CHELTENHAM TOWNSHIP SCHOOL DISTRICT

Student Registration Packet

_____

Student Name

For Registrar/School Personnel Use Only

Registrar Name_____ Date_____

Student ID Number_____ **School Assigned To:**_____ **Grade**_____

Special Education: Yes ☐ **No** ☐ **ELL: Yes** ☐ **No** ☐ **Foster Student: Yes** ☐ **No** ☐ **Multiple Occupancy Yes** ☐ **No** ☐
Early Intervention: Yes ☐ **No** ☐ **Homeless: Yes** ☐ **No** ☐ **Student Support Affidavit: Yes** ☐ **No** ☐

Assigned Placement: **Yes** ☐ **No** ☐ _____ Home School_____

Re-Enrollment_____ Yes ☐ No ☐ SDCT School last enrolled, if applicable_____

PA Secure ID_____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

PARENT/GUARDIAN CHECKLIST FOR REGISTRATION

Please use this checklist as a guide to ensure you have all of the required documents for your registration appointment.

- ☐ Three (3) Proofs of Residency
  - ➢ Deed, Lease, or Tax Bill
  - ➢ Current Utility Bill (Electric, Cell Phone, Telephone or Water)
  - ➢ Driver's License or Vehicle Registration
- ☐ Parent/Guardian Photo Identification (Driver's License or Passport)
- ☐ Child's Birth Certificate, Passport, or Baptismal Certificate
- ☐ Immunization Records
- ☐ Individualized Education Program (IEP), Evaluation Report or Re-Evaluation Report, (ER or RR) or Notice of Recommended Educational Placement (NOREP), if applicable
- ☐ Pupil Registration Form
- ☐ Parent/Guardian Information
- ☐ Student Data Form
- ☐ Physical Examination Form (must be signed by a physician)
- ☐ Student Health History
- ☐ Dental Examination Form
- ☐ Medication Administration Physician Order and Parental Consent Form
- ☐ Home Language Survey Form
- ☐ Pupil Emergency Information Form
- ☐ Request for Records Form
- ☐ Request for Release of Information to School District of Cheltenham Township Form
- ☐ Verification Form (For students entering grades 1st through 12th)

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
STUDENT REGISTRATION FORM

Student's Legal Name _____
First Middle Last

Address _____
House/Apt # Street Name

_____
City State Zip

Home Telephone_____ Sex: Male_____ Female _____

Date of Birth_____ Place of Birth (City, State)_____

Phone Number to appear in student directory: Yes _____ No _____

Ethnicity: To assist the school district with Federal mandated reporting, please check one of the following:

1. American Indian □ (Native American or Alaskan) (Not Hispanic) Native
2. Asian □ (East, Far East Mid-Eastern)
3. African American □
4. Hispanic or Latino □
5. Native Hawaiian/Other Pacific Islander □
6. Caucasian □

Previous School Attended

Former School Name:_____ Grade/Date Last Attended_____

Former School Address:_____

Former School District Withdrawal Date:_____

Reason for Withdrawal: _____

Has the student ever received special education services? ☐ Yes ☐ No
If yes, please explain? _____

Does your child have a current IEP/GIEP/504 Accommodation Plan? ☐ Yes ☐ No
(If yes, please provide copies of the most recent IEP/GIEP/504 Accommodation Plan, Evaluations and Re-Evaluations.)

Child resides with: ☐ Mother ☐ Father ☐ Both ☐ Other _____

If other, please indicate relationship_____

Child's parent(s): ☐ Single □ Married □ Separated □ Divorced □ Widow/Widower □ Foster □ Adoptive

Primary physical custodial parent/guardian: _____

Special custodial court instructions Yes ___No ___ **(If yes, please provide a copy of the court order.)**

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
PARENT/GUARDIAN INFORMATION

Parent Name_____ Male____ Female____

Address_____

Home Phone_____ E-mail_____

Occupation_____ Employer's Name and Address_____

Business Phone_____ Cell _____

Parent Name_____ Male____ Female____

Address_____

Home_____ E-mail _____

Occupation _____ Employer's Name and Address_____

Business Phone_____ Cell_____

(If the student resides with a Guardian(s) other than a Parent, please complete this section.)

Guardian(s) Name _____ Male____ Female____

Address_____

Home Phone_____ E-mail _____

Occupation _____ Employer's Name and Address_____

Business Phone _____ Cell _____

_____

Other children (living in the home)	Date of Birth	M/F	Grade/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I DO HEREBY DECLARE THAT I AM A RESIDENT OF CHELTENHAM TOWNSHIP AND RESIDE AT THE ADDRESS LISTED ON THIS FORM. ALL INFORMATION REGARDING RESIDENCY IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSE INFORMATION WILL RESULT IN THE IMMEDIATE REMOVAL OF THE STUDENT AND I WILL BE PERSONALLY LIABLE FOR THE ANNUAL TUITION RATE.

Parent/Guardian Signature _____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

PENNSYLVANIA INFORAMTION MANAGEMENT SYSTEM
STUDENT DATA FORM

Student's Name_____

PLEASE PRINT FIRST MIDDLE LAST NAME

School_____

District Entry Date _____
(First Day entering Cheltenham schools) YYYY-MM-DD

School Entry Date _____
(First day entering current school) YYYY-MM-DD

State Entry Date _____
(First day as a Pennsylvania student) YYYY-MM-DD

Entered U.S. Schools _____
(First day entering any U.S. school) YYYY-MM-DD

Home Language (Primary) _____

Country of Birth _____

Race/Ethnicity- **(Choose all that apply)**

Native American/Alaska Native___
Caucasian_____ Asian_____
African American____ Hispanic___
Native Hawaiian/Other Pacific_____

Birth Date Verification: **(select one)**

Birth Certificate ____
Baptismal Certificate ____
Passport ____
Other Official Document ____

City of Birth _____

State of Birth _____

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 ☐

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)

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

Pennsylvania School Health Law Requirements

The Pennsylvania School Health Law **requires** all students to have **Medical** and **Dental** exams within one year **prior to a student's entry** into the grade in which an exam is required:

- Medical Exam (for all new students and Kindergarten, 6th grade & 11th grade)
- Dental Exam (for all new students and Kindergarten, 3rd grade & 7th grade)

If the student's examination history does not meet these timelines, please make the necessary arrangements to have the examinations. If a student is entering the School District of Cheltenham Township and/or the 6th or 11th grade, it is recommended that the aforementioned examinations be conducted by a family physician and/or dentist, who is familiar with the student's health history and would be in the best position to recommend immediate steps for necessary remedial care.

Under regulations of the Pennsylvania Department of Health, the following immunizations are required for all students, in grades K-12, as a condition for attendance to school. **Those children whose immunization record is incomplete or not provided will be excluded from school.**

Children **IN ALL GRADES** need the following:

- 4 doses of tetanus* (1 dose on or after the 4th birthday)
- 4 doses of diphtheria* (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chicken pox) vaccine or history of disease
- A Tuberculosis (TB) test **with negative reading** is required of any new enrollee from foreign countries, homeless, TB endemic area and any situation deemed high risk.

* Usually given as DTP or DTaP or DT or Td
**Usually given as MMR

Children **ENTERING** 7th grade need the following:

- 1 dose of tetanus, diphtheria, accellular pertussis (Tdap)

  (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (MCV)

If your child is exempt for medical reasons or religious beliefs, please provide written documentation stating the reason. If your child is exempt from immunizations, he/she may be removed from school during an outbreak. Please return completed forms to your child's school nurse.

H514.027

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 or 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

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

STUDENT HEALTH HISTORY

(This is not a student physical exam.)

THIS FORM SHOULD BE FILLED OUT BY A PARENT OR GUARDIAN BEFORE THE TIME OF REGISTRATION

Your child's success in school rests to a great extent on his/her well-being. The information requested on this form will assure your child has a successful educational experience.

Name:_____

Grade:_____ Birth Date:_____ Nickname:_____

Home Address:_____

Home Phone:_____Work Phone_____Cell _____

Parent/Guardian: Mother: _____ Father:_____

Emergency Contact Name_____Phone#_____

Emergency Contact Name_____Phone#_____

Person with whom child lives_____

Physicians:

Primary Care Physician_____Phone#_____

Current Specialty Physician_____Phone#_____

Does your child have a health problem? (check where appropriate)

Asthma_____Diabetes_____Vision_____Sickle Cell Anemia_____Injury_____

Anemia_____Hearing_____Seizures/Convulsions_____Heart_____

Explain_____

_____

Does your child take medication?_____Name of medication(s)_____

Any allergies to medications or insect stings?(If yes, list on reverse side)_____

Has your child ever had a concussion or been knocked unconscious?_____

Has your child ever had a convulsion or seizure?_____

Does your child wear any removable dental appliance? (retainer,bridge)_____

Does your child wear glasses or contact lenses? Yes____No_____ Hearing Aid? Yes_____No_____

Has any family member had sudden death or a heart attack before age 50?(circle what applies)_____

Has your child had any heart disease, murmur, extra beats, or high blood pressure?_____

Has your child ever been dizzy or passed out from exercise?_____

Does your child have any missing organs (kidney, testicle, eye, etc.)_____

Has your child engaged in any chemical or substance usage?_____

Does your child experience any menstrual irregularities (Females)?_____

Has your child ever induced vomiting, or engaged in binge eating or purging?_____

Is there anything more about your child's health that you think is important for us to know?_____

Explain:_____

Allergies: Medications or foods to be avoided_____

Reactions_____

Additional Data: Birth weight_____Premature_____Normal Birth_____

Please describe any birth defects_____

Is your child receiving medical treatment at present? Yes_____No_____

Is your child restricted from physical activity? Yes_____No_____

Describe:_____

Is your child receiving treatment at present for a physical or mental ailment? Yes_____No_____

Has your child had any operations or serious injuries?_____

Describe:_____

Date _____ Signature_____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

Medication Administration Physician Order / Parent-Guardian Consent

Student Name:_____Date/Time:_____

School:_____Teacher/Grade:_____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a Medication Administration Consent form signed by the student's parent/guardian and a Medication Order from a licensed prescriber. **All medications must be in an original prescription bottle/container from a pharmacy**. All medications must be delivered in person by the student's Parent/Guardian.

Parent/Guardian Consent:

I give my permission for my child,_____, to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature:_____Date:_____
Parent/Guardian name printed: _____Phone:_____

Licensed Prescriber Medication Order:

Patient's
Name:_____Date:_____
Name of
Medication:_____
Route and dosage: _____Time of administration:_____
Directions:_____
_____

Discontinuation date:_____

Allergies:_____

Licensed Prescriber signature:_____

Licensed Prescriber name printed:_____Phone:_____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
HOME LANGUAGE SURVEY

Student Name _____ School Year 20___to 20_____

Address_____

Phone _____E-mail _____Age _____ DOB _____

Gender _____ School _____ Grade ___Country of Origin_____

Other Countries of Residence (Please List)

_____

1. What was the first language your child learned to speak ?_____
2. What language (s) does your child speak most often at home? _____
3. What language (s) is (are) spoken in your home? _____
4. Does your child speak any language (s) other than English? _____
   If yes, which one (s)? _____
5. Do you, parents/guardians, read English? ☐ YES ☐ No
   If no, what language (s) do you read? _____

Survey completed by _____

Signature of Parent or Guardian

To be completed by School District of Cheltenham Township

English as a Second Language Evaluation Report

Examiner _____Date of Evaluation_____

Reason for Evaluation_____

Assessment Instruments Used: _____

Diagnostic Information:

Listening: _____

Speaking: _____

Reading:_____

Writing: _____

Recommendations: _____

_____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
STUDENT EMERGENCY CARD

Name of Student_____ **Date of Birth** _____

Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____

School _____ **Grade**_____ **Home Room** _____

TO PARENT OR GUARDIAN: In case of an **ACCIDENT OR SUDDEN ILLNESS**, please furnish the following information for emergency calls:

Parent/Guardian Name_____ **Employer** _____
Work Phone_____ **Cell Phone**_____

Parent/Guardian Name_____ **Employer**_____
Work Phone_____ **Cell Phone**_____

Parent/Guardian E-mail_____

LIST TWO INDIVIDUALS WHO COULD PICK UP YOUR CHILD IF PARENT/GUARDIAN CANNOT BE REACHED IN CASE OF ILLNESS OR EMERGENCY DURING SCHOOL HOURS:

Name_____ **Home Phone** _____ **Work Phone**_____

Name_____ **Home Phone**_____**Work Phone** _____

Family Physician _____ **Phone #**_____

Family Dentist _____ **Phone #**_____
Please note any custody information:
_____

HEALTH INFORMATION:

List medical concerns, i.e., Allergies _____

List your child's medications _____

Type of Medical Insurance_____ **Policy Number**_____
In case of an emergency where hospital treatment is necessary and the parent/guardian cannot be reached, I hereby give permission to take the above named student for treatment. I authorize the release of medical information.

Signature of Parent/Guardian_____ **Date**_____

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
2000 Ashbourne Road
Elkins Park, PA 19027

REQUEST FOR RECORDS

To: Registrar/_____ Date:_____
(Name of student's previous school)

Address:_____

Telephone Number:_____

Student's Name:_____ Date of Birth:_____

The above student will enter the School District of Cheltenham Township on:_____

Please send all school records (academic/ standardized test data/ official transcripts/ attendance/ discipline/ health/immunization/special education records) to the Secretary's attention at the following circled location below:

Cheltenham Elementary
7853 Front Street
Cheltenham, PA 19012
Phone: 215-635-7415
Fax# 215-517-4528

Myers Elementary
7609 Montgomery Avenue
Elkins Park, PA 19027
Phone: 215-517-4540
Fax# 215-517-4543

Cedarbrook West
1331 Ivy Hill Road
Philadelphia, PA 19150
Phone: 215-8816427
Fax# 215-576-5610

Glenside Elementary
400 Harrison Avenue
Glenside, PA 19038
Phone# 215-881-6440
Fax# 215-886-6797

Wyncote Elementary
8149 New Second Street
Elkins Park, PA 19027
Phone# 215-881-6410
Fax# 215-885-7613

Cedarbrook Central
500 Rices Mill Road
Wyncote, PA 19095
Phone: 215-881-6427
Fax# 215-517-3771*

Elkins Park
8149 New Second
Elkins Park, PA 19027
Phone# 215-881-4941
Fax# 215-635-7492

Cheltenham High
500 Rices Mill Road
Wyncote, PA 19095
Phone: 215-517-3768
Fax# 215-517-3771

Cedarbrook East
7631 Waters Road
Cheltenham, PA 19012
Phone# 215-881-6427
Fax# 215-881-6143

PARENT SIGNATURE REQUIRED:_____

SIGNATURE OF SCHOOL OFFICIAL:_____

***Please Note: When faxing records to Cedarbrook Central, please ensure that you address the fax request to the Secretary of Cedarbrook Middle School.**

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

VERIFICATION

I, _____verify that I am the parent

of_____ and that

_____ has not been previously suspended or expelled from any public or private school in Pennsylvania or any other state pursuant to an offense involving weapons, alcohol, drugs or other violent acts except as listed below. I understand that false statements herein are made subject to the penalties of 18 PA. C.S.A. Section 4904, relating to unsworn falsifications to authorities.

_____

Signature of Parent/Guardian

Date:_____

List all previous suspensions or expulsions for any public or private school in Pennsylvania or other state pursuant to an offense involving, weapons, alcohol, drugs or other violent acts:

SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP
2000 ASHBOURNE ROAD ELKINS PARK PA 19027
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION/RECORDS

DATE: _____

STUDENT: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

Name/Title/Agency _____ Name/Title/Agency _____

Address _____ Address _____

Telephone _____ Telephone _____

_____ Evaluation Report

_____ Individualized Education Program (IEP)

_____ IEP for Speech/Language only student

_____ Speech Evaluation

_____ Psychiatric Evaluation

_____ Social Worker Reports

_____ Neurological Evaluation

_____ Counseling/Therapeutic

_____ Behavior Therapist Records

_____ Private Therapist Records

_____ Medical History/Evaluation

_____ Discharge Summary

_____ All records/files on site in residential facility, Private/parochial School, hospital, day treatment program, etc.

_____ School reports, academic record, standardized test data, instructional support information, attendance, discipline and health/immunization records

_____ Verbal/written communication with psychologist counselor, teacher, principal, other related staff, nurse, therapist, doctor

_____ Other records. Please specify: _____

_____

This consent will begin the date of this authorization and will expire one year later on _____ unless revoked by me in the interim. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially and in compliance with federal and state regulations.

_____ _____

Date Parent/Guardian Signature

(Or student over 18)

THIS INFORMATION IS FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED RY LAW.

DUPLICATION WITHOUT WRITTEN CONSENT OF THE PARENT/GUARDIAN AND STUDENT (IF NEEDED) IS PROHIHITED.