



Kindergarten Registration Appointment Materials

2017-2018 Age Eligibility – a child must be five years of age on or before August 31, 2017. There are no exceptions to this eligibility cutoff date.

Page 1: Checklist

Page 2: Registration Form and Home Language Survey

Page 3: Speech Language Form

Page 4: Health History Form

Use this checklist to prepare the required documents necessary for registration.

Proof of Child's Age

Birth Certificate, Baptismal Certificate, or Valid Passport

Immunization Records

Proof of Residency

Property Deed or Current Rental Lease and

Proof of Residency - Supporting Documents (choose 2 from the following list)

Current Utility Bill

Current Credit Card Bill

Current Bank Statement

Current Mortgage Statement

Current Vehicle Registration

Welfare Card

Property Tax Bill

Central Bucks Registration Form and Home Language Survey

Central Bucks Health History Form

Parent/Guardian Picture Identification

If applicable, bring your child's previous school information: name, address, and phone number of school.



Central Bucks School District

Registration Application

Page (1)

Official Use
School Year _____
School _____
Date _____
Signature _____

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

Address _____ Grade _____ Date of Birth _____
 _____ Gender Male Female

Student Resides with: Both Parents (same address) Mother Father Stepparent Guardian/Other*

Residency: Resident Foster (1305) Shelter (1306) Guardianship* (1302)

Own Rent Reside with District Resident

If both parents reside separately please provide a copy of court order/custody agreement.

Parent/Guardian Name: _____ (Circle)	Parent/Guardian Name: _____ (Circle)
Address _____	Address _____
Phone: _____ (Home)	Phone: _____ (Home)
_____	_____
(Cell)	(Cell)
_____	_____
(Work)	(Work)
Email: _____	Email: _____

* *If person registering student is other than the biological parents additional documentation is required.*

Guardian Relationship to Student: Foster Placement Agency Name: _____

Stepparent Grandparent Relative Family Friend

Court Order Placement Date _____ 1302 Date _____

Please list two local emergency contacts in the event parent/guardian(s) cannot be reached:

1. _____ Phone (1) _____ (2) _____

2. _____ Phone (1) _____ (2) _____



Central Bucks School District Student Survey

Page (2)

Student Name _____ Nickname _____

Previous schools attended:

School Name	Address	Grades
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth City _____ Birth State _____ Birth Country _____

1st PA school enrollment date _____ 1st US School enrollment date _____

Date entered US _____ Special Education plans: 504 Yes No IEP Yes NO

Federal Ethnicity Hispanic Not Hispanic

Federal Race (Check One or More): White Black/African American Asian
 Native Hawaiian/Pacific Islander American Indian or Alaska Native

Home Language Survey:

What was the student's first language? _____

Does the student speak a language other than English? _____

What language is spoken in your home? _____

Has the student been enrolled in an ESL/ELL program in the US? Yes Dates _____ NO

Siblings/Others living in Household:

Names	Relationship to student	DOB	CB Student
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

If parents are divorced or separated are you providing the school district with a custody order? _____

By signing below I am allowing Central Bucks School District to register my child as a student. I also certify the information provided on this application is true and accurate and providing false or incomplete information/required registration documentation may delay enrollment.

X _____ Date _____
Parent/Guardian Signature

Central Bucks School District
School Health Services Health History

(to be completed upon enrollment)

A copy of the student's current immunizations is required to register.

To Parents or Guardian: The following information is requested for our records.

Grade Entering _____ Date _____

Previous school attended _____ State _____

Address _____ City _____

Student's Name _____ Home Phone _____
Last First Middle

Birthdate _____ Male _____ Female _____ Parent's Work Phone _____
Month/Day/Year

Mailing Address: _____
Street City/Town Zip

Father _____ Mother _____
Last First Last First

Guardian _____ Relationship _____
Last First

Student's Physician _____ Date of last exam _____ Health Insurance _____

Student's Dentist _____ Date of last exam _____ Dental Insurance _____

Are Community Services needed? Free Dental and Health Care? _____ Yes _____ No
Free/Reduced Lunch Program? _____ Yes _____ No

A. Disease History/ Illnesses

Check any of the following and put a date next to all that apply.

Chicken Pox _____ Lyme Disease _____ Kidney Disease _____ Bleeding Disorder _____
Pneumonia _____ Heart Disease _____ Gastrointestinal _____ Seizure Disorder _____
Diabetes _____ ADD ADHD _____ Headaches _____ Skin Disorder _____
Please describe: _____

B. Health History Please check yes or no.

1. Does your child have frequent ear infections or trouble hearing? No Yes
2. Does your child have any trouble with eyes or vision ? No Yes
3. Has your child ever had a serious illness? No Yes
4. Has your child ever had any surgery? No Yes

Please describe if the answer was "yes" to any of the above questions

C. Allergy History

1. Does your child have any environmental allergies? No Yes
Explain _____
2. Has your child ever had an allergic reaction to **any** medications? No Yes
Please describe what happened. _____
3. Has your child had an allergic reaction to any foods? No Yes



CENTRAL BUCKS SCHOOL DISTRICT

School _____

Date _____

Child's Name _____

Date of Birth _____

Parent's Name _____

Phone _____

Address _____

Please check all the appropriate areas below. You may make additional comments, if desired, on the back of this form.

YES NO HEARING

Child has history of ear infection(s). If so, approximate number _____
Treated by Dr. _____

Child complains of frequent earaches.

Child has "draining ears" and some liquid other than wax has been noted more than once in the outer ear.

Child may have a hearing problem.

Child has a known hearing loss. If so, please describe: _____

YES NO SPEECH AND LANGUAGE

Child has difficulty making and using many sounds.

Child has difficulty making and using a few sounds.
If possible, list examples: _____

Child talks very little.

Child speaks one or two words at a time and rarely uses complete sentences.

Child may have a voice problem: pitch, volume, rate, quality (hoarseness, harshness, nasality).

Child is not fluent; repeats, hesitates, prolongs sounds, or grimaces during speech.

Child may need help from the Speech/Language Therapist concerning his/her speech or language development.