Please share any additional information about your child (social/emotional/educational/family history) you may have about your child: \_\_\_\_\_

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**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# STUDENT EMERGENCY INFORMATION / VERIFICATION

Last Name (Legal): \_\_\_\_\_

First Name (Legal): \_\_\_\_\_

Middle Name (Legal): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
Street Address City State Zip

Mailing Address (if different): \_\_\_\_\_  
Street Address City State Zip

## PARENT / GUARDIAN

*PLEASE INDICATE IF GUARDIANS BELOW ARE OTHER THAN A PARENT*

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Employer Name

**IF MILITARY MEMBER:** Active  Retired

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Employer Name

**IF MILITARY MEMBER:** Active  Retired

## ALTERNATE CONTACTS

*TO BE CONTACTED IN THE EVENT SCHOOL IS UNABLE TO REACH A PARENT/GUARDIAN*

\_\_\_\_\_  
Name Phone Relationship to Student

\_\_\_\_\_  
Name Phone Relationship to Student

\_\_\_\_\_  
Name Phone Relationship to Student

\_\_\_\_\_  
Name Phone Relationship to Student

## CUSTODY INFORMATION

In order for the school to maintain the safety and confidentiality of our students, please check the following box if applicable. All information will be kept confidential.

There is/will be a current custody agreement on file in the school office (including PFAs). \*

*\*Please Note - For agreements to be followed, a copy must be in the school office.*

**ALERTNOW CONTACT NUMBERS**

AlertNow is a rapid, parent notification system. *The numbers listed below as A1 and A2 will be the number that is contacted for mundane events such as weather-related school closures, reminders about parent conferences or report cards. These numbers should be the parent/guardian’s cell or home numbers.* In the case of a school-wide or district-wide emergency or an unplanned early dismissal, the AlertNow system will call ALL Contact Numbers listed below. Students should have a minimum of three (3) AlertNow Contacts, however you do not have to list five numbers.

PRIORITY	CONTACT NAME	PHONE NUMBER
A1		
A2		
A3		
A4		
A5		

**CENSUS**

*PLEASE LIST ALL MEMBERS IN THE HOUSEHOLD (INCLUDING THE STUDENT):*

NAME OF HOUSEHOLD MEMBER	DATE OF BIRTH	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT

**PHOTO RELEASE INFORMATION**

**YES**, I give my permission to Manheim Central School District to use photographs, interviews or video tapes of my child for school district publications.

**NO**, I do not give my permission.

YEARBOOK INCLUSION:  **YES**     **NO**

*I understand and agree that there will be no compensation for use of these written or visual materials. I also agree to release and discharge Manheim Central School District from all claims and demands of any nature whatsoever, arising from or with respect to the use of any photographs, interviews, movies or videotapes.*



## MEDICAL INFORMATION

**PLEASE LIST ANY MEDICATION TAKEN EITHER AT HOME OR SCHOOL:**

MEDICATION	DOSAGE	TIME TAKEN	REASON

**HAS YOUR CHILD HAD ANY RECENT IMMUNIZATIONS?**  Yes  No

Recent Immunization \_\_\_\_\_

Date Administered \_\_\_\_\_

**DOES YOUR CHILD WEAR GLASSES/CORRECTIVE LENSES?**  Yes  No

**DOES YOUR CHILD HAVE ALLERGIES TO MEDICATION, FOOD, BEE STINGS, etc.?**  Yes  No

If yes, please describe: \_\_\_\_\_

### PHYSICIAN INFORMATION

Family Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Family Dentist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Access  No Insurance

**In case of accident or serious illness, parent/guardian or emergency contact person will be notified. I hereby authorize school personnel to act for me according to their best judgment in any emergency requiring medical attention.**

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please Note: For the safety & well-being of each child, information on this form will be shared only on a need to know basis.*

### REQUIRED PHYSICAL EXAMINATION FOR ENTRY INTO SCHOOL

The PA School Health law requires a complete physical exam upon *original entry to school and in the 6th and 11th grades.*

Please check one of the following:  I wish to have my family doctor examine my child at my own expense.

I wish to have the school doctor examine my child.

I wish to have the school dentist examine my child.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICATION AUTHORIZATION

Per guidelines on MCSD Health Services Standing Orders, the school nurse will administer the following medication as needed ONLY with your authorization: Tylenol, Ibuprofen (Advil, Motrin, Nuprin), Benadryl – age/weight appropriate doses, Antacid for stomach upset, Anbesol and Visine. (throat lozenges – middle and high school students only)

#### **CHECK ONE BOX ONLY:**

I authorize the school nurse to administer any of the above listed medications.

I authorize the school nurse to administer only the following medications: \_\_\_\_\_

Please call BEFORE administering any medication.

## HEALTH HISTORY

- Yes  No Is your child under treatment for a skin problem (ex: psoriasis, eczema)? If so, what treatment is needed at school?  
\_\_\_\_\_
- Yes  No Does your child have any trouble with his/her ears or hearing? Does child have hearing aids? \_\_\_\_\_  
Will child require special seating? \_\_\_\_\_
- Yes  No Does child get frequent colds or throat infections with a fever?
- Yes  No Were child's tonsils removed?
- Yes  No Was child ever diagnosed with pneumonia? If yes, when? \_\_\_\_\_
- Yes  No Has child ever had a convulsion or fit (seizure)? If yes, what type: \_\_\_\_\_  
Medication child is on? \_\_\_\_\_  
What special restrictions, meds or care will need to be provided at school for child? \_\_\_\_\_
- Yes  No Does child complain frequently of headaches? If yes, what medication or special care will be needed at school?  
\_\_\_\_\_
- Yes  No Has child ever had a fainting spell? If yes, was child treated by a doctor? \_\_\_\_\_  
Restrictions at school: \_\_\_\_\_
- Yes  No Does child have a heart murmur that requires doctor's care? If yes, please list restrictions or special care needed at school: \_\_\_\_\_
- Yes  No Does child have asthma or wheezing? If yes, list medication or inhaler(s) needed at school: \_\_\_\_\_
- Yes  No Is your child toilet trained? If no, please describe: \_\_\_\_\_
- Yes  No Is constipation a problem for your child? Does child have bladder or kidney problems?  
If yes, please describe: \_\_\_\_\_  
Special care needed at school: \_\_\_\_\_
- Yes  No Has child been diagnosed with juvenile rheumatoid arthritis? If yes, please indicate care required at school: \_\_\_\_\_
- Yes  No Does child have frequent trouble sleeping?
- Yes  No Is child diabetic? If yes, when was child diagnosed and what special care is needed at school? \_\_\_\_\_
- Yes  No Has child been diagnosed with ADD or ADHD or another condition? If yes, please describe: \_\_\_\_\_  
Special care or treatment needed at school: \_\_\_\_\_  
Medications: \_\_\_\_\_
- Yes  No Has child been diagnosed with Tourette's syndrome?
- Yes  No Has child been diagnosed or treated for tuberculosis?
- Yes  No Has child ever been in the hospital or had an operation? If yes, indicate when and what for: \_\_\_\_\_
- Yes  No Has child had other illnesses, accidents or fractured bones? If yes, please describe: \_\_\_\_\_
- Yes  No Does child require any other restrictions, special care or medications at school other than listed above?  
If yes, please describe: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_