



Otto-Eldred School District

143 R. L. Sweitzer Drive

Duke Center, PA 16729

(814) 817-1380 opt. 3 Fax 814-817-4050

Matthew D. Splain, Superintendent

Jodi L. Flexman, Business Manager

Otto-Eldred Elementary School

5 Bennett Street

Eldred, PA 16731

(814) 817-1380 opt. 1 Fax 225-4917

Otto-Eldred High School

143 R. L. Sweitzer Drive

Duke Center, PA 16729

(814) 817-1380 opt. 2 Fax 817-4050

## AUTHORIZATION FOR RELEASE OF RECORDS

PREVIOUS SCHOOL DISTRICT \_\_\_\_\_ FAX \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_

DOB \_\_\_\_\_ GRADE \_\_\_\_\_ ENTRY DATE (pending paperwork) \_\_\_\_\_

The above-named student is enrolling in Otto-Eldred School District.

**I hereby authorize the release of the following information to Otto-Eldred School District.**

	Permanent Student Records		PA Secure ID Number (if applicable)
	Current Report Card		Attendance & Discipline
	Complete Health/Dental Record		Special Education Records IEP/ER **

**\*\* Please forward Spec. Ed. records via IEP Writer.**

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE/S

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
CURRENT ADDRESS

\_\_\_\_\_  
DATE

**FAX OR EMAIL ALL RECORDS TO:**

Suzanne Strait, Registrar  
Otto-Eldred School District  
143 Sweitzer Drive  
Duke Center, PA 16729  
Office: 814-817-1385  
Fax: 814-817-4050  
[sstrait@ottoeldred.org](mailto:sstrait@ottoeldred.org)

**Receiving District:**

**Please complete and enclose a copy of this form with student records.**

Name of Staff Member Sending Records: \_\_\_\_\_

Phone: \_\_\_\_\_ Date Records Sent: \_\_\_\_\_

# OTTO-ELDRED SCHOOL DISTRICT REGISTRATION FORM

Household Information				
Household/Surname (Primary Last Name):				
Residence Physical Address:				
PO Box:	City:	State:	Zip:	
Household Primary Phone:		Household Primary Email:		
Student Information				
First Name:	Nickname:	Middle Name:	Last Name:	
Date Of Birth:	Birth City/State:		Grade:	
Ethnicity: (Choose one) Hispanic/Latino            Non-Hispanic Latino			Gender: Male                      Female	
Race: (Choose one or more) White            American Indian/Alaskan            Asian            Black/African American            Hawaiian/Pacific Islander				
School History				
Name of previous school attended:			City:	State:
Has this student ever repeated any grade?		YES      NO	If yes, what grade(s):	
Does this student have Special Placement or Special Education?   YES      NO   If Yes, Please Specify: Individualized Education Program ( <b>IEP, this includes Speech</b> ): , Gifted IEP ( <b>GIEP</b> ) or Section <b>504</b> Service Agreement				
FATHER/Guardian/Foster Father Information				
First Name:		Last Name:		
Address (if different from Household):		City, State, Zip Code		
Home Phone:	Cell Phone:		Work Phone:	
Primary Email:	Relationship to Student:	Resides in Household?      YES      NO		
		Legal Custody?      YES      NO		
MOTHER/Guardian/Foster Mother Information				
First Name:		Last Name:		
Address (if different from Household) :		City, State, Zip Code		
Home Phone:	Cell Phone:		Work Phone:	
Primary Email:	Relationship to Student:	Resides in Household?      YES      NO		
		Legal Custody?      YES      NO		

The Otto-Eldred School District does not discriminate on the basis of sex, and prohibits sex discrimination, including sex-based harassment, in any education program or activity that it operates, as required by Title IX of the Education Amendments of 1972, 20 U.S.C. §§1681 et seq., and its regulations, 34 C.F.R. Part 106. Individuals may report concerns or questions to the District's Title IX Coordinator, Mr. Nicholas LaBella. The District's full Title IX Notice of Nondiscrimination is located at [www.ottoeldred.org](http://www.ottoeldred.org).

**OTTO-ELDRED SCHOOL DISTRICT  
REGISTRATION FORM**

<b>Emergency Contacts</b> (In addition to parents/guardians already listed)	
<b>Emergency Contact (#1)</b>	
Name:	Relationship to Student:
City/State:	
Home Phone:	Cell Phone:
<b>Emergency Contact (#2)</b>	
Name:	Relationship to Student:
City/State:	
Home Phone:	Cell Phone:
<b>Emergency Contact (#3)</b>	
Name:	Relationship to Student:
City/State:	
Home Phone:	Cell Phone:



# 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: \_\_\_\_\_  
(Month/Day/Year)

**Questions for Parents or Guardians**

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

Interpreter Provided ☐ No ☐ Yes

Otto-Eldred School District  
**PARENTAL REGISTRATION STATEMENT**

Any willful false statement made herein shall be a misdemeanor of the third degree.  
This form shall be maintained as part of the student's disciplinary record.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an action of offense involving a weapon, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property."

I hereby swear or affirm that I am the parent/guardian, or other person having lawful charge of the above-named student, and that he/she is a lawful resident of the Otto-Eldred School District. I also swear or affirm that my child:

**WAS PREVIOUSLY SUSPENDED**

\_\_\_\_\_ YES \_\_\_\_\_ NO

**WAS PREVIOUSLY EXPELLED**

\_\_\_\_\_ YES \_\_\_\_\_ NO

**IS PRESENTLY SUSPENDED**

\_\_\_\_\_ YES \_\_\_\_\_ NO

**IS PRESENTLY EXPELLED**

\_\_\_\_\_ YES \_\_\_\_\_ NO

from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information, and belief.

**If this student has been or is presently suspended or expelled from another school, please complete:**

Name of the School/School District from which student was suspended or expelled:

\_\_\_\_\_

Dates of Suspension/s: \_\_\_\_\_ Dates of Expulsion/s: \_\_\_\_\_

Reason for Suspension/Expulsion: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Otto-Eldred School District**  
**Medical Information and Authorization for School Health Services**

The following information is needed in order for the school nurse to give the most effective medical attention and treatment to your child. Please complete and return this form by the end of the first week of school.

Student's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical conditions, mental/emotional conditions, physical limitations and recent surgeries:

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Did your child sustain any type of head injury over the summer? \_\_\_ No \_\_\_ Yes, date \_\_\_\_\_

Does your child have a severe allergy? (Food, insect sting, medication, other) Please specify.

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What treatment is necessary? \_\_\_\_\_

Does your child require an Epi-pen or rescue inhaler during school? \_\_\_ Yes \_\_\_ No

List any daily medications taken; please give name, dose and frequency:

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Immunizations received this year and date (please provide copy for your child's record)

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In the case of an extreme emergency, and we are unable to contact you, your child will be transported to a nearby hospital. Please indicate Hospital preference.

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Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

I give my permission to make the information on this form available to authorized school and transportation personnel if necessary. I also give permission to my child's health care provider/dentist to share any necessary information relating to my child's health with the school nurse.

Signature \_\_\_\_\_

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

(COMPLETE BOTH SIDES)

## PERMISSION TO GIVE OTC (over the counter) MEDICATION

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

The following medications may be given on an as needed basis after assessment by the school nurse if there are no contraindications or allergies and with parental consent. Medications will be administered as directed by the manufacturer.

**If you are able, please provide acetaminophen or ibuprofen in the original container with your child's name on it for their use.**

**Please draw a line through any of the following medications that you do NOT want used in the treatment of your child.**

NON-ASPIRIN PAIN RELIEVER (Acetaminophen, Tylenol for pain or fever)

ANTI-INFLAMMATORY PAIN RELIEVER (Ibuprofen, Advil, Motrin for pain or fever)

ANTACID (Tums)

BENADRYL (diphenhydramine for allergic reactions)

THERA TEARS, EYE WASH OR CONTACT SOLUTION (minor eye irritations, contacts)

HYDROCORTISONE CREAM 1 % (for skin irritations or rashes)

COUGH DROP (for scratchy throat or cough)

CALADRYL CREAM (Minor skin irritations or rashes)

ANBESOL OR ORAGEL (toothache pain)

TRIPLE ANTIBIOTIC OINTMENT (minor cuts and wounds)

The school nurse may also use the following:

- Burn Gel for minor burns
- Vaseline for chapped lips
- Ice pack for sprains and strains

I authorize the use of the above medications, unless crossed out, for my child.

Authorization is in effect for the **2024-2025** School Year.

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

(COMPLETE BOTH SIDES)

**Otto-Eldred School District**  
**RESIDENCY AFFIDAVIT, 24PS 13-1302**  
**Commonwealth of Pennsylvania, McKean County**

I/We attest that all information provided here is correct and current. I/We understand that if residency should change, for any reason, it is the responsibility of the resident to notify the school district and amend the residency affidavit. Any false statements can and will be punishable by law.

I/We, \_\_\_\_\_, currently reside at:  
(Resident's Name)

Address: \_\_\_\_\_

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

Child(ren): \_\_\_\_\_

I/We: ☐ RENT ☐ OWN

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**HOMEOWNER/TENNANT VERIFICATION**

Property Owner or Lessee (renter): \_\_\_\_\_

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

I hereby attest that I am the legal owner or lessee (renter) of the property above. I further swear that the above-mentioned parent/guardian and child(ren) is/are living on a permanent basis at the above address.

Homeowner or Tennant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Through my notarized signature, I/we grant the School District permission to investigate the above information that I/we have presented in this affidavit for confirmation and factual accuracy.

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

Notary's Signature: \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.





Otto-Eldred School District  
**STUDENT RESIDENCY QUESTIONNAIRE**


Dear Parent or Guardian,

**The McVinney-Vento Act, as amended by the No Child Left Behind Act of 2001**, defines homelessness and outline the rights of homeless students. Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren). Thank you for your cooperation.

1. Student name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

2. In what type of setting is the student living now?  
(Check one box below)

SECTION A	SECTION B
<p><input type="checkbox"/> In an emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p><b>CONTINUE to Question 2 if you checked any box in SECTION A</b></p>	<p><input type="checkbox"/> None of the choices in Section A apply.</p> <div style="text-align: center;"></div> <p>If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.</p>

3. Contact number for person completing the form: \_\_\_\_\_

Address where student is now living:

\_\_\_\_\_

4. The student lives with: \_\_\_\_\_

Check all that apply

- ☐ Parent(s) or legal guardian
- ☐ Relative, friend(s), or other adult(s)
- ☐ Alone
- ☐ Other: \_\_\_\_\_

5. School student attended last: \_\_\_\_\_
- Address of school: \_\_\_\_\_
- \_\_\_\_\_
- Telephone number of school: \_\_\_\_\_
- Contact person at school (if known): \_\_\_\_\_

6. Does the student have an IEP or a Chapter 15/504 agreement?

- ☐ NO
- ☐ YES. Please explain: \_\_\_\_\_

The staff person who is helping you register will contact the homelessness coordinator to review the information provided. If homelessness is verified, additional information will be needed to complete enrollment. The Homelessness Coordinator will contact you by the end of the next school day (or sooner) to share the determination regarding homeless status, to gather additional information and to discuss the plans for placement.

Signature of Parent/Legal Guardian: \_\_\_\_\_

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

**NOTE TO STAFF: All forms with a checked box in Section A are to be faxed immediately to the Homeless liaison to eliminate any delay.**