

Wallenpaupack Area School District Student Data Sheet – 2011-2012

Student name:				
Last	First	Middle	Date of Enrollment	
		- -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth date: MM/DD/YY	Age	Grade	Social Security Number	
Birth Country:	<input type="checkbox"/> US		If birth country not US, US Entry Date:	
	Other:		If birth country not US, School Entry Date:	
Birth Place: City, State				
Ethnicity Check all that apply		<input type="checkbox"/> White non Hispanic	<input type="checkbox"/> Latino/Hispanic	<input type="checkbox"/> Black/African American non-Hispanic
		<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> American Indian/Alaskan Native	
504 Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Gifted IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	Title 1 Services <input type="checkbox"/> Yes <input type="checkbox"/> No	IEP <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please complete page 2</i>	Bus No.:

Emergency Contact Information

In case of emergency, please give names and phone numbers, other than your own to be contacted:	
Name:	Phone Number:
	Relationship:
In case of emergency, please give another name and phone number to contact in case of emergency:	
Name:	Phone Number:
	Relationship:

Home Language Survey

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify Limited English Proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

1. What is/was the student's first language?			
2. Does the student speak a language other than English? (Does not include languages learned in school) If yes, specify the language:			
3. What language(s) is/are spoken in your home?			
4. Has the student attended any United States school in any 3 years during his/her lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes,	Name of School	State	Dates Attended
5. Person completing Home Language Survey, if other than parent/guardian:			
6. If needed, English-speaking contact			
	Name (Last, First)		Phone Number

**The school district/charter school/full day AVTS 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/charter school /full day AVTS 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/charter school /full day AVTS 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/charter school /full day AVTS in the future.*

Parent/Guardian Signature

Date:

School Official Signature

Date

For Office Use Only:	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment	<input type="checkbox"/> Proof of Residency <input type="checkbox"/> Birth Certificate
	<input type="checkbox"/> Immunization <input type="checkbox"/> Grades to Date <input type="checkbox"/> Contact Information <input type="checkbox"/> 1302 <input type="checkbox"/> 1305 <input type="checkbox"/> Other (describe)	
	<input type="checkbox"/> WNPS <input type="checkbox"/> WSES <input type="checkbox"/> WNIS <input type="checkbox"/> WAMS <input type="checkbox"/> WAHS <input type="checkbox"/> WHC	Student ID:

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Student name:		
Last	First	Middle

IEP services begin date:	
IEP services exit date:	
Challenge type:	<input type="checkbox"/> Autistic/Autism <input type="checkbox"/> Deaf-blindness <input type="checkbox"/> Hearing impairment including deafness <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Multiple Disabilities <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Specific Learning Disability <input type="checkbox"/> Speech or Language Impairment <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Visual Impairment including Blindness <input type="checkbox"/> Other Health Impairment <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Infants and Toddlers with Disabilities

Please describe the type of services or accommodations your child received: