Date: _____

North Brunswick Township Public Schools Registration Form

Directions to Parent/Guardian: The information requested below is necessary for completing the enrollment process. In some instances you may, for privacy reasons, not be able to respond to a question. The parent/guardian should understand that his/her responses to these questions will be of great help to the district and the state in planning a program that meets the unique needs of his/her child. If the parent/guardian declines to respond to a question, leave the item blank. However, please be aware that the school must make a determination for some items left blank. Please make every effort to respond as fully as possible in order to expedite the process and to avoid follow-up contacts for more information.

STUDENT INFORMATION SECTION - PLEASE PRINT ALL INFORMATION

Child's Full Name: _____ Gender: _____
Last First Middle

Ethnicity: Hispanic _____ Not Hispanic _____

Race (circle one or more): White Black or African American American Indian or Alaskan Native Asian Hawaiian Native/Other Pacific Islander

Child's Permanent or Home Address:

Address:_____ City/State/Zip_____

Rent: _____*Exp. Date* _____ Own: _____ Lot # _____ Block # _____ Housing Type: _____ Affidavit: Yes _____ No _____

Mailing Name: _____ Relationship _____ Home Phone # _____

Child's City of Birth: _____ Child's State of Birth: _____ Child's Country of Birth:_____

Child's Date of Birth: _____ Birth Certificate # _____

Has your child attended Preschool? Yes _____ No _____ If yes, what school? _____ How many years? _____

If, applicable, what was the last grade completed by your child? _____

Office Use Only *Student ID #:* _____ *School:* _____

Family Code: _____ *Copies to: Transportation ___ Special Services ___ Technology___*

Previous School Attended:_____ Previous Grade: _____ Phone Number: _____

Address: _____ City/State/School: _____

Has your child previously attended school in North Brunswick? Yes _____ No _____ If yes, What school? _____

Is your child homeless? Yes ____ No _____

If the child' s parent(s) are not residents of North Brunswick Township, state the reasons why the child is residing with you in North Brunswick?_____

Has your child ever been referred to or evaluated by the Child Study Team? Yes_____ No _____ If yes, where and when? _____

Is your child classified? Yes_____ No _____ If yes, where and when? _____

Does your child have an IEP? Yes_____ No _____ If yes, did you provide a copy of the IEP? Yes_____ No _____

Are there any educational problems that your child has which you feel the school should be aware of? Yes_____ No _____ If yes, please specify. _____

_____

Has your child ever been retained? Yes_____ No _____ If yes, what grade? _____

Primary Language of Child: _____ (The language or dialect first learned by your child or first used by the Parent/Guardian with your child. This is often referred to as the first language spoken.)

Home Language: _____ Dialect: _____

Does your child receive English-Language Learner (ELL) services? Yes_____ No _____ If yes, where? _____

Does your child qualify to receive federal support as an immigrant? Yes____ No ____ Is your child an immigrant? Yes____ No ____ A**n immigrant is a student who is age 3 to 21 and was NOT born in the U.S. and has not been attending one or more schools in any one or more states for more than three full academic years.**

US Entry Date:_____ First Entry Date into a U.S. School:_____

Does the child living with you hold an F-1 visa? Yes_____ No _____ If the answer is yes, please explain._____

PARENT / FAMILY INFORMATION SECTION

Parent Status: Married ___ Divorced ___ Separated ___ Single ___ Remarried ___ Custody/Child Lives with:_____

Are either or both parents connected with the military?
_____ **Not Military Connected** - student is not military connected. Active Duty _____ **Active Duty** - student is a dependent of a member of the Active Duty Forces (Full Time Army, Navy, Air Force, Marine Corps or Coast Guard). _____ **National Guard or Reserve** -student is a dependent of a member of the National Guard or Reserve Forces.

Mother/Guardian 1 Name:_____ Email:_____

Guardian: Indicate your relationship to the child: _____

Address if different than student_____ Phone #_____ Cell Phone # _____

E-Mail Address _____

Place of Employment:_____ Address_____ Work #_____

Father/Guardian 2 Name:_____ Email:_____

Guardian: Indicate your relationship to the child: _____

Address if different than student_____ Phone #_____ Cell Phone # _____

E-Mail Address _____

Place of Employment:_____ Address_____ Work #_____

Children in family (including pupil) in order of age, oldest first…

	Name	Gender	Birth date	School Name, City, State	Public or Non -Public	Grade
1.						
2.						
3.						
4.						
5.						

Health Information

List any allergies: _____

List any medications your child is currently taking: _____

List any present or past physical conditions or special disabilities which might interfere with the normal function of your child in the classroom: _____

_____

Special health recommendations you wish the school to consider: _____

FamilyDoctor_____Address_____Phone_____

Circle where applicable: · Child wears contact lenses: Yes / No Hard / Soft · Child has allergies: Yes / No · Child wears dental appliances Yes / No

EMERGENCY INFORMATION:

If Guardian(s) cannot be contacted, list 3 people who will assume responsibility for your child in an emergency.

	Name	Relationship	Address	Phone Number	Cell Number
1.					
2.					
3.					

If none of the above can be contacted, what do you wish the school to do if the child is sick or injured?_____

In case emergency room treatment becomes necessary, which medical facility do you prefer? Circle One: Robert Wood Johnson Hospital or St. Peter's University Hospital

CUSTODIAL RIGHTS: Name_____Relationship:_____ has *LEGAL CUSTODY* of the child.

Legal documents must be on file at the school the child is attending. The other parent/guardian □ *May* □ *May Not* speak with the child and/or sign the child out of school. Identification is required for parent/guardian.

CONFIDENTIALITY: I will notify the school in writing if I do not want relevant medical information to be shared with appropriate staff, as needed.

EMERGENCY SCHOOL CLOSING: ___No. It is *NOT NECESSARY* to notify me. I have instructed my child what to do.

___Yes. It *IS NECESSARY* to notify me. I can be reached at (phone #)_____

SCHOOL DIRECTORY: □ *I DO* □ *I DO NOT* give permission for my child's information (name, address, phone #) to be included in the PTSO/PTA/PTO school directory for NBTS staff students.

CHANGE OF INFORMATION: I will immediately notify the Principal, in writing, in the event any of the above information changes. Parent/Guardian's Initials _____

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

Yes_____ My child has health insurance. Name of Insurance Company _____

No _____ My child does not have health insurance

If 'No', NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Parent/Guardian Initials _____

I certify that the foregoing statements made by me are true. I am aware that if any of them are willfully false, I will be subject to legal action. As per State Law and Board Policy, if it is discovered that my child (children) is (are) illegally attending the North Brunswick Schools and not living in North Brunswick, I will be responsible for payment of accrued tuition fees. In addition, I acknowledge that I will be responsible for any legal expenses incurred by North Brunswick Board of Education in relation to the situation.	**IMPORTANT** **I understand that in the final disposition of an emergency the judgment of the school authorities will prevail. The recommendation of the parent/Guardian, as indicated here will be respected whenever possible.**

Parent/Guardian Signature: _____ Date: _____

For Office Use Only

Grade: _____ *New Entry:* _____ *Re-Entry:* _____

Custody Issue: Yes _____ *No* _____ *Copy of Custody Papers: Yes* _____ *No* _____ *Docket #:* _____

Program Type: _____ *Current School Entry Date:* _____ *Entry Code:* _____ *Year of Graduation:* _____ *Class of:* _____

Registrar: _____ Entered by: _____ Date Entered_____

North Brunswick Township Schools

North Brunswick, New Jersey 08902

IMMUNIZATION and PHYSICAL EXAMINATION REQUIREMENTS

All Students are required to have complete immunizations and a physical exam upon entry into school, as required and stipulated in the *New Jersey State Sanitary Code Requirement*, Chapter 14 Regulations, within 30 days of this registration. The exam must have been done no more than 365 prior to the first day of school entry. This examination should be conducted by your private physician. A Certified School Nurse will review immunization records and will notify parents/guardians of any deficiencies.

RETURN THIS FORM TO THE SCHOOL NURSE ONCE COMPLETED BY YOUR PHYSICIAN, PRIOR TO YOUR CHILD'S FIRST DAY OF SCHOOL.

School _____ Grade _____

Student (Last, First) _____ Student Id# _____

Date of Birth _____ Sex _____ **Height** _____ **Weight** _____

BP _____ Resting Pulse _____

Scoliosis _____

MD Documentation: **Vision:** **Hearing:**

Developmental Delay: _____

Allergies: _____

Current Medications: _____

Handicap(s) that would effect school performance: _____

Emotional or Behavioral Abnormalities (such as excessive activity level or attention deficit): _____

Enter Immunization Record (MM/DD/YR)

DPT	1.	2.	3.	4.	5.	Tdap
Polio	1.	2.	3.	4.	5.	
Hepatitis B	1.	2.	3.			
MMR	1.	2.				

Measles 1. _____ 2. _____	Mumps _____	Rubella _____	HIB _____		
Meningitis _____	PNEUMOCOCCAL_____	INFLUENZA _____			

Varicella Vaccine _____ Varicella Lab Evidence _____ Varicella Disease (Age) _____

Mantoux Test /Date Given: _____ Date Read: _____

Negative: _____ mm Positve: _____mm

Chest x-ray /Date: _____ Normal: _____ Abnormal: _____

Therapy: ☐Case ☐Reactor Date Started: _____ Date Finished: _____

-OVER -

Physical Examination	Please Describe Each Area
General Appearance, Posture, Gait	
Behavior during examination	
Skin	
Eyes: External	
Eyes/Optic Fundi	
Ears/External Canals	
Earls/Tympanic membranes	
Nose, Mouth, Pharynx	
Teeth and Gums	
Lymph Nodes	
Heart	
Lungs	
Abdomen (including hernia)	
Genitalia	
Bones, Joints, Muscles	
Reflexes- Symetry	

ARE ANY FURTHER TESTS, TREATMENT OR CONSULTATIONS RECOMMENDED? ☐ **Yes** ☐ **No**

MAY THIS STUDENT PARTICIPATE IN A FULL PHYSICAL ACTIVITY PROGRAM AT SCHOOL? ☐ **Yes** ☐ **No**

If YES, please describe: _____

_____

Significant observations and comments (Include only findings that are relevant to education): _____

_____

Summary of current medical information/relevance to educational performances: _____

_____

Date of examination _____ Physician's signature: _____

Physician's Name (Please print): _____

Physician's Address: _____

Physician's Phone Number: _____

North Brunswick Township Schools

STUDENT HEALTH ASSESSMENT

TO BE FILLED OUT BY PARENT

School: ☐JA ☐JD ☐LP ☐Prsns ☐LMS ☐NBTHS Date:

Student (Last, First) _____ Birth Date _____ Grade _____

☐Parent/☐Guardian _____

Address _____

Home Phone # _____ Work # _____ Mobile # _____ Other Day# _____

Physician _____ Phone # _____

Address _____

Dentist Name _____ Phone # _____

LIST OTHER CHILDREN IN THE FAMILY:

Name _____ Birth Date _____ Name _____ Birth Date _____

Name _____ Birth Date _____ Name _____ Birth Date _____

HEALTH HISTORY

FOR *ALL YES* RESPONSES: PLEASE GIVE DETAILED INFORMATION ON REVERSE SIDE

	Yes	No		Yes	No		Yes	No
Pregnancy Problems			Birth was premature			Mother has Chronic or Serious Illness		
Delays in Walking			Labor & Delivery Problems			Father has Chronic or Serious Illness		
Delay in Talking								

DOES YOUR CHILD HAVE:						HAS YOUR CHILD *EVER* HAD):					
	Yes	No		Yes	No		Yes	No		Yes	No
Frequent Colds			Vision Problems			Convulsions			Nervous Habits		
Frequent Sore Throat			Eyeglasses			Epileptic Seizures			Serious Illness		
Life Threatening Allergies (Submit Medical Documentation)			Hearing Problems			Coordination Problems			Chicken Pox		
			Hearing Aid			Operation (explain)			Other (explain)		
Allergies (explain)			Emotional Problems			Serious Injury					
Asthma			Poor Eating Habits			Frequent Stomachaches					
			Poor Sleep Patterns			Frequent Headaches					

Presently, is your child under medical treatment? (Yes? Explain)		
Does your child take any medication? (Yes? Explain)		
Has your child been *ever* been referred to a physician for further care for VISION, HEARING, and/or SCOLIOSIS?		

PLEASE USE THE REVERSE SIDE TO NOTE ANYTHING ABOUT YOUR CHILD THAT MIGHT PRESENT A SPECIAL PROBLEM

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of health information to occur between my child's physician(s), the School Health Services Nursing Staff and all Staff Members who are in contact with my child.

_____ _____ _____

Parent/Guardian Signature Relationship to Child Date

_____ _____ _____

Parent/Guardian Signature Relationship to Child Date