

Bristol Borough School District
1776 Farragut Avenue
Bristol, PA 19007
Phone: 215-781-1000 x1014 - Fax: 215-781-1012

Student Registration Checklist

The following documentation is necessary when you enroll your child in the Bristol Borough School District. When you have gathered all the necessary documents, please return these items to the **BRISTOL BOROUGH SCHOOL DISTRICT ADMINISTRATION BUILDING** to register your child. Thank you.

Student Name _____ **Date** _____

Previous Address: _____

Documents to be completed and returned at Registration:

1. Dental Form & Physical Form or proof of appointment
2. Health History Form
3. Technology Form
4. Child Custody (please provide documentation)
5. Previous school information/most recent report card
6. Parent Portal/E-Mail address form

Documents Required at Registration:

1. Student Registration Form
2. Affidavit of Tenant Occupancy (required if a tenant **MUST** be completed, signed, and notarized by your landlord and your signature where indicated).
3. Lease or Settlement Papers (HUD#1) or Property Tax Invoice
4. Proofs of Residency (three (3) from the list)
 - Bank Statement
 - Utility turn on statement or any utility bill
 - Driver's License/State Identification Card (If license/State Identification Card address differs from new address change of address card is also required
 - Vehicle Registration Card **OR** Insurance I.D. Card
 - Any bill receipt indicating new address
 - TV/Cable/Satellite Activation or Statement
 - Cell phone or Telephone Statement
5. Birth Certificate
6. Immunization Record
7. Home Language Survey
8. Affirmation of Prior Discipline Record (Act 26) - **Not Required**

For Kindergarten Students.

ALL PAPERWORK MUST BE SUBMITTED AT THE SAME TIME. NO PARTIAL PAPERWORK WILL BE ACCEPTED. THANK YOU.

BRISTOL BOROUGH SCHOOL DISTRICT STUDENT REGISTRATION FORM - PART I

Date of Registration: _____ Grade of Entry: _____

Student's Name: **(MUST BE WRITTEN AS IT APPEARS ON BIRTH CERTIFICATE)**

_____ Male: ___ Female: ___

Address: _____ Apt. #: _____ Foster Child: Y or N

Home/Cell Phone: _____

Date of Birth: _____ Birth City: ___ Bristol ___ Langhorne ___ Phila. ___ Other: _____

Birth State: ___ Pa ___ NJ ___ Other: _____ Birth Country: ___ U.S. ___ Other: _____

Race: ___ Amer. Ind./Alaskan Native ___ Asian ___ Black ___ Hispanic ___ Multi-Racial ___ White ___ Hawaiian/Pac Islander

What year did child enter PA Schools? _____ What year did child enter our school district? _____

PARENT INFORMATION:

Father's Last Name First Name
___ Living at home ___ Separated ___ Divorced ___ Custody ___ Deceased

Race: ___ Asian ___ White ___ Black
___ Hispanic ___ Hawaiian
___ Amer Ind/Alask Native
___ Multi-Racial

Mother's Last Name First Name
___ Living at home ___ Separated ___ Divorced ___ Custody ___ Deceased

Race: ___ Asian ___ White ___ Black
___ Hispanic ___ Hawaiian
___ Amer Ind/Alask Native
___ Multi-Racial

Guardian's Last Name First Name Middle

OFFICE USE ONLY

Emergency Contact Phone Number

Start Date: _____
Student ID # _____
Homeroom # _____
Teacher: _____

Child's Name _____

PART 2

Other Children living in the household:

Last Name	First Name	Date of Birth	Relationship	School

Child's Previous Education Information (Please start with most recent school)

Name of School	Address	City, State, Zip Code	Country
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Name of School	Address	City, State, Zip Code	Country
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Has your child ever attended Bristol Borough Public Schools? Y N What school year? _____

Has your child ever been retained? Y N If so, which grade(s)? _____

Has your child ever been tested for Special Education? Y N If so, when? _____

Has your child received Special Education Services? Y N If so, when? _____

Does your child have an IEP (Including Speech and Language)? Y N

Does your child have Medical Assistance? Y N

Has your child been classified as gifted? Y N

Has your child ever attended English Language Learners Classes? Y N Exited *If exited, date: _____

**If yes, date first enrolled in US school? _____ and date first enrolled in ESL? _____

Did your child receive any other services? Y N If so, which services? _____

(Revised 9/2013)

BRISTOL BOROUGH SCHOOL DISTRICT
HOME LANGUAGE SURVEY*

School

_____ Snyder-Girotti Elementary _____ Middle School _____ Bristol High

Date: _____

Student's Name: _____ Grade: _____

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

2. Does the student speak a language other than English? ___ Yes ___ No
*If yes, specify the language (Do not include languages learned in school).

3. What language(s) is/are spoken at home? _____

Person completing this form (If other than parent/guardian)

Signature:

Parent/Guardian Signature: _____

Parent/Guardian (Print Name): _____

*The school district 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 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 may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enroll in the school district in the future.

PLEASE READ, SIGN AND RETURN THE FOLLOWING:

STATEMENT OF RESPONSIBILITY FOR INTERNET USE

The members of the school community of the Bristol Borough School District (the "District") have the opportunity to access the Internet for educational use. It is understood that every person's use of this system cannot be monitored at all times. It is also understood that the use of the District's network is a privilege. As we foster independent use of this resource, reasonable procedures and standards for appropriate behavior are expected from all users.

Use of the District network to access Internet is extended to users to enhance curriculum studies and to facilitate technological literacy. The use of the District Network by minors is necessary to achieve this goal and is subject to procedures and standards for appropriate network behavior as set forth in the District's "Acceptable Use Policy for Technology", a copy of which is incorporated in the student handbook and/or available from the school office.

I understand and will abide by the District's "Acceptable Use Policy for Technology". I understand that Internet activity is monitored by the District. I understand that should I commit such a violation of the District "Acceptable Use Policy Policy", my access privileges will be revoked, school disciplinary action may be taken, and appropriate legal action may be taken.

Student's Signature: _____ Date: _____

Student's Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Print): _____

(Required of all students)

**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			BOOSTERS & DATES	
	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 above named 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 _____.

Result of Diagnostic Studies: _____
Preventive Anti-Tuberculosis – Chemotherapy ordered. No Yes _____ Date _____

Significant Medical Conditions (√)

If Yes, Explain

	Yes	No	
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 (√)

	Normal	Abnormal	Not Examined	Comments
▪ 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 Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number

BRISTOL BOROUGH SCHOOL DISTRICT
Student Health History

Name of Person _____ Relationship to Child _____ Date _____
Completing Form

STUDENT'S HEALTH HISTORY

Student's Name _____ D.O.B. _____ AGE _____
Home Address _____ Phone # _____
Previous School's Name: _____
Address: _____

A. Pre-Natal History **Circle Answer**

1. Did the mother have any illness during the pregnancy? YES NO
2. Did the mother take any medicines or drugs? YES NO
(Other than iron or vitamins)

B. Developmental History

1. What was the baby's birth weight? _____
2. Did the baby have any trouble while in the hospital? YES NO
3. Did the baby have any special problems in the first six (6) months? YES NO
4. At what age did the child sit alone without support? _____
5. At what age did the child walk alone without support? _____
6. At what age did the child say two or three words together? _____
7. Can the child use the toilet without help? _____

C. Family Health History

1. Circle any one of the following conditions that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:
Allergy Seizures Asthma
Tuberculosis Cancer Lead Poisoning
Drug/Alcohol Addiction Sickle Cell Diabetes
Vision Problems Hearing Problems Heart Disease
Nervous Breakdown Anemia Learning Problems
Other Inherited or Family Diseases: _____
2. Do any other family members have medical problems? If yes, please list: _____

D. Student Health History

1. Is the child taking any medications? If yes, please explain.
-
2. Has the child had more than six colds or throat infections, with a fever within a year? YES NO
3. Has the child had any trouble with ears or hearings? YES NO
4. Has the child had any trouble with eyes or vision? YES NO
5. Has the child ever had a convulsion (fit or seizure)? YES NO
6. Has the child had any trouble with teeth? YES NO
7. Does the child complain of headaches? YES NO
8. Has the doctor ever said the child had a heart murmur? YES NO
9. Does the child often have diarrhea? YES NO
10. Has constipation ever been a problem for this child? YES NO
11. Have you ever seen blood in the child's stool? YES NO
12. Does the child complain of frequent belly aches? YES NO
13. Does the child have any problems with passing water? YES NO
14. Does the child have any skin problems? YES NO
15. Has the child ever had asthma or allergies (bees, pollen, dust or medications)? YES NO
16. Has the child ever had an allergic reaction? YES NO
If yes, explain. _____
-
17. Does the child seem to have trouble breathing through the nose? YES NO
18. Does the child snore at night? YES NO
19. Does the child have trouble sleeping? YES NO
20. Has the child ever complained of pain in the arms or legs? YES NO
21. Has the child ever had swelling of any joints or limping? YES NO
22. Does your child have any blood disorders? YES NO
23. Has your child had any operations or serious accidents? YES NO
If yes, please explain. _____

Please circle any of the following behaviors that apply to your child:

- | | |
|--------------------------------|------------------------------|
| Bed Wetting | Fighting with other children |
| Wetting during the day | Feelings easily hurt |
| Thumb sucking | Sad and sulky |
| Overly active | Lying |
| Clumsiness | Clings to parents |
| Daydreams | Destroys things |
| Shy | Temper tantrums |
| Jealous of brothers or sisters | Disobedient |
| High strung/Easily upset | Nightmares |
| Stammering or stuttering | Stubborn |

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 19____

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
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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	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
				T	S	R	Q	P	O	N	M	L	K				
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



Dear Parent or Guardian,

Bristol Borough School District introduced a new grade keeping system that will allow parents and guardians to access their child's grade assignments and grades in each of their classes on a daily basis.

Parents and guardians are encouraged to apply for a password by signing below and including an email address. Once you are entered into our system, we will send you a letter with specific directions on how to log onto our system.

Student Name:

Parent or Guardian Name:

Parent or Guardian Signature:

Parent or Guardian Email:



Bristol Borough School District

1776 Farragut Avenue
Bristol, PA 19007
(215) 781-1000 Ext 1040
(215) 781-1012 Fax

AFFIRMATION OF PRIOR DISCIPLINE RECORD

**NOT REQUIRED FOR KINDERGARTEN STUDENTS*

A Willful false statement on this affirmation is a misdemeanor of the third degree and shall be immediately reported to the appropriate authorities.

DIRECTIONS: Check the applicable paragraph, provide all appropriate information, and sign this document.

Paragraph 1:

_____ The undersigned affirms that _____ has not been suspended or expelled from any public or private school in Pennsylvania or any other state for an act of offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence against persons and/or property committed on school premises, at any school sponsored activities or on any public or private conveyance providing transportation to or from a school or school sponsored activity.

Paragraph 2:

_____ The undersigned affirms that _____ in Pennsylvania or another state for one or more acts or offenses involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for an act of violence against persons and/or property committed on school premises, at a school sponsored activities or on a public or private conveyance providing transportation to or from a school or school sponsored activity.

If you checked paragraph two, explain the circumstances in detail. Include the school name, dates of suspension or expulsion, and a description of the incident giving rise to the suspension or expulsion.

CHECK ONE OF THE FOLLOWING: ___ **IS NOT** presently suspended or expelled.
___ **IS** presently suspended or expelled. Please Explain Below.

Date: _____ Student's Signature: _____

Date: _____ Parent's/Guardian Signature _____

Date copy sent for verification: _____ BBSD Staff Member Initials: _____

Name of Sending School District _____

Sending School Please Complete:

___ Student did not violate Act 26 ___ Student did violate Act 26

Return to: _____

If the student has been involved in offenses involving weapons, alcohol, or drugs or willful infliction of injury to persons or an act of violence against persons and/or property committed on school premises, at a school sponsored activities or on a public or private conveyance providing transportation to or from a school or school sponsored activity, please forward appropriate disciplinary documentation.

Signature of Sending District Administrator

Title

Date