HOPEWELL AREA SCHOOL DISTRICT
ENROLLMENT CHECK OFF LIST

Student Name:_____ Date:_____

Initial	Date	
_____	_____	Fill Out Enrollment Packet:

☐ Enrollment Forms
☐ Act 26 Form*
☐ HIPAA Notice of Privacy Practices*
☐ Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)*
☐ Explanation of Good Faith Effort Form (HIPAA)*
☐ Internet Policy*
☐ Free and Reduced Lunch Form
☐ Home Language Survey*
☐ Request for Release of Records

_____	_____	Proof of Residency*
_____	_____	Send Signed HIPAA Forms to Nurse
_____	_____	Received Copy of Birth Certificate* (Elementary Only)
_____	_____	Documentation by Doctor of Immunization*
_____	_____	Send Immunization to Nurse (Notification of New Student)
_____	_____	Health Room Emergency Card Completed by Parent
_____	_____	**Check Enrollment For Special Ed./Notify Counselor If YES**
_____	_____	**Check Student Residency Form, Caregiver Form, and Missing Enrollment Documentation Form**
_____	_____	Provide Student Schedule (Grades 7-12)
_____	_____	Assign Student Homeroom
_____	_____	Enter Information in Computer
_____	_____	Create White File for Student
_____	_____	Complete Yellow Card for Student
_____	_____	Mail or Fax Request for Records – Previous School
_____	_____	**NOTIFY COUNSELOR(S) WHEN RECORDS ARRIVE**
_____	_____	Upon Receipt of Records File into Proper Grade Files
_____	_____	Send Information to Bus Garage
_____	_____	Provide Student Planner and District Calendar

*__Required documentation for enrollment__.

December 3, 2002 – Revised July 23, 2003; 7/13/04, 10/06

Hopewell Area School District

Enrollment Procedure - Kindergarten

- **Please return this folder with the following forms completed to the best of your ability:**

1. Student registration Form (2 pages)
2. Student Residency Form, Caregiver's Authorization Form, Affidavit for Missing Enrollment Documentation (4 pages)
3. Census Enumeration Questionnaire (1 page)
4. Acknowledgement of Receipt of Notice of Privacy Practice, page 46 (1 page)
5. Internet Safety/Acceptable Use Agreement (2 pages)
6. Home Language Survey (2 pages)
7. Bus Information Form (1 page)
8. Health History Form (1 page)
9. Medical Information Authorization Form (2 pages)
10. Hopewell Area School District Medication Policy (1 page)
11. Student History (3 pages)
12. Vision Screening Consent Form (1 page)
13. Emergency Contact Information Card (1 page)

- **The following items are also required before a student will be permitted to enroll:**

1. **Immunization records** (Please refer to sheet listing all vaccination requirements for the new school year)

2. **ORIGINAL birth certificate** (A photocopy will be made at the time of registration and the original document will be immediately returned to you.)

3. **Proof of residency - any TWO of the following:**
    - Lease or purchase agreement regarding property
    - Current automobile, health, or life insurance policy
    - Current motor vehicle registration
    - Tax payments
    - Current utility bill

- **The documents listed below are yours to keep for your information:**

1. Hopewell School District Notice of Privacy Practices (pages 40-45)
2. Letters from Transportation Department (2 pages)
3. Don't Wait – Vaccinate Now (1 page)

HOPEWELL AREA SCHOOL DISTRICT

CHARLES M. REINA, Ed.D., Superintendent

DAVID SMAIL
DIRECTOR

TRANSPORTATION DEPARTMENT
2025 MARATTA ROAD
ALIQUIPPA, PENNSYLVANIA 15001-4142
PHONE: 724-375-3606
724-375-6166
FAX: 724-378-8838

Dear Parent/Guardian:

Welcome to Hopewell Area School District! We in the Transportation Department wish for your child's first year in the school district to be an exciting one.

In today's times, it has become necessary for parents/guardians to work and place their child(ren) with childcare services. If this is your case, we ask that you inform the Transportation Department ***prior to July 1st of every new school year*** of childcare/alternate stop requests, in order to have your child assigned at the appropriate stop. Please be aware that students will be scheduled at their regular assigned bus stop **unless a request in writing has been received by the Transportation Department.** Most requests will be accepted: however, there are times when accommodations cannot be made, and you will be notified if such is the case. Keep in mind that requests will be honored for ***existing stops only*** (stops where there are school students assigned, not at the childcare service address), ***stops for the same address each day, and stops within the area serviced by buses from your school.*** Having these requests in by **July 1st** helps our department when we are working on the bus schedules. Requests after **July 1st** will be considered on a space available basis until **August 1st**. Assignments after that date may take up to 3 weeks to process, and availability of bus seating cannot be assured. Remember to include the childcare service name, address and phone number, along with the alternate stop desired, on all requests. You may contact the bus garage with requests by one of the following methods:

Mail Request to:	Hopewell Schools Transportation Department 2025 Maratta Road, Aliquippa, PA 15001
Fax Request to:	724-378-8838
Email Request to:	petrof@hopewellarea.org

If we can be of any assistance, please do not hesitate to contact our department at either 724-375-3606 or 724-375-6166.

Sincerely,

David E. Smail
Transportation Director

HOPEWELL AREA SCHOOL DISTRICT

CHARLES M. REINA, Ed.D., Superintendent

DAVID SMAIL
DIRECTOR

TRANSPORTATION DEPARTMENT
2025 MARATTA ROAD
ALIQUIPPA, PENNSYLVANIA 15001-4142
PHONE: 724-375-3606
724-375-6166
FAX: 724-378-8838

Dear Parent or Guardian:

Application for special transportation requests for students must be made each school year, and it is important to note that District bus routes are subject to change at any time. The Hopewell Area School District transportation policy for baby sitter stops is as follows:

The District will cooperate with working parents and a reasonable babysitting arrangement. This means the child will be picked up and/or discharged at the same loading zone EVERY DAY. (The child may be picked up at one location and dropped off at a different location, but this must be done on an everyday basis.) Items 1 through 5 below determine if such an arrangement can be honored. The parent or guardian may request IN WRITING that a student be reassigned to a different loading zone and/or route. Each written request shall be reviewed by the Transportation Department and may be granted in accordance with the following criteria:

1. The route is operated from the student's assigned school.
2. The route does not have to be changed or extended.
3. The students assigned to the vehicle shall not exceed the legal limits for the vehicle.
4. The change does not increase the cost to the school district.
5. The change shall be LONG-TERM except under emergency conditions.

Please contact the Transportation Department by **July 1st** with your written request to make arrangements for your child(ren). This may be done by mail at 2025 Maratta Rd., Aliquippa, PA 15001; by fax at 724-378-8838; or by e-mail at petrof@hopewellarea.org.

Please keep this policy in mind should you need to make any alternate transportation arrangements after July 1st or before school has started. Vehicle capacity limits the ability to grant requests. This also includes when students go to friends' houses; prior approval **must** be obtained as not all buses have extra room. We appreciate your cooperation.

Please call the Transportation Department at 724-375-3606 if you have any questions.

Sincerely,

David E. Smail
Transportation Director

Hopewell Area School District

Student Registration Form

School Name	Present Grade Level	Date

Student Last Name	First Name	Middle Name	Gender
Birth Date	**Birthplace**	**Cell Phone**	**Home Phone**

Ethnic Category (check one) _____African American _____American Indian _____Asian-Pacific Islander

_____Hispanic _____White _____Multi-racial (please specify)

Home Language	Date your student first started school in the USA (Mo/Yr)

PRIMARY HOUSEHOLD INFORMATION | Name(s) of person(s) WITH WHOM STUDENT IS LIVING:

Living With (check one)

___Both Parents ___Mother Only ___Father Only ___Agency

___Guardian ___Mother/Stepfather ___Father/Stepmother ___Stepfather/Stepmother ___Other

In the event that the child is not living with parents, a copy of any legal proceeding must be attached to the enrollment form.

Father's Name

_____ _____

(Last) (First)

Employment_____

_____

Phone_____

Mother's Name

_____ _____

(Last) (First)

Employment_____

_____

Phone_____

Present Address _____

Street

_____ _____ _____ _____

City State Zip Township

PREVIOUS SCHOOL INFORMATION | Number of previous schools attended_____

Last School Attended	Grade	Phone	FAX

Address of Previous School _____

_____ _____ _____

City State Zip

Has your child ever attended the Hopewell Area School District? _____YES _____NO

If Yes, School(s) Attended_____ Grade(s) Attended_____

Has your child ever participated in a Special Education Program? _____YES _____NO
If Yes, please specify:_____
_____

Contact Person_____

Has your child ever been enrolled in any remediation program such as Title I? _____YES _____NO

If Yes, please specify:_____
_____

Contact Person_____

SECOND HOUSEHOLD INFORMATION

Name of Parent(s)/Guardians OTHER THAN those listed under Primary Household Information:

Last Name	First Name	Relationship to student	Phone
Last Name	First Name	Relationship to student	Phone

Mailing Address	City	State	Zip

EMERGENCY INFORMATION

List two local persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your child if he/she becomes ill or injured and you cannot be reached. We will attempt to contact parents first.

Name	Relationship to student	Address	Phone
Name	Relationship to student	Address	Phone

RESIDENCY INFORMATION

Please provide two or more of the following documents:

_____Lease or Purchase Agreement _____Current Motor Vehicle Registration _____ Current Utility Bill Regarding Property

_____Current Automobile, Health or Life Insurance Policy _____Tax Payments

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE YOU SIGN

I understand that I must be a resident, living within the boundaries of the Hopewell Area School District, to register my child/children for school and I have provided the Hopewell Area School District with accurate information pertaining to my residency. Furthermore, I am aware that the Board reserves the right to verify claims of residency, dependency and guardianship and to remove from school attendance as a nonresident any student whose claim is invalid.

Signature of Parent/Guardian_____ Date_____

Hopewell Area School District

Student Residency Form

This form is intended to address requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. The question below is to assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Vento Act. ***In the event the child is not staying with his/her parent(s) or guardian(s), use the Caregiver's Authorization form to address guardianship issues.***

1. Presently, where is the student living? ***Check <u>one</u> box*:**

Section A	Section B
☐ in a shelter ☐ with more than one family in a house or apartment ☐ in a motel, car or campsite ☐ with friends or family members (other than parent/guardian) ***CONTINUE: If you checked a box in Section A, complete #2 <u>and</u> the remainder of this form.***	☐ **Choices in Section A do not apply** ***STOP: If you checked this section, you do <u>not</u> need to complete the remainder of this form. Please print your name, sign and date this form in the shaded area below and submit to school personnel.***

2. The student lives with:

☐ 1 parent	☐ a relative, friend(s) or other adult(s)
☐ 2 parents	☐ alone with no adults
☐ 1 parent & another adult	☐ an adult that is not the parent or the legal guardian

School: _____

Name of Student:_____ Birth Date:_____ Place of Birth: _____

I, (name)_____ declare, under penalty of perjury, as follows:

1. I am the parent/legal guardian of (name of student)_____ who is of school age and is seeking admission to _____ School District.
2. Since (date)_____ our family has not had a permanent home.

I declare that the information provided here is true and correct and of my own personal knowledge and that, if called upon to testify, I would be competent to do so.

Name (Please print):_____

Signature: _____

Date: _____

I receive my mail at:_____

Address: _____

Phone number(s):_____ E-mail Address: _____

I can be reached for emergencies at : _____

Hopewell Area School District

Caregiver's Authorization Form

(Please complete this form ONLY if child lives with someone other than parent/legal guardian.)

This form is intended to address the McKinney-Vento Homeless Education Assistance Improvement Act of 2001 (P.L. 107-110) requirement that homeless children are to have access to education and other services. The McKinney-Vento Act specifically states that barriers to enrollment must be removed. In some cases, a child or youth who is homeless may not be able to reside with his/her parent or guardian.

Instructions:

- To authorize enrollment in school of a minor, complete items 1 through 4 and sign the form.
- To authorize enrollment and school-related medical care, complete all items and sign the form.

The minor named below lives in my home, and I am 18 years of age or older:

1. Name of minor: _____
2. Minor's birth date: _____
3. Place of birth: _____
4. My home address: _____
5. Check one or both (for example, if one parent was advised and the other could not be located):

   ↑ I have advised the parent(s) or other person(s) having legal custody of the minor as to my intent to authorize medical care and have received no objection.

   ↑ I am unable to contact the parent(s) or legal guardian(s) at this time to notify them of my intended authorization.

6. My date of birth: _____
7. My state driver's license or identification card number: _____

I declare under penalty of perjury that the foregoing information is true and correct.

Signature:_____ Date: _____

Printed Name:_____

Hopewell Area School District

Affidavit for Missing Enrollment Documentation

(Please complete this form ONLY when enrollment documentation is missing.)

I, _____, based upon my personal knowledge, answer the following questions as noted in my handwriting concerning a student's missing enrollment documentation. The following information is missing:

- ☐ Proof of residency
- ☐ Proof of guardianship
- ☐ Proof of identity
- ☐ Birth certificate
- ☐ Immunization record
- ☐ School physical/health record
- ☐ School record

Student's Name:_____ Birth Date:_____

In accordance with the McKinney-Vento Homeless Education Assistance Improvements Act of 2001, (P.L. 107-110), states and localities are required to address barriers to the enrollment of students meeting the definition of homelessness.

1. Who are the parents, parents by legal adoption, legal guardians, or persons having legal custody of the student being enrolled?
   _____
   _____

2. Where is the student currently staying?
   _____
   _____

3. Do you have legal custody imposed by a court order or have you been designated as a court-appointed guardian for the pupil being enrolled?
   _____
   _____

4. What court entered such order and what type of case was it (i.e., custody hearing, etc)?
   _____
   _____

5. Why are you unable to present a copy of documentation for the items checked on page 1 for the student that you are enrolling?
   _____
   _____

6. To the best of your knowledge has the student ever been reported to any law enforcement agency as a missing child?

   _____

   _____

   If the response to question #6 is yes, identify by name and address the law enforcement agency and date of report.

   _____

   _____

7. Is this affidavit being used to enroll a student who is missing immunization records, health records, school records or proof of identity?

   ☐ **Yes** ☐ **No**

   If the response to #7 is **Yes**, what was the name and location of the last school the student attended?

   School Name: _____

   Address: _____

   Phone Number: _____

_____ _____

Date Signature

_____

Print Name

HOPEWELL AREA SCHOOL DISTRICT
CENSUS ENUMERATION QUESTIONNAIRE

HEAD OF HOUSEHOLD:

Title **Last Name** **First Name** **Birth Date**

Present Address **City** **State** **ZIP Code** **Telephone**

Employer **Occupation**

Work Address **City** **State** **ZIP Code**

Work Telephone **Extension #** **Work Hours (From ______ to ______)**

PLEASE LIST ALL OTHERS WHO RESIDE AT THIS ADDRESS:

Title **Last Name** **First Name** **Birth Date**

Employer/Student **Occupation (if applicable)**

Work Address **City** **State** **ZIP Code**

School Address **City** **State** **ZIP Code**

Title **Last Name** **First Name** **Birth Date**

Employer/Student **Occupation (if applicable)**

Work Address **City** **State** **ZIP Code**

School Address **City** **State** **ZIP Code**

Title **Last Name** **First Name** **Birth Date**

Employer/Student **Occupation (if applicable)**

Work Address **City** **State** **ZIP Code**

School Address **City** **State** **ZIP Code**

Title **Last Name** **First Name** **Birth Date**

Employer/Student **Occupation (if applicable)**

Work Address **City** **State** **ZIP Code**

School Address **City** **State** **ZIP Code**

PLEASE USE THE REVERSE SIDE OF THIS SHEET IF ADDITIONAL SPACE IS NEEDED.

HOPEWELL AREA SCHOOL DISTRICT
NOTICE OF PRIVACY PRACTICES

Hopewell Area School District ("HASD") is committed to protecting the privacy of our students. We take very seriously our obligation to maintain the privacy of healthcare information that is shared with us confidential and secure. The terms "you" and "your" used throughout this Notice refer to the individual student to whom the healthcare information pertains.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice. HASD is required by law to maintain the privacy of certain healthcare information, known as Protected Health Information "PHI". PHI may include your child's name, address, and other identifying data or information on your child's health or the health services that have been or may be furnished to your child. HASD is also required to provide your child with a notice of its legal duties and privacy practices regarding your child's PHI and to abide by the terms of this notice currently in effect. This notice describes HASD's privacy practices, lets you know when the district is permitted to use and disclose your child's PHI and advises you of your rights. HASD requires that all of its employees, staff, and independent contractors comply with these privacy practices.

Use and Disclosure of PHI for Treatment, Payment and Health Care Operations. By law, HASD is permitted to use and disclose PHI for treatment, payment and health care operations in most cases, without your permission for the following reasons.

1. ***Treatment*** generally means the care and services provided by doctors, hospitals and other healthcare providers. HASD at times, performs various functions which make it a healthcare provider, for example: state mandated physicals, dental exams, or hearing tests; distribution of first aid and medication; athletic training or conditioning; occupational or physical therapy; student assistance; or psychological counseling services. When we perform such healthcare services or the related assessment, referral or support activities, either directly or through a third party, we are permitted to obtain, use and disclose verbal and written information about you and regarding your medical condition. This includes PHI received or transferred by phone, fax, written, electronic or other means.

2. ***Payment*** means any activities that HASD must take in order to get reimbursed for services we provided to you and includes: organizing your PHI; verifying eligibility for services; coordinating benefits; submitting bills; or accessing available funding for such services, either directly or through a third party. For example, HASD seeks funding for payment from various federal and/or state programs for some health related services provided to our students.

3. ***Health Care Operations*** means activities undertaken by HASD that are required for its operations. Such activities may be performed by HASD or in some instances by a third party. These activities may include: quality assessment and improvement activities; credentialing and licensing; training programs; and other management, legal or financial services. For example, HASD evaluates staff performance to ensure that our policies and procedures are followed for internal reviews.

Reminders, Information and Fundraising. HASD may contact you to remind you of scheduled appointments for healthcare related services, to notify you about other services we provide or health-related benefits and services that may be of interest to you. For example, mandated student physicals, dental exams or athletic training events.

Use and Disclosure of PHI Without Your Authorization. Under certain circumstances, HASD may use or disclose your child's medical information without your written authorization or other permission, or your opportunity to object. These circumstances are as follows:

1. In treatment situations by receiving and disclosing medical and identifying information about your child via telephone, written, electronic or other oral means; communicating with the appropriate parties and completing and filing the required written documentation regarding treatment.
2. In treatment situations, for our use in order to treat your child, to obtain payment for services provided to your child, or for other health care operations.
3. To another health care provider for the treatment activities of that provider.
4. To another health care provider or entity for the payment activities of that provider or entity.
5. To another health care provider or entity for the health care operations of that provider or entity if the provider receiving the information has or had a relationship with your child and the PHI pertains to that relationship.
6. To a family member, relative, friend or other individual involved in your child's care, or for disaster relief. HASD may provide medical information about your child to such individuals if we obtain your verbal agreement, if we give you an opportunity to object to such disclosure and you do not object, or if we infer from the circumstances that you would not object. When we are not able to obtain your agreement or because you are not immediately present, we will use our professional judgment to determine whether it is in your child's best interest to disclose such information to a family member, relative, friend or other individual involved in your child's care. Only health information relevant to that person's involvement with your child's care will be disclosed. For example, we may inform the person whom you list as an emergency

contact for your child in emergency or health related situations involving your child.

7. As required by law. Numerous state, federal and local laws permit or require certain uses and disclosures of medical information. In such cases, HASD may only use or disclose your child's medical information to the extent authorized by law.
8. To a public health authority. HASD may be asked or required by law to disclose medical information to a public health authority under the following circumstances:
    a. to report a birth, death, disease or injury;
    b. as part of a public health investigation;
    c. to report child or adult abuse or neglect, or domestic violence;
    d. to report adverse events such as product defects, to tract products or assist in product recalls or repairs or replacements, or to conduct post-marketing surveillance as required by the Food and Drug Administration; and
    e. to notify a person about exposure to a possible communicable disease.
9. For health oversight activities including: audits, government investigations, inspections, disciplinary proceedings and other administrative and judicial actions undertaken by the government or its contractors by law to oversee the health care system;
10. For health care fraud and abuse detection or compliance related activities.
11. For judicial and administrative proceedings. HASD may disclose medical information as required by a court or administrative order or in some cases pursuant to a subpoena, discovery request or other legal process.
12. To law enforcement. Police and other law enforcement may seek medical information from HASD. We may release this information to law enforcement under limited circumstances, such as when the request is accompanied by a warrant, or when law enforcement needs specific information to locate a suspect or to stop a crime.
13. To coroners, medical examiners and funeral directors. HASD may release information regarding a decedent to such persons as authorized by law or in order to identify the deceased, determine cause of death, or carry out other duties.
14. For organ, eye and tissue donation. HASD may release medical information to organ, eye and tissue procurement organizations and similar entities in order to facilitate such types of donation, if applicable.
15. For research purposes. HASD may be approached by researchers to provide medical information for research purposes, such as tracking a particular condition. We may provide medical information to a researcher if the researcher has obtained a special waiver from a committee established under federal law to oversee medical research to allow the researcher to not have to obtain the individual's permission prior to collecting the information. Also, the researcher must demonstrate that the information is necessary to the research and poses a minimal risk of an

inappropriate use or disclosure. If the researcher does not obtain the waiver, then HASD may not disclose the information without your Authorization.

16. To avert a serious threat to health and safety. HASD may use or disclose your child's medical information to avert a serious and imminent threat to an individual or the public's health and safety.
17. For military and other specialized governmental functions. Medical information may be disclosed for military, defense, national security, intelligence or correctional activities.
18. For workers' compensation. HASD may share medical information regarding work-related illness and injuries in order to comply with workers' compensation laws.
19. In a manner that does not personally identify your child.

Any other use or disclosure of PHI, except those listed above will only be made by HASD after receiving a written authorization for your child. An Authorization is a written document that must specifically identify the information that we seek to use or disclose and when and how we seek to use or disclose it. **You may revoke an Authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on your Authorization.**

Individual Rights. You have a number of rights with respect to your child's PHI. Such rights are as follows:

1. **Restrictions**. You have the right to restrict how we use and disclose your child's medical information that we have for treatment, payment or health care operations purposes, or to restrict the information provided to family, friends and other individuals involved in your child's health care. However, we do not have to agree to any restrictions, but if we do, we will abide by our agreement unless the information is needed in order to provide your child with emergency treatment. For example, if you request a restriction on information that is needed to provide your child with emergency treatment, then we may use such information and disclose it to a health care provider so that they may provide your child with emergency treatment. Any restrictions must be agreed to in writing by HASD. Please contact the Privacy Officer listed at the end of this notice if you wish to request a restriction.

2. **Confidential Communications**. You have the right to request that HASD reasonably accommodate you regarding the way in which we communicate to you involving your child's health, health care services or payment. For example, you may ask that we communicate with you only at your home. If we receive such a request in writing, we will do our best to reasonably accommodate such request.

3. **Access**. You have the right to review your child's educational record as defined under the Family Educational Rights and Privacy Act (FERPA).

FERPA controls the privacy of information entered into a student's record, including health related information. However, there may be instances where health information is not entered into the student's educational record by school personnel or is not considered a part of the educational record and in such cases, FERPA does not apply and HIPAA does. Under HIPAA, you have the right to inspect and copy most of your child's medical information maintained by HASD under HIPAA. We have forms available for you to use to request access to your child's PHI. Normally, we will provide you with access within 30 days of your request. We may charge you a reasonable copying fee. In limited cases, we may deny you access to your child's medical information. You may appeal certain types of denials. If we deny access, we will provide you with a written response and inform you about your appeal rights. Please contact the Privacy Officer listed at the end of this notice if you wish to inspect and copy your child' medical information maintained under HIPAA.

4. **Amendment**. You have the right to ask HASD to amend written medical information that we may have about your child under HIPAA. For example, you can request that we correct incorrect information in your records. We will generally amend your information within 60 days of your request and will notify you when we have amended your child's information. We are permitted by law to deny your request to amend only in certain circumstances, such as when we believe that the information that you have asked us to amend is accurate and complete. You can appeal our denial of your request to amend the written medical information. Please contact the Privacy Officer listed at the end of this notice if you wish to request an amendment to your child's medical information.
5. **Accounting**. You have the right to request an accounting from HASD of certain disclosures of your child's PHI made by us during the last six (6) years prior to the date of your request after April 14, 2004. We will generally provide you with an accounting of information that we have used or disclosed for treatment, payment or health care operations, or when we share your child's PHI with our business associates. We are also not required to give you an accounting of our uses or disclosures of PHI for which you have already provided us with a written authorization. Please contact the Privacy Officer listed at the end of this notice if you wish to request an accounting of your child's medical information that we have used or disclosed, which is not exempt from the accounting requirement.
6. **Electronic and Paper Notices**. We currently maintain a web site that provides information about our school district. HASD is required to prominently post its Notice of Privacy Practices on such web site and to make the notice available electronically through the web site. If you have obtained this Notice electronically, you may obtain a paper copy by requesting such notice from the Privacy Officer listed below. HASD's web site is found at www.hopewellarea.org.
7. **Complaints**. You may complain to HASD, or to the Secretary of the United States Department of Health and Human Services if you believe that your

privacy rights have been violated. Under no circumstances will HASD take any retaliation against your child for filing a complaint. If you have any questions, comments or complaints, please contact the Privacy Officer listed below.

Revisions to Privacy Notice. HASD reserves the right to change the terms of this Notice at any time. Any revised Notice will be promptly posted at the Administration Offices and also posted on our web site, if we maintain a web site, at the time of such revision and available at the Administration Offices for you to request a copy. We also reserve the right to make the new Notice provisions effective for all PHI that we maintain.

Privacy Notice/Compliance Contact Officer. If you have any questions or comments or if you wish to file a complaint or exercise any of your individual rights listed in this Notice, please contact:

Dr. Charles M. Reina
Superintendent
2354 Brodhead Road
Aliquippa, PA 15001
(724) 375-6691

Effective Date. The effective date of this Notice of Privacy Practices is April 14, 2004.

HOPEWELL AREA SCHOOL DISTRICT
ACKNOWLEDGMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Hopewell Area School District's Notice of Privacy Practices.

_____ _____

Date

Signature of Parent/Guardian or
Other Representative

_____

Print Name of Student

PLEASE PRINT

Last Name _____First Name _____Graduation Yr _____

Hopewell Area School District
Internet Safety/Acceptable Use Agreement

Internet access is available throughout the District in libraries, computer labs, and classrooms and is a powerful educational tool. It offers incredible learning opportunities but requires responsible actions. Before students are permitted to use the Internet, this agreement must be signed and returned to the school office.

If the user is a student under the age of 18, the parent or legal guardian of the student must also sign the agreement on the reverse side. Before signing this agreement, please carefully read the Internet Safety/Acceptable Use Policy in the student handbook. The Policy is also available on-line at www.hopewellarea.org. Once signed, this agreement will remain in effect until the district is notified in writing by the parent/legal guardian.

Student:

I understand that Hopewell Area School District's Internet service is provided for educational purposes only. I agree that I will use the Internet only for educational purposes, and I will not misuse it by accessing areas that are explicitly non-educational. Misuse can come in many forms, including, but not limited to, such actions as pornography, racism, sexism, illegal solicitation or other illegal actions, inappropriate and vulgar language, as well as any other use that in the opinion of the District does not further an educational purpose. I understand that if I have any question as to whether a particular use of the Internet is inappropriate, I should consult with the appropriate representative of the District before proceeding with the questionable use. I understand that I am solely responsible for my conduct and the appropriate use of the Internet.

I have been informed by the District and understand that the District uses a filtering device to block out unacceptable Internet sites. The District will also monitor my use of the Internet in terms of both time and subject matter. I fully understand that this is not a representation or guarantee by the District that all unacceptable sites will be eliminated. I understand that the use of such methods by the District will in no way relieve me of my responsibility as set forth in this Agreement and that I am responsible for my own conduct and will not misuse the Internet.

I understand and will abide by the provisions of this contract. I further understand that the use of the Internet is a privilege and that any inappropriate use of the Internet or violation of the rules and regulations for the use of the Internet may result in disciplinary action in accordance with the District's Disciplinary Code, the revoking of my access privileges and/or user's account and any other appropriate actions, including legal actions, that the District deems advisable. I will not hold the Hopewell Area School District responsible for or legally liable for materials distributed from or acquired through the Internet. I also agree to report any misuse of the Internet to my teacher or building principal.

I have read and understand the Hopewell Area School District Internet Safety/Acceptable Use Policy and agree to comply with and be bound by that policy.

Student's Signature _____Date _____

If the student is under the age of 18, the student's parent or legal guardian must sign the agreement on the reverse side

BOARD ADOPTED MAY 28, 2002

Parent/Guardian:

As the parent/guardian of _____, I have read this contract and understand that Hopewell School District's Internet service is provided for educational purposes only. I also understand that it is impossible for Hopewell Area School District to restrict all access to controversial materials. I am fully aware that the District uses a filtering device in an attempt to block out unacceptable Internet sites. The District will monitor my child's use of the Internet in terms of both time and subject matter. I understand, acknowledge and agree that the use by the District of such monitoring or filtering devices is no representation or guarantee on the District's part that this will prevent my child from gaining access to an unacceptable Internet site. I will not hold Hopewell Area School District responsible for or legally liable for materials distributed or acquired from the network, or as a result of my child accessing an unacceptable Internet site. I understand that any violation of the above provisions may result in all or any of the following disciplinary action, discipline in accordance with the District's Disciplinary Code, the revoking of my student's access privileges and/or user account and any appropriate legal action. I accept full responsibility if my student uses the Hopewell Area School District Internet account either in or out of the Hopewell Area School District setting.

I/we have read and understand the Hopewell Area School District Internet Safety/Acceptable Use Policy and agree to comply with and be bound by that policy.

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____ Date _____

The Hopewell Area School District maintains a website (www.hopewellarea.org) and may post names or pictures of students involved in school activities, honor rolls, scholarship awards, field trips, etc. The District newsletter is published to the web throughout the year. Please indicate your preference by checking the appropriate box below:

☐ I give permission for the name(s) and/or photograph(s) of my child(ren) to appear on the web page and electronic newsletter.

☐ I **DO NOT** want the name(s) and/or photograph(s) of my child(ren) to appear on the web page or the electronic newsletter.

Parent/Guardian Signature_____ Date _____

BOARD ADOPTED MAY 28, 2002

HOPEWELL AREA SCHOOL DISTRICT
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.

DISTRICT SCHOOL: _____ DATE: _____

To the parent/guardian:

Please answer the following questions. All questions must be completed. This is a mandatory form which must be placed in the student's permanent record folder as well as the District's ESL folder.

Student's Name _____ _____Male _____Female

1. **In what country was the student born? _____**

2. **What is/was student's first language? _____**

3. **Does the student speak a language(s) other than English (*do not include languages learned in school)*?**

   _____Yes _____ No If yes, specify the language(s):_____

4. **What language(s) is/are spoken in your home? _____**

5. **Has the student ever received ESL (English as a Second Language) instruction?**

   _____Yes _____No

6. **Has the student attended any United States school in any 3 years during his/her lifetime?**

   _____ Yes _____ No If *Yes*, complete the chart below:

NAME OF SCHOOL	STATE	DATES ATTENDED

HOPEWELL AREA SCHOOL DISTRICT
HOME LANGUAGE SURVEY (page 2)

7. Does the student currently have an IEP (Individualized Education Plan)? _____Yes _____ No

The District cannot request the following items from individuals whose first language is not English:

- **Wage Tax Form**
- **Visas/Passports**
- **Social Security cards**

**The District may only request the following:
- Immunization records
- A local address (no proof necessary)

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

DISTRICT PERSONNEL SIGNATURE DATE

FOR OFFICE USE ONLY:

PLEASE FORWARD A <u>COPY</u> OF THIS HOME LANGUAGE SURVEY FORM TO THE SUPERINTENDENT.

DATE FORWARDED:

**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 school as well as from students who enroll in the school district/charter school/full day AVTS in the future.*

Hopewell Area School District
Bus Information Form

Effective Date:_____ **ACTION:** _____

ADD: _____

DELETE: _____

CHANGE: _____

Student's Name _____
(First) (Last)

Address
(Street name and number – no P.O. box numbers) _____
_____
_____

Alternate Address
Childcare Services
(Street name necessary) _____
_____

(Subject to Approval)

Telephone Number _____

Emergency Number _____

Parent or Guardian _____

Name of school student is moving to: _____

Name of school student is moving from: _____

PRESENT GRADE (circle): **K 1 2 3 4 5 6 7 8 9 10 11 12**

Name of road/street or bus stop _____

AM Bus # _____ **PM Bus #** _____

Attention Parents/Guardians

DON'T WAIT ----------VACCINATE NOW

Children IN ALL GRADES need the following:

- **4 doses of tetanus***
  (1 dose on or after the 4th birthday)
- **4 doses of diphtheria***
  (1 dose on or after the 4th birthday)
- **3 doses of polio**
- **2 doses of measles****
- **2 doses of mumps****
- **1 dose of rubella (German measles)****
- **3 doses of hepatitis B**
- **2 doses of varicella (chickenpox) vaccine or history of disease**

*Usually given as DTP or DTaP or DT or Td
**Usually given as MMR

Children ENTERING 7th grade need the following:

- **1 dose of tetanus, diphtheria, acellular pertussis (Tdap)**
- **1 dose of meningococcal conjugate vaccine (MCV)**

These requirements allow for medical reasons and religious beliefs.
If your child is exempt from immunizations,
He/she may be removed from school during an outbreak.

Pennsylvania's school immunization requirements can be found in 28 PA.CODE CH.23 (School Immunization)
Contact your health care provider or 1-877 PA HEALTH for more information

pennsylvania
DEPARTMENT OF HEALTH

HOPEWELL AREA SCHOOL DISTRICT HEALTH SERVICES

Health History Form

Student name_____ Grade_____
Last First

Parent names: Father_____
Last First

Mother_____
Last First

Address:_____
City State Zip code

Physician Name_____

Please circle if student has any of the following conditions:

ADD / ADHD	yes	no
Anemia / bleeding disorder	yes	no
Asthma	yes	no
Allergies (list below)	yes	no
Cerebral palsy	yes	no
Cystic fibrosis	yes	no
Diabetes	yes	no
Gastrointestinal problems	yes	no
Hearing / visual problems	yes	no
Heart disease	yes	no
Psychological	yes	no
Scoliosis	yes	no
Seizure disorder	yes	no
Other (explain)	yes	no

Please list or explain **yes** answers_____

_____

Does your child take medication?_____Why?_____

Name of medication_____

Is your child presently receiving treatment from a doctor?_____

Reason_____

Parent signature_____Date_____

HOPEWELL AREA SCHOOL DISTRICT
MEDICAL INFORMATION AUTHORIZATION FORM

Hopewell Senior High	724-375-6691 Option 3	Fax: 724-378-1705
Hopewell Junior High	724-375-6691 Option 2	Fax: 724-378-2594
Hopewell Elementary	724-375-6691 Option 1-1	Fax: 724-375-4729
Margaret Ross Elementary	724-375-6691 Option 1-3	Fax: 724-378-8555
Independence Elementary	724-375-6691 Option 1-2	Fax: 724-375-5141

In order to comply with federal and state laws the Hopewell Area School District requires that this form be completed in its entirety.

I authorize the school nurses of the Hopewell Area School District to use / disclose the following Protected Health Information from the records of:

_____

Student Name

as described below: **Any other HASD teacher or staff member, including substitutes, building principals and secretaries who may be responsible for my child.**

This information is requested for the purpose of: **To inform any such staff member or administrator who may be responsible for my child of any serious medical conditions, allergies, medications and/or emergency contacts.**

The information to be used / disclosed is identified as follows (please check all that apply):

_____Medical history & physical exams	_____Psychiatric/Psychological evaluation
_____Occupational therapy	_____Physical therapy
_____IEP	_____ERs
_____Discharge summary instructions	_____Immunization records
_____Physician orders	_____Verbal information

__X__Other (please specify): **Any health information appearing on the Student Health History Information Form submitted to the school nurse regarding serious medical needs/conditions, allergies, medications or health insurance.**

This authorization expires: upon graduation

I understand the following:

- **That the information used or disclosed may include records relating to my identity, diagnosis, prognosis and treatment;**

- **That the information used or disclosed may relate to psychiatric disorders, drug and/or alcohol use, AIDS and HIV, as the same are permitted by the Mental Health Procedures Act, the Confidentiality of Alcohol and Drug Abuse Individual Records Act, the Confidentiality of HIV-Related Information Act and the Privacy Rule of the Health Insurance Portability and Accountability Act;**

- **That I have the right to revoke this authorization at any time, except to the extent that Hopewell Area School District has already acted in reliance on the Authorization and that such revocation must be made in writing and directed to the Privacy Officer, the District Superintendent;**

- **That the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law;**

- **That Hopewell Area School District may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization, except as provided by law; and**

- **That if the Hopewell Area School District seeks this Authorization for the use or disclosure of Protected Health Information, the district must provide me with a copy of the signed Authorization.**

_____ _____

Date Signature of Parent/Legal Guardian/Personal Representative

_____

Print Name

_____

Specify Relationship / Authority

HOPEWELL AREA SCHOOL DISTRICT

ADMINISTRATIVE OFFICES

2354 BRODHEAD ROAD
ALIQUIPPA, PENNSYLVANIA 1501-4501

724-375-6691 Central Office
724-375-6688 Business Office
724-375-0942 Telecopier

CHARLES M. REINA, Ed.D.
SUPERINTENDENT

JOHANNAH M. ROBB, CPA
BUSINESS ADMINISTRATOR

Dear Parent/Guardian:

It is the policy of the Hopewell Area School District that any student who is required to take a prescribed medication must comply with these school regulations:

A. Written orders from a physician should detail the name of the drug, dosage, time interval that the medication is to be taken, and diagnosis or reason for the medication to be given.

B. Written permission must be provided by the parent or guardian requesting that the school district comply with the physician's order.

C. Medication should be brought to school in a container appropriately labeled by the pharmacy or physician. Please contact the school nurse in your building regarding the supply of medication that you will be sending and means of delivery.

HOPEWELL AREA SCHOOL DISTRICT MEDICATION POLICY

As an indication that you have read and understand the above, would you please sign below and return with your enrollment packet.

STUDENT'S NAME_____

PARENT'S SIGNATURE_____

STUDENT HISTORY

Student Name_____

A. Medical History (check those that apply to your child and supply dates):

Condition	✔	Date(s)	Condition	✔	Date(s)	Condition	✔	Date(s)
Asthma			Intestinal Worms			Seizures/Spells		
Bronchitis			Measles (3 day)			Smallpox		
Chicken Pox			Measles (9 day)			Tonsillitis		
Diabetes			Menstrual			Tuberculosis (self)		
Diphtheria			Mumps			Tuberculosis (family)		
Enuresis (Bed wetting)			Pleurisy			Typhoid		
Epilepsy			Pneumonia			Whooping Cough		
Hernia (Rupture)			Poliomyelitis			Crippling Handicap		
Hemophilia			Rheumatic Fever			Other		
Influenza			Rheumatism					
Heart Disease			Scarlet Fever					

B. Allergies: _____Plants _____Bees and insects _____Animals

_____Food _____Drugs _____Other

C. Is medication needed for allergy: At home? _____No _____Yes
At school? _____No _____Yes

Name of medication(s)_____

Is medication needed for any other condition: At home? _____No _____Yes
At school? _____No _____Yes

Name of medication(s)_____

D. List any operations, injuries, or hospitalizations. Give dates: _____
_____
_____

E. Physical education activity: _____Limited _____Not limited
If activity is to be limited, please explain:_____
_____

F. Does your child wear: Contact lenses? _____No _____Yes Glasses? _____No _____Yes

G. Is your child presently under medical treatment? _____No _____Yes
If so, give name of physician:_____
Reason for treatment:_____
_____

Student Name_____

H. List any physical handicap about which the teachers should know:_____
_____

I. List any known serious sensitivity or other condition requiring IMMEDIATE MEDICAL ATTENTION:
_____
_____

J. Pregnancy:

1. Birth: _____Normal Term _____Premature
   _____Birth Weight _____Rh Baby
2. Did the mother have any illness during pregnancy?_____
3. Did the mother take any medicine or drugs (other than vitamins) during pregnancy? _____No _____Yes
4. Difficult birth? _____No _____Yes Explain:_____
   _____
5. Was there a health problem or handicap present at birth? _____No _____Yes
   At what age was the diagnosis made?_____
   List physicians or agencies which made the diagnosis: _____
   _____
   _____
6. Breast or bottle fed? _____

K. Early childhood:

- At what age did the child begin to talk?_____
- How old was your child when he/she began to talk in sentences?_____
- At what age did he/she walk?_____
- Which hand does he/she most often use?_____
- Does he/she prefer different hands for different activities? _____No _____Yes
  Examples:_____
  _____

L. Dressing habits:

- Does your child dress him/herself? _____Completely _____Partially _____Not at all
- Can he/she use the toilet by him/herself? _____No _____Yes
- Are there any problems connected with toilet habits at the present time? _____No _____Yes
  Examples:_____
  _____

M. Emotional life:

- Is your child usually happy? _____No _____Yes
- Is he/she friendly with other children? _____No _____Yes
- Does he/she like being with adults? _____No _____Yes
- What fears does your child have?_____
  _____
- Does your child have any nervous habits? _____No _____Yes
  Examples:_____
  _____
- Does your child show anger easily? _____No _____Yes
- Do you consider your child to be (circle all that apply):
  Bashful Timid Backward Nervous Short-tempered Sickly Stubborn

Student Name_____

N. Put a circle around any of the following things which worry you about your child:

1. Bedwetting
2. Wetting during the day
3. Thumb sucking
4. Stammering or stuttering
5. High strung or easily upset
6. Too restless
7. Shy
8. Sad or sulky
9. Feelings easily hurt
10. Wanting too much attention
11. Wanting too much comfort or support from parent
12. Daydreams
13. Nightmares
14. Temper tantrums
15. Contrary or stubborn
16. Disobedient
17. Lying
18. Selfish in sharing
19. Jealous of brothers or sisters
20. Fighting with other children
21. Purposely destroys things
22. Feeding self
23. Bowel or bladder habits
24. Any other problem not mentioned (please explain)

Signature of parent or guardian:_____Date:_____

HOPEWELL AREA SCHOOL DISTRICT
VISION SCREENING CONSENT FORM

In the fall of each school year, a free vision screening will be offered to your child. No physical contact is made with your child and eye drops are not necessary.

I, the undersigned, give permission for my child, _____, to have a free vision screening examination by Dr. Nancy Wiggins. I understand the following:

- There is no charge to participate in the vision screening process.
- I will be contacted with the results.
- The information obtained from this vision screening is to be considered a preliminary procedure only and does not constitute a diagnosis of vision problems. It should be part of a comprehensive eye care program which includes periodic optometric/ophthalmologic exams.
- I understand that I am responsible for arranging a full eye exam with an eye care professional if my child has been referred as a result of the vision screening test.
- I understand that the organization conducting the screening will not be held accountable for any errors of commission, omission, or other misdiagnosis.

☐ Yes, I do wish to have the vision screening.

☐ No, I do not wish to have the vision screening.

_____ _____

Child's name Parent/Guardian Signature

_____ _____

Date Phone

Hopewell Area School District Emergency Contact Information

- ***Information must be completed by parent/guardian & returned to school***

Student's Last Name_____ **First Name**_____ **GR____ HR_____**

Address_____ City_____ Home Phone #_____

Father/Guardian (Please Circle)

Name_____ Employer_____

Cell Phone Number _____ Work Phone Number_____

Mother/Guardian (Please Circle)

Name_____Employer_____

Cell Phone Number _____ _Work Phone Number_____

Stepfather_____ Phone_____ Stepmother_____ Phone_____

Email address_____

- *Since the care and treatment of the student is primarily the responsibility of the parent/guardian, every effort will be made to contact the parent/guardian first.*

Please list **Parent Substitutes** who can be contacted regarding student's care in the event a parent cannot be located

Name_____ Relation_____

Phone_____ _____Address_____

Name_____ _____Relation _____

Phone_____ _____Address_____

Name_____ _____Relation _____

Phone_____ _____Address_____

Names and grades of brothers and sisters _____
_____

SCHOOL EMERGENCY PROCEDURE

Your schools have adopted the following procedures in caring for your child when he becomes sick or injured at school:

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer –
2. The school will call the father's, mother's or guardian's cell phone and/or place of employment. If there is no answer –
3. The school will call the other telephone number(s) listed.
4. If none of the above answer, the school will call an ambulance and/or paramedics, if necessary, to transport the child to a local medical facility.
5. The school will continue to call the parents or guardians until one is reached.

PLEASE SIGN BELOW: If I cannot be reached and the school authorities have followed the procedures described, I agree to assume any expenses for moving and medically treating my child.

_____

Parent/Guardian Signature Date