Greater Johnstown SCHOOL DISTRICT

Pleasant Avenue Elementary • Warren Street Elementary • Knox Middle School • Johnstown High School

William T. Crankshaw, Ed.D.
Superintendent of Schools
Alicia D. Koster
Assistant Superintendent
Nicole M. Panton
Director of Curriculum & Instruction

Administration Center
1 Sir Bills Circle
Johnstown, New York 12095
Telephone: 518-762-4611
Fax: 518-762-6027
https://www.johnstownschools.org

STUDENT REGISTRATION CHECKLIST

Please turn in the the following documentation to complete the registration process

Student Name: _____ Date: _____

_____ Registration Packet

_____ Proof of Residency - **must provide 2**

- ☐ Drivers License
- ☐ Utility Bill
- ☐ Telephone Bill
- ☐ Copy of Deed/Mortgage Statement
- ☐ Lease Agreement
- ☐ Pay Stub
- ☐ Auto Insurance ID Card
- ☐ Bank Statement
- ☐ Voter Registration Card
- ☐ Mail (not personal)
- ☐ Change of address form from the Post Office (must be stamped)

_____ Transportation Form, if applicable

_____ Custody Papers, if applicable

REGISTRATION FORM
GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Johnstown, NY 12095

Student's Full Legal Name: _____
(First) (Middle) (Last)
Sex: _____Male _____Female Grade: _____ Date of Birth _____

Street Address (Actual Residence not PO Box): _____
Street number and Name
_____, New York Zip Code: _____
City/Village
Mailing Address (PO Box Acceptable): _____

Parent/Guardian: _____
Name
Home Telephone: _____
Cell Number: _____
Work Number: _____
E-mail address: _____

Custody: Child's legal custodian is _____ Relationship: _____
Child lives with: _____ Relationship: _____
Is there a custody issue? _____
*If custodial rights have been altered, then proof must be in writing. See below for acceptable proof.

Order of Protection* __ (*If an order of protection exists, it must be submitted to building principal at time of student enrollment)

Parent/Guardian Information

	Name	Home Address	Work Place and Phone Number
Mother (include maiden name)			
Father			
Step Mother			
Step Father			
Legal Guardian			

Is this a foster placement: _____ Yes _____ No
If yes, name of county _____
If yes, copy of DSS 2999 Form required

☐ **Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement _____ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.**

Brother(s) and Sister(s) Information

Name (First and Last)	Sex	Birth Date	Living at Home	Present Grade	School Attending

What Mode of Communication does/do the Parent(s) prefer:

[ ] Written Notice [ ] Phone Calls [ ] Email [ ] Person to Person

_____ Date: _____

Signature of Parent, Guardian or Student (for unaccompanied homeless youth)

Business Office Signature	**Date**

PROOF OF VERIFICATION OF AGE PROVIDED:

[ ] Birth Certificate
[ ] Baptismal Certificate
[ ] Other (see list below): _____

EVIDENCE OF CUSTODY PROVIDED:

[ ] Judicial Custody Papers
[ ] Guardianship papers
[ ] Signed affidavits

PROOF OF RESIDENCY PROVIDED:

[ ] Copy of Deed
[ ] Copy of Purchase Contract, with Letter from Attorney (including date/time of closing)
[ ] Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease or live with
[ ] Third party statement establishing the physical presence of the parent(s)/guardian(s) in the school district
[ ] Other (see list below): _____

Other proofs of Age:

Passport;
Official driver's license;
State or other government issued identification;
School photo identification with date of birth;
Consulate identification card;
Hospital or health records;
Military dependent identification card;
Documents issued by federal, state or local agencies;
Court orders or other court-issued documents;
Native American tribal documents'

Other proofs of Residency:

Pay Stub;
Income tax form;
Utility or other bills;
Membership documents based upon residency (e.g. library cards)
Voter registration document(s)
Official driver's license, learner's permit or non driver ID
State or other government issued ID
Documents issued by federal, state or local agencies

GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Suite 101
Johnstown, NY 12095

Racial/Ethnic Identification – please answer both of the following questions.

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
   Yes ____ No ____

2. Select one or more races from the following five racial groups: (Check all groups that apply to your child.)

   ☐ American Indian or Alaska Native – a person having origins in any of the original peoples of North America

   ☐ Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent

   ☐ Native Hawaiian or other Pacific islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands

   ☐ Black – a person having origins in any of the black racial groups of Africa

   ☐ White – a person having origins in any of the original peoples of Europe, North Africa or the Middle East

3. What language does/do the parent(s) prefer to speak?
   ☐ English
   ☐ Other: _____
   (Please specify)

_____

Signature of person filling out form Relationship Date

Revised 2/26/21
lac

Greater Johnstown School District
Johnstown, NY 12095

EMERGENCY CONTACT INFORMATION AUTHORIZATION

In order to adequately care for your child when he/she is in school, we need to have up-to-date information about your child's care, as well as a current health and medical history. Please complete this form and return it to the school immediately.

Student's Name _____ _____ _____
Last First M.I. Grade Building

Birthdate _____ Sex _____

Siblings attending Johnstown Schools (include name, grade and school) _____

_____

Student lives with: ___ Parents ___ Mother ___ Father ___ Guardian

_____
Father/Guardian Home Address Home Phone Work Phone

_____
Mother/Guardian Home Address Home Phone Work Phone

Children will be released to parent/guardians and only those others listed below. This includes releases for any purpose, at any time, including at dismissal. Be sure to list all individuals that you may delegate for this responsibility and include all information. If there are any changes during the year, please contact the main office of your child's school to report them.

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

Please complete back of form
Revised 2/14

Greater Johnstown School District
Johnstown, NY 12095

Health Record Update

Student Name _____ Grade _____

Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station. If the students lives with relatives or others due to lack of housing or other similar situation, or if the student is temporarily housed in a shelter awaiting permanent foster care placement. _____

CHILD FIND – The Greater Johnstown School District has an obligation to evaluate, with parental consent, and offer to students determined to be disabled who reside in the District, a free and appropriate public education. If you believe your child has a disability that requires specialized instruction or special accommodations to benefit and/or access our programs and services, please contact your child's building principal or the Director of Special Education at 518-736-1708 to discuss the process to initiate a referral to the Committee on Special Education or the §504 Team. If you suspect your child has a disability which adversely affects his/her educational performance and which may require special education and you are enrolling your child in a nonpublic school and are seeking supports for your child while he/she attends school there, you may initiate a referral by writing to the CSE in the school district where the nonpublic school is located.

Does your child have or recently been diagnosed with asthma?	**YES**	**NO**
Does your child have any significant allergies (peanut, bee sting, latex, etc)?	**YES**	**NO**
Does your child have a seizure disorder as diagnosed by a physician?	**YES**	**NO**
Does your child have diabetes?	**YES**	**NO**
Does your child wear glasses or contacts?	**YES**	**NO**
Does your child wear a hearing aide or suffer from a hearing problem?	**YES**	**NO**
Has your child sustained any significant injury, surgical procedure, or recent hospitalization?	**YES**	**NO**
Does your child take any medication on a regular basis?	**YES**	**NO**

If you have answered YES to any of the above questions, please explain the specific conditions, the specific type of allergy, any activity restrictions, any special care required, the name and dosage of any prescribed medications.

Please list and explain any other health concerns you have for your child.

_____

_____

_____

I hereby give the Health Office permission to share this information with the school staff for the safety of my child.

_____ _____
Parent/Guardian Signature Date

In an emergency, when reasonable attempts to reach those people I have identified on the Emergency contact Information Form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred physician or dentist is not available, by another physician or dentist, and the transfer of my child to ANY hospital readily accessible.

_____ _____
Parent/Guardian Signature Date

Refusal To Consent

I do not give my permission for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to _____

_____

_____ _____
Parent/Guardian Signature Date

Revised 7/10

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RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby request and authorize the release of all current records: report cards/academic grades; health records (immunizations and physical examinations); psychological/psychiatric evaluations; IEP (Individualized Education Plan); social history; other evaluations/reports including occupational therapy, physical therapy, speech/language, hearing, vision, etc.; counseling records; 504 Plan; birth certificate; and any other information you feel may be pertinent regarding the following student:

Student's Name	Grade	Date of Birth
_____	_____	_____

Previous School:_____

Address:_____

Phone Number:_____ Fax Number:_____

PLEASE SEND GENERAL EDUCATION RECORDS TO:

- Grades K-1: Pleasant Avenue Elementary School, 235 Pleasant Avenue, Johnstown, NY 12095
  - Fax: 518-762-1217 or Email: psalatel@johnstownschools.org
- Grades 2-4: Warren Street Elementary School, 110 Warren Street, Johnstown, NY 12095
  - Fax: 518-762-8805 or Email: jfriers@johnstownschools.org
- Grades 5-7: Knox Middle School, 400 South Perry Street, Johnstown, NY 12095
  - Fax: 518-762-3127 or Email: khoutz@johnstownschools.org
- Grades 8-12: Johnstown High School, 1 Sir Bills Circle, Johnstown, NY 12095
  - Fax: 518-736-1489 or Email: canagnostopulos@johnstownschools.org

PLEASE SEND SPECIAL EDUCATION RECORDS TO:

- Special Education Department, 1 Sir Bills Circle, Johnstown, NY 12095
  Fax 518-762-6027 or Email: jbump@johnstownschools.org

ANY OTHER QUESTIONS CONTACT:
registration@johnstownschools.org or 518-762-4611 ext. 3120

X_____ _____
Parent/Guardian Signature Date

_____
Relationship to Student

GREATER JOHNSTOWN SCHOOL DISTRICT

Administration Center
1 Sir Bills Circle, Johnstown, NY 12095
Phone 518-762-4611
Fax 518-762-5654

SCHOOL ENTRANCE HEALTH HISTORY

Dear Parents/Guardians:

Please complete this questionnaire to the best of your ability and return it to the Health Office of your child's school. This information is for the school medical record kept for each child and is of great help to the school nurse and doctor in understanding and helping to safeguard your child's health. Thank you very much.

SCHOOL _____ **Grade** _____

CHILD'S NAME _____ **Nickname** _____

Birthdate _____ **Place of Birth** _____ **Sex** _____

Father's Name _____ **Place of Employment** _____
Phone _____

Mother's Name _____ **Place of Employment** _____
Phone _____

Home Address _____ **Phone** _____

Name of Doctor _____ **Address** _____

Name of Dentist _____ **Address** _____

Other Children in Family: **Birthdates:**

_____ _____
_____ _____
_____ _____
_____ _____

1. **Is your child currently being treated for an illness or ongoing condition?** _____
   If yes, please describe _____
   _____
   _____

2. **Is your child currently taking any medication?** _____
   If yes, what medication? _____
   Why? _____

3. **Do you consider your child's health to be: Good** _____ **Fair** _____ **Poor** _____

4. Can your child participate in all school activities? _____

5. Does your child have any allergies (Foods, animals, medicines, bee stings, dust, pollen, other) _____

   If he/she is allergic to bee stings, what actions do you want school personnel to take? _____

6. Please check if your child has had any problems with:

Asthma	( )	Persistent cough or wheeze	( )
Eczema	( )	Tiring Easily	( )
Frequent headaches	( )	Stomach aches or vomiting	( )
Dizziness or fainting spells	( )	Bowel movements	( )
Convulsions and/or Epilepsy	( )	Hernia	( )
More than 3-4 colds per year	( )	Kidney/urinary problems	( )
Tonsils or adenoids	( )	Painful joints	( )
Strep throat	( )	Feet or walking	( )
Frequent nosebleeds	( )	Bedwetting	( )
Anemia	( )	Frequent temper tantrums	( )
Heart problems	( )	Rapid changes of mood	( )
Diabetes	( )	Eating problems	( )

   If so, is the condition under the care or observation of a doctor? If YES, a statement from your physician is required.

7. Has your child had any:

Serious injuries	_____	Describe	_____
Serious illnesses	_____	Describe	_____
Accidents	_____	Describe	_____
Operations	_____	Describe	_____

8. Has your child had any of the following diseases?

   Measles _____ Chicken Pox _____ Rheumatic Fever _____

   German Measles _____ Mumps _____ Pneumonia _____ Scarlet Fever _____

9. When did your child last have a complete physical examination? _____

10. Does your child have any eye problems? (difficulty seeing, crosses eyes, frequently reddened or watery eyes)

    _____

11. Does your child wear glasses? _____

12. Does your child have any ear or hearing problems? (frequent earaches, draining from ears, difficulty hearing)

    _____

13. Does your child wear a hearing aid? _____

14. Has your child worn braces or corrective shoes? _____Are they still being worn?

    _____

15. Does your child have any speech problems (stuttering, difficult to understand, delayed speech development) _____

16. Is a language other than English spoken at home? _____

17. Will your child require any special health care in school? _____
If yes, please describe: _____

18. Do you have any concerns about your child's general health, behavior, or emotional well-being of which the school should be aware?

_____

19. Was this a normal, full-term pregnancy? _____

20. At what age did your child walk? _____ Talk? _____ Toilet train? _____

21. How did your child develop compared to other children the same age?
Faster _____ Slower _____ About the same _____

22. Please check if your child had any of the following experiences which might influence his social or physical development:

Frequent changes in residence	( )
Death in family	( )
Fires	( )
Accidents/Injuries	( )
Other	( )

23. Please check if you expect that your child may have any of the following problems when he/she begins school:

Leaving home for the first time	( )
Getting along with a new adult	( )
Dressing, eating, toileting by himself	( )
Getting along with other children	( )

24. Family History: Please check any that apply to your immediate family and explain the persons relationship to your child (mother, father, sister, aunt, grandmother, etc.)

Physical disability (describe) _____
Epilepsy _____
Diabetes _____
Intellectual and Developmental Disabilities _____
Depression _____
Vision Problems _____
Hearing Problems _____
Thyroid Problems _____
Scoliosis/back problems _____
Convulsions _____
Heart Problems _____
Other _____

25. Are there other concerns regarding your child that you feel the school should be aware of: _____

Parent/Guardian Signature _____ Date _____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		**GENDER:**
		❑ Male ❑ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	_____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other	_____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 _____ *specify*		❑ Parent 2 _____ *specify*	
	❑ Guardian(s) _____ *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	_____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	_____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	_____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	_____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. *If referred for an evaluation, has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Greater Johnstown SCHOOL DISTRICT

Pleasant Avenue Elementary ● Warren Street Elementary ● Knox Middle School ● Johnstown High School

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Dear Parents and Guardians:

The School District very much appreciates the valuable service volunteers provide as classroom helpers, field trip chaperones, PTSA members, and in offering assistance with extra-curricular activities.

Greater Johnstown School District Policy No. 3150 states that all volunteers shall be subject to screening procedures, which may include, but are not limited to, reference checks, a criminal history check and request of information regarding previous criminal convictions, and investigation to determine whether a volunteer has a history of child abuse.

In an effort to protect the safety and security of children and school staff, it is required that volunteers complete a School Volunteer Application containing a consent to a criminal background check regarding convictions for child abuse or endangerment, sex or drug related offenses, or crimes of violence. While a prior criminal history will not automatically prohibit an individual from performing as a volunteer, any individual who refuses to consent to a criminal background check may be ineligible to be a volunteer in the Greater Johnstown School District.

A Volunteer Application form is attached and additional copies are available at each school. Applicants with children in more than one building need only submit paperwork at one site. Volunteers who are approved will be added to a District-Wide registry for the school year. District employees who volunteer will not have to go through an additional background check if they have already undergone background clearances.

It is hoped that everyone will understand that for the safety of our students and staff, these requirements are essential.

Thank you.

GREATER JOHNSTOWN SCHOOL DISTRICT

ADMINISTRATION CENTER
1 Sir Bills Circle, Suite 101 • Johnstown NY 12095
Telephone (518) 762-4611 • Facsimile (518) 762-6379

SCHOOL VOLUNTEER APPLICATION

NOTICE: PURSUANT TO DISTRICT POLICY, ALL VOLUNTEERS SHALL BE SUBJECT TO SCREENING PROCEDURES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, 1) REFERENCE CHECKS, 2) A CRIMINAL HISTORY CHECK AND REQUEST OF INFORMATION REGARDING PREVIOUS CRIMINAL CONVICTIONS, AND 3) INVESTIGATION TO DETERMINE WHETHER A VOLUNTEER HAS A HISTORY OF CHILD ABUSE.

Volunteer Name: _____
(First) (Middle) (Last)

Maiden/Alias/Other Names: _____

Your Date of Birth: _____
Month/Day/Year

Address: _____
(Street) (City) (State) (Zip)

If at current address less than five years, list previous residence(s): _____

_____

Telephone: _____

Are you currently an employee of the Greater Johnstown School District? ____No ____Yes Position/Building _____
(Employees who have already received background clearances do not have to go through an additional background check)

Are you a (circle one) parent/guardian/family member of a student in the Greater Johnstown School District? ____Yes ____No

Child(ren) Name(s)	Grade/Teacher	School

Please respond to the following questions truthfully. Disclosure of a prior criminal history will not automatically prohibit volunteer status.

	Yes	No	
1.	____	____	Have you ever been convicted of child abuse or endangerment?
2.	____	____	Are you required to register as a sex offender?
3.	____	____	Have you ever been convicted of a felony?

MY SIGNATURE BELOW INDICATES THAT I CONSENT TO A CRIMINAL BACKGROUND CHECK FOR CONVICTIONS OF CHILD ABUSE OR ENDANDGERMENT, SEX AND DRUG OFFENSES, AND CRIMES OF VIOLENCE; THAT I WILL ABIDE BY ALL APPLICABLE SCHOOL RULES AND BOARD OF EDUCATION POLICIES AND REGULATIONS; AND THAT THE INFORMATION PROVIDED BY ME IS TRUE, COMPLETE AND CORRECT.

Application Date: _____ _____
(Signature of Volunteer Applicant)

FOR SCHOOL USE ONLY:

APPROVED _____ DISAPPROVED _____ DATE: _____ SIGNATURE OF PRINCIPAL: _____

STUDENT TRANSPORTATION REQUEST FORM

GJSD Transportation Office: 518.762.4611 Extension 3145 Fax: 518.762.3127

2023-2024 Academic School Year

One of our most important District responsibilities, in partnership with HFM BOCES Shared Transportation Department and its families, is to ensure the safe transportation of our students to and from school on a daily basis.

This form should only be used if you qualify for transportation based on the policy listed below.
When requesting transportation for your Student(s), please complete the following information in its entirety. One Request Form per student is required.

Students are eligible for **Home to School** transportation based on the following GJSD Policy:

POLICY: Students are eligible for transportation as follows:
https://www.johnstownschools.org/policy-5730-transportation-students/

- ***Kindergarten*** ***Student must live ½ mile or more from the school they attend, as determined by the District standard of measure.***
- ***Grades 1-8*** ***Student must live 1.5 miles or more from the school they attend, as determined by the District standard of measure.***
- ***Grades 9-12*** ***Student must live 2.5 miles or more from the school they attend, as determined by the District standard of measure.***

Parent/Guardian Filing Request: _____

Student's Name (Last, First, Middle):_____

Parent/Guardian Name(s): _____

Home Address (Primary): _____

Telephone Contact: _____ Alternate: _____

A.M. Pick Up Location: _____

P.M. Drop Off Location: _____

Start Date of Service: _____

The following **Adults** are authorized to accept my student from the bus:

_____

_____

_____

I hereby give my consent for transportation to be arranged as per the information provided herein.

Signature of Parent/Guardian: _____ Date: _____

Signature of School Official: _____ Date: _____

Transportation Request Forms are to be completed and returned to the Building Principal. **Transportation requests may take up to one to two weeks to process before service will begin.**

ADK 5-17-23