Kindergarten Registration Requirements

As stated in the Delaware Valley School Policy, your child(ren) must be five (5) years old on or before September 1 to attend Kindergarten in that school year.

Kindergarten Registration and screening is by appointment at your child's school in the Spring. Registration appointments will be made after your paperwork is turned in.

YOUR CHILD WILL NOT BE PUT ON OUR KINDERGARTEN REGISTRATION LIST UNTIL THE FOLLOWING PAPERS ARE TURNED IN.

REQUIRED REGISTRATION DOCUMENTS:

1. **ORIGINAL** BIRTH CERTIFICATE
   The official state seal must be affixed to the birth certificate.
   (Your original will be copied and returned to you.)

2. CURRENT DOCTOR'S RECORD OF CHILDHOOD IMMUNIZATIONS
   If incomplete, updates can be turned in over the summer but the current record needs to be turned in now. The following ***compulsory*** immunizations must be completed for your child to start school:
   - **At least 4 doses of Diphtheria, Tetanus, Pertussis (Dtap), with the 4th dose on or after the 4th birthday**
   - **4 doses of Polio with the 4th dose on or after 4th birthday AND at least 6 months after previous dose**
   - **2 doses of Measles, Mumps & Rubella**
   - **3 doses of Hepatitis B (spaced according to PA DOH guidelines)**
   - **2 doses of varicella immunization or verification of chicken pox disease**

3. TWO FORMS OF PROOF OF RESIDENCY
   Two forms are required. Homeowners must provide current Real Estate or School Tax Form, Renters must provide either a Lease or the landlord's current Real Estate or School Tax Form accompanied with the enclosed, signed, Landlord Affidavit. The second proof should be a utility bill with matching legal parent/guardian name and address.

4. PROOF OF PARENT/GUARDIAN IDENTITY
   This must be a photo ID of the legal parent/guardian(s) (for example a Pennsylvania Driver's license) indicating the address corresponding with the address on the proof of residency.

5. CUSTODY & GUARDIANSHIP PAPERS
   Any court documents or formal agreements explaining custody arrangements should be turned in for us to make a copy. If the child resides with a grandparent or relative, Guardianship papers are required. Prospective guardian(s) must attend a mandatory meeting with the Building Principal and complete guardianship papers. (Any court documents or formal agreements explaining this custody arrangement.)

6. COMPLETED REGISTRATION PACKET
   Student Registration Form, Health Registration Form, Nurse's Developmental History, Teacher's Registration Form, Acceptable Use User's Agreement, Publicity Release Form, Home Language Survey, and Bussing Form, are to be completed, signed by parent where requested and turned in to your child's school before Spring Registration, or turned in to Support Services during summer registration.
   (The Doctor signed physical and dental forms can be turned in now or over the summer if needed.)

PLEASE Contact your child's school directly to find out when and how they would like you to turn in your Registration packet and documents.

Delaware Valley Elementary School office: Susan Rustin at 570-296-1823, email: SRustin@DVSD.org
Dingman Delaware Primary School office: Donna Frable at 570-296-3132, email: DFrable@DVSD.org
Shohola Elementary School office: Laura Lamberton 570-296-3603, email: LLamberton@DVSD.org
Support Services, Summer enrollment office: Carol Ann Dardia (570) 296-1889, email: CDardia@DVSD.org

KINDERGARTEN STUDENT REGISTRATION School ID#:

Today's Date: _____ Student Birth Date: _____ Gender: _____

Student Name: (Last) _____ (First) _____ (Middle) _____

Previous school grade (circle one): Pre-K K None School Phone number: _____

Previous school Name: _____

Ethnic Origins (circle one): White Black Hispanic Asian Pacific Islander

(If multi-racial circle two) American Indian/Alaskan Native

Home Phone: _____

Student lives with: _____

Physical Address: _____ Mailing Address: _____

_____ _____

(City, State, ZIP) (City, State, ZIP)

Primary Parent/ Legal Guardian 1st contact:

Name: (Last) _____ (First) _____ Relationship to Child: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Signature: _____

Secondary Parent/Legal Guardian 2nd contact:

Name: (Last) _____ (First) _____ Relationship to Child: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Lives with Child: ___Yes, ___ No, ___Partially

---

Doctor Name and Phone Number: _____

Non-Custodial Parent Name, Address, & Phone Number: _____

_____

Guardian/Custody Alert (Please bring legal documentation to Registration): _____

_____

_____

FOR OFFICE USE ONLY

___ Birth Certificate
___ Immunizations
___ Proof of Residency
___ Proof of Identity
___ Guardianship Papers
___ Home Language Survey

Previous PA School ID #:_____

Special Ed: Y_____N_____ Trans. _____
Photo/Video: Y_____N_____
Internet Usage: Y_____N_____

Enrollment Code: _____ Enrollment Date: _____

DELAWARE VALLEY SCHOOL DISTRICT
MILFORD, PENNSYLVANIA 18337
HEALTH REGISTRATION FORM

Date of Entry _____ Teacher _____
Grade _____ School _____

Dear Parent:

When your child enters school, we establish a cumulative record file on him/her to enable us to have a greater understanding of your child's needs. All information, of course, will be kept strictly confidential, so please answer every question. Birth certificate and Immunization Record must be presented at registration.

PLEASE PRINT NEATLY. Thank you for your cooperation.

Has your child ever attended school in DVSD?_____
If yes, what grade? _____

Pupil's Name _____

Mailing Address _____
No. Street
_____
Town State Zip Code

Home Telephone No. _____

Birthdate _____ Birthplace _____ Community or Road _____

Last School Attended: _____ City or Town: _____ Grade: _____

	Father or Male Guardian	Mother or Female Guardian Name
Name		
Relation to Child		
Occupation		
Cell Phone		
Work Phone		
Email		

Child lives with: Both Parents_____ Father _____ Other person _____ (name & relationship to student)
Language spoken in home _____

OTHER CHILDREN IN FAMILY

Name	Birthdate	School	Name	Birthdate	School

If parent is not available in Emergency, call:

1. _____
2. _____

Physician to be called in Emergency: _____
Name Address Phone No.

DISEASE & HEALTH HISTORY

Asthma or Bronchitis: _____
Foods, Drugs, Hay Fever, Grasses, Animals – PLEASE BE SPECIFIC: _____
Any Hospitalization, stitches or fractures?
_____
Family History of Color Blindness: _____If yes, whom? _____
Eye Glasses Yes_____ No _____ Contacts Yes_____ No_____It is advised that every child wearing eye glasses should receive periodic eye examinations. The school would appreciate a report of exam and name of examiner together with any recommendations for school.

Does your child have any other medical conditions? Yes_____No_____
List: _____
Does your child take any medication? Yes_____ No_____If so please list_____
Will your child need to take medication at school ? Yes_____ No_____ Please list:_____
Do you have health insurance for your child? Yes _____ No _____

DELAWARE VALLEY SCHOOL DISTRICT
NURSE'S DEVELOPMENTAL HISTORY

Name of Child: _____ Birthdate: _____

A child's development since birth influences his/her total health and growth. Please answer the following questions:

History of Birth:

1. Mother's age at child's birth: _____.
2. Were there any unusual conditions during pregnancy (i.e. bleeding, infection, German Measles, medication, high blood pressure)? _____ Yes _____ No
   If yes, which illness and when did illness occur? _____
3. Was the baby premature? _____ at what month was baby delivered? _____
4. What was the baby's weight at time of birth? _____
5. Was delivery normal? _____ Forceps delivery? _____ C-Section? _____
   If C-Section, why? _____
6. Were there any conditions or problems in the child after birth (i.e. Jaundice, need for oxygen, birth injuries, or birth defect?) _____ Comment _____
7. Was the labor difficult? _____ How long was labor? _____
8. RH factor or any other blood problem? _____
9. Apgar at 1 minute _____ at 5 minutes _____

History of Infancy and Childbirth:

Has your child shown any of the following? (Answer Yes or No)

1. Extreme Activity _____ Comment: _____
2. Extremely Tired/Sleepy _____ Comment: _____
3. Frequent Headaches _____ Comment: _____
4. Temper Tantrums _____ Comment: _____
5. High Fevers _____ Comment: _____
6. Fainting _____ Comment: _____
7. Convulsions/Seizures _____ Comment: _____
8. Feeding Problems _____ Comment: _____
9. Bowel/Bladder Problems _____ Comment: _____
10. Allergies _____ Comment: _____
11. Frequent Stumbling/Falling _____ Comment: _____
12. Poor Coordination _____ Comment: _____
13. Nail Biting _____ Comment: _____
14. Eye Blinking _____ Comment: _____
15. Stuttering _____ Comment: _____
16. Bed Wetting _____ Comment: _____
17. Thumb Sucking _____ Comment: _____
18. Other Habits/Problems _____ Comment: _____
19. Any Injury to Eyes/Head/Neck _____ Comment: _____
20. Any Hospitalizations _____ Comment: _____
21. Any family history of birth defects _____ Comment: _____
    Disorders, heart disease, diabetes, TB? _____ Comment: _____
22. Has your child been to any clinic or other agencies? _____ Comment: _____
23. At what age did your child first sit alone_____, walk along _____, crawl ____, said single words _____, talking ____, sentences _____, first tooth _____, bowel trained ____, bladder trained _____.
24. Is there any other pertinent health information we should be advised of? _____

_____

_____

Delaware Valley School District

Teacher's Kindergarten Registration Information

Pupil's Name: _____ Sex: _____ Birthdate: _____

General Information

1. Does your child have the opportunity to play with children his/her own age? (please circle) Yes / No
2. Is your child able to dress himself/herself? (Tie shoes, zipper, buttons, etc.)

   Comment: _____
3. Which hand is used for (please circle):

   Eating: Left / Right Writing: Left/ Right Playing: left/ Right
4. Does your child use (please circle): Crayons: Yes/ No Scissors: Yes/ No Glue: Yes/ No

   Clay: Yes/ No Blocks: Yes/ No
5. What time does your child go to bed at night: _____ To Sleep: _____
6. Does your child still take naps (please circle): Yes/ No
7. Are there any home/neighborhood problems/situations which may affect your child at school? Yes/ No

   If yes please comment: _____
8. Do you read to your child? Yes/ No Comment: _____
9. Does your child listen to and carry out directions? Yes/ No
10. Does your child have any strong fears (thunder, dark places, etc.)?

    Comment: _____
11. Is there a computer/iPad in the home: Yes/ No Does your child us the computer/iPad: Yes/ No
12. Is there additional information you can give about your child which could help us make his/her first year at school pleasant and successful? (Please use other side to comment if needed.)

    _____

    _____

Previous Schooling

13. Did your child attend preschool? Yes/ No Where? _____
14. Did your child have early intervention through CDD (Center for Developmental Disabilities)? Yes/ No
15. Has your child/family had a BSC (Behavior Specialist) or TSS (Therapeutic Support Staff) during preschool? Yes/ No

Any information you can provide to better assist your child in the school learning environment is greatly appreciated. We want a smooth transition and the best opportunity for your child.

No. 815-AR-1

DELAWARE VALLEY SCHOOL DISTRICT

ADMINISTRATIVE REGULATION

REVISED: 8/6/2013

Acceptable Use of the Communications and Information Systems

USER AGREEMENT
ACKNOWLEDGMENT AND CONSENT FORM

Students

I have received, read, and understand the Acceptable Use of Communications and Information Systems Policy # 815 and will comply with them. My parent(s)/guardian(s) have also reviewed it with me. In addition, I have been given the opportunity to obtain information from the School District and my parent(s)/guardian(s) about anything I do not understand. If I have further questions, I will ask my building principal and my parents. Additionally, I understand that if I violate the Policy, other School District policies, regulations, rules, or procedures, I am subject to the School District's discipline, and could be subject to ISP and website rules, and local, state and federal rules and procedures.

Name of Student _____

Signature of Student _____

Date of Signature _____

Parent(s)/Guardian(s)

As the parent/guardian of a student of the School District, I have received, read, and understand the Acceptable Use of the Communications and Information System Policy # 815. In addition, I reviewed the Policy with my child and answered questions he or she asked. If either my child or I have further questions I will ask the building principal. I agree to have my child comply with the requirements of this Policy, other School District policies, regulations, rules, and procedures. Additionally, I understand that if he or she violates the Policy, other School District policies, regulations, rules, or procedures he or she is subject to the School District's discipline, ISP and website rules, as well as local state and federal laws and procedures.

Name of Parent _____

Signature of Parent _____

Date of Signature _____

No. 911-AR-1

ADMINISTRATIVE REGULATION

DELAWARE VALLEY SCHOOL DISTRICT

REVISED: 8/6/2013

911-AR-1. PUBLICITY RELEASE FORM

Student Name: _____

School and Grade: _____

Birth Date: _____ Telephone Number: _____

I give my permission to use my son's/daughter's name and picture for:

Newspaper Publications
District Website
Newsletters
District Brochures
Radio/TV
District Publications
Student of the Month/Student Awards

YES_____ NO_____

It is the practice of the district to involve students in activities that are positive and that promote individual self-esteem and cooperation among our students.

Questions or concerns may be directed to: _____
Administrator

_____
Telephone Number

Parent/Guardian
Signature _____ Date _____

Parent/Guardian Name
(Please print) _____

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: _____

Current grade: _____ School of Enrollment: _____

Questions for Parents/Guardians: Please answer all three questions.

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 Name: _____ Relationship to Child: _____

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____

Interpreter Provided ☐ No ☐ Yes

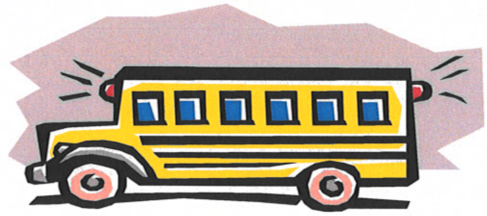
The school district has the responsibility under the federal law to serve students who are limited English proficient and need English Language Development (ELD) services. Given this responsibility, the school district has the right to ask for the information it needs to identify English Learners (ELs). As part of the responsibility to identify ELs, the school district 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 in the future.

For Office Use Only:

Date Received: ___/___/___
ELD Staff Member: _____
_____

Revised: 12/2021

Kindergarten Registration School Bus Information



PLEASE BRING THIS FORM TO KINDERGARTEN REGISTRATION
Complete all information and PRINT CLEARLY

Student Name: ____
Last *First* *Middle*

Street (911) Address: ____
Street *Town* *Zip*

Mailing Address (if different): ____
Town *Zip*

Home Phone: ____________________ Date of birth: ______________ Male ___ Female ___

1st Emergency Contact: ______________________________ School Time Phone: ________________
check one ____*Mother* ______*Father* ____*Guardian*

2nd Emergency Contact: ______________________________ School Time Phone: ________________

*(**Local** contact who can assume responsibility for the student)* *Relationship to student*________________

If you live in a development or private community, list the name: ________________________________

Which community entrance is closest to your home: ________________________________

List the first and last names of your other children who attend school with this kindergarten student so that they can be assigned to the same bus: ____

____

What bus do the other children ride now? Bus #: ___________ Bus stop: ________________________

If your kindergarten student will be going to a babysitter or day care center, you must complete either *a Request for Bus Service to a Licensed Child Care Facility* or a *Request for Bus Service to Private Child Care*. These forms will be available at kindergarten registration. Bus changes for childcare are permanent changes.

++
For Office Use Only:

Bus #: _______________ Bus Stop: ______________________________

DELAWARE VALLEY SCHOOL DISTRICT

REQUEST FOR BUS SERVICE TO A

LICENSED CHILD CARE FACILITY

The Delaware Valley School District will consider requests for change of bus assignments to a private child care provider under the following conditions as set forth in Delaware Valley School District Board Policy 810: Pupil Bus Transportation (Section 2 B 6) :

- The request is submitted and signed by the child(ren)'s parent/guardian.
- There is space and continues to be space on the bus.
- The stop is at a Board approved licensed child care facility.
- The stop is used both to and from school.
- The stop is used on all school days including delayed openings and early dismissals.
- The licensed child care facility is listed on the child(ren)'s emergency cards.
- An additional emergency contact is listed for the child(ren).
- The change will require three (3) days to implement.

I authorize the Delaware Valley School District to transport my child(ren) to the licensed child care provider indicated below. I understand that this is a permanent change for everyday, both to and from school. I understand this is the only change from the stop of my residence that will be permitted this year. I will not request any other change for any reason. Also, I understand that overcrowding on the bus to which my child(ren) is/are assigned may cause the Delaware Valley School District to revoke permission for this change.

Signature of Parent/Guardian _____ Date: _____

Student Name:	Home Address:
School Attending:	Grade:
Home Telephone:	Parent Work Telephone:
Bus Stop Location Nearest Home:	

REQUESTED TRANSPORTATION ARRANGEMENTS

Licensed Child Care Facility:	Date of Change:
Address of Child Care Facility	Child Care Facility Telephone:
Additional Emergency Contact Name:	Additional Emergency Contact Telephone:
Other Information:	

Return this form to: Delaware Valley Transportation Office
258 Routes 6 & 209
Milford, PA 18337

FAX: 570-296-1818

FOR OFFICE USE ONLY

Date School Notified:	

DELAWARE VALLEY SCHOOL DISTRICT

PRIVATE PHYSICIAN'S REPORT OF

PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

Name of School _____Grade_____ Homeroom_____

Name of Child _____Date of Birth_____ Sex: M F

PLEASE ATTACH CURRENT IMMUNIZATION RECORD FROM DOCTOR OR CLINIC

Medical History (if yes, explain)

Allergies ---------- Y N _____ Hypertension----------Y N _____

Asthma---------- Y N _____ Neuromuscular Disorder ---------Y N _____

Cardiac---------- Y N _____ Orthopedic Condition---------- Y N _____

Drug/Alcohol Dependency---- Y N _____ Respiratory Illness----------Y N_____

Diabetes----------Y N _____ Seizure Disorder---------- Y N_____

Gastrointestinal Disorder-------Y N _____ Skin Disorder----------Y N_____

Hearing Disorder----------Y N _____ Vision Disorder----------Y N_____

Other (specify) ----------Y N _____

Please list any special medical problems or medications the student takes.

_____

PHYSICAL EXAM

Height_____ Weight_____ BMI_____ Pulse_____ Blood Pressure_____

System	Normal	Abnormal	Deferred	Comment/Screening Result
Hair/Scalp				
Skin				
Eyes & Vision Screening				OD OS REFER
Ears & Hearing Screening				PASS FAIL REFER
Nose & Throat				
Teeth & Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular/Extremities				
Spine/Scoliosis				
Psycho-Social Screening				WNL REFER: Y N

Is the child under treatment ? _____Yes _____No

Does the child have any restrictions on play or physical education activities? _____Yes _____No

Date of Exam_____

Signature of Examiner_____ Phone_____

PRINT name_____

Delaware Valley School District

Dear Parent:

School health law requires all children who are in **grade K, three and seven** to have a complete dental examination.

When the required examination is completed by your family dentist, please have them complete the form below.

If you are on an every six month schedule, please mail this form to your dentist and request it be completed for the last dental visit. **Any exam done within one year of August of this year is acceptable.**

The students who are not examined by your own dentist will be examined by school dentist.

We appreciate your cooperation in this program.

School Nurses
Delaware Valley School District

FAMILY DENTIST REPORT

Child's name_____ Teacher's Name_____

School_____ Grade_____

1. This student last visited my office on _____

2. All necessary corrections were made at that time. Yes_____ No_____

3. If the above answer is no, please indicate the dental correction needed:

_____Primary teeth _____Permanent teeth _____Fillings _____Extractions

_____Gross Malocclusion

_____Prosthetic replacement for lost or missing teeth

_____Other_____

This child is currently under my supervision for the above condition. Yes _____ No_____

4. This child receives topical fluoride applications under my supervision.

_____Yearly _____Every 6 months _____Never

_____ _____
Dentist Signature Date

_____
Dentist Address

Delaware Valley School District

Office of Support Services -- 258 Route 6 & 209, Milford, Pennsylvania 18337
570-296-1883 FAX: 570-296-1818

Affidavit of OWNER/LANDLORD in support of Tenant(s) Proof of Residency

As the OWNER/LANDLORD of the premises described below, I provide this verification in satisfaction of the Proof of Residency requirement for all students enrolling in the Delaware Valley School District. The following persons reside permanently at the address indicated below.

NOTE: No student will be enrolled in any Delaware Valley School until proper Proof of Residency is accepted.

Proof of residency type:_____

Tenants: Mr./Mrs./Ms. _____

School Age Children: _____ _____
_____ _____
_____ _____

Tenant's Mailing Address: _____
_____

Township of Residence (Attach copy of Current Tax Statement):
_____

Exact location of Residence: _____
_____
_____

I certify that the information provided in this Affidavit is true and accurate.

_____ _____
Signature of Owner/Landlord *Date*

_____ _____
Name of Owner/Landlord (Print) *Daytime Telephone Number*

NOTICE: Individuals signing this form are hereby certifying that the above information is true and correct. False statements contained herein are subject to criminal prosecution under 18 P.C.S.A. Section 4904 related to unsworn falsification to authorities. Penalties for unsworn falsification to authorities include imprisonment for up to one year and fines up to $2,500.00.