# Kindergarten

Registration Period: March 4-28

Kenilworth Public Schools
Harding Elementary School

www.kenilworthschools.com
426 Boulevard
Kenilworth, New Jersey 07033
908-276-5936

Dear Parent/Guardian:

Attached please find the kindergarten registration packet for the Kenilworth School District. Please fill out all pages accordingly. Kindergarten registration will be **scheduled by appointment only** between ***March 4 and March 28.*** Please call Mrs. Dutkevicz at (908) 276-5936 ext. 1512 or email Lorrell_Dutkevicz@kenilworthschools.com to schedule your appointment.

- All children are eligible for kindergarten registration if they will be five (5) on or before October 1, 2019.

To register your child, please bring the following required documents to your appointment:

1. **Completed Registration Packet** (**Including** Physical Examination Report and Certification of Immunization form filled out by doctor.)
2. **Child's Birth Certificate** (Please bring original and a copy.)
3. **Current tax bill, mortgage statement or lease** (Please bring original and a copy.)
4. **Two (2) current utility bills** (Please bring originals and a copy.)
5. **Custody Papers** (If applicable) (Please bring original and a copy.)

Please be sure to fill out the registration packet completely, and bring it with you to your appointment with the required documents listed above. **Your child's registration will only be complete once ALL required documents are provided. If any items are missing, you will be required to reschedule your appointment.**

If you know of any parents/guardians of eligible children who have not received this information, please advise them to contact the Harding School main office. Should you have any further questions, please do not hesitate to contact Mrs. Dutkevicz at (908) 276-5936 ext. 1512.

Sincerely,

Kathleen Murphy

# Checklist

- ☐ Registration Information Form (3 pages)
- ☐ Home Language Survey
- ☐ NJ Smart Data Sheet
- ☐ Military Status Sheet
- ☐ Custody Alert Form (Attach court documents if applicable)
- ☐ Student Health Information Form
- ☐ Comprehensive Physical Examination Form **<u>(Must be filled out by doctor)</u>**
- ☐ Certification of Immunization Form **<u>(Must be filled out by doctor)</u>**
- ☐ Child’s Birth Certificate (ORIGINAL)
- ☐ Current Tax Bill, Mortgage Statement or Lease
- ☐ 2 Current Utility Bills
- ☐ Custody Papers (If applicable)

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# Registration Information

| Name of Student | | Preferred Name | |
|---|---|---|---|
| Street | | | |
| City | | State, Zip | |
| Home Phone | | Grade | |
| Previous Address | | Previous Phone | |

| Is this the student's Primary Residence? YES NO | Starting Date | Is the student's address temporary? YES NO | Is the student currently Homeless? YES NO |
|---|---|---|---|
| Gender ☐ Male ☐ Female<br>☐ Migrant<br>☐ Immigrant | Ethnicity ☐ Native American/Eskimo ☐ Asian/ Middle Eastern ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native<br>☐ Hispanic/Latino ☐ African/African American<br>☐ Caucasian/European | | |
| Date of Birth | | Birth Place | |

| Mother/Guardian Information | | | |
|---|---|---|---|
| Mother/Guardian | | Marital Status | ☐ Single ☐ Married ☐ Divorced<br>☐ Separated ☐ Widow |
| Address | | | |
| Home Phone | | Work Phone | |
| Cell Phone | | Email Address | |
| Employer | | Occupation | |
| Employer Address | | | |

## Father/Guardian Information

| Father/Guardian | | Marital Status | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow |
|---|---|---|---|
| Address | | | |
| Home Phone | | Work Phone | |
| Cell Phone | | Email Address | |
| Employer | | Occupation | |
| Employer Address | | | |

## EMERGENCY CONTACT INFORMATION

| Name | | | |
|---|---|---|---|
| Relationship to Child | | Work Phone | |
| Day Phone | | Cell Phone | |
| Physician | | Phone | |
| Physician's Address | | | |

## HEALTH INSURANCE

Do you currently have health insurance ☐ YES ☐ NO

If yes, what is the name of the Health Care Provider? ______________________________

______________________________

______________________________

______________________________

## CUSTODY

Does anyone other than the parent have legal custody of student? ☐ YES ☐ NO

**If yes, please explain and provide a copy of legal custody order**.

______________________________

______________________________

______________________________

## OTHER CHILDREN IN HOUSEHOLD

| Name | Date of Birth | Gender | School |
|---|---|---|---|
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |

## PREVIOUS SCHOOL INFORMATION

| | | | |
|---|---|---|---|
| Name of school child last attended | | | |
| Address, City, State, Zip | | | |
| School's Phone | | School's Fax | |
| Last grade Attended | | Last day attended | |

## PREVIOUS SCHOOL INFORMATION

| |
|---|
| What language is most often spoken at home? |
| Do you have concerns about your child's learning needs, such as reading, writing, math, emotional, or behavioral? YES NO<br>If yes, please explain: |
| Is your child or has your child ever been classified for special education? YES NO<br>If yes, provide a copy of your child's IEP |
| Is your child currently eligible for Section 504? YES NO<br>If yes, provide your child's accommodation plan |
| Is your child currently eligible for Intervention & Referral Services (I&RS) or Pupil Assistance Committee (PAC)? YES NO<br>If yes, provide your child's accommodation plan |

**REQUIRED NOTICE**: Eligibility to attended school is subject to review and re-evaluation. There is a potential for assessment of tuition in the event that an initially admitted applicant is later found ineligible.

**ASSISTANCE**: Questions regarding residency requirements may be addressed to the Board Secretary of the Kenilworth Public Schools, (908) 276-5936.

Parent/Guardian Signature: ______________________________________________ Date: _____________

# Home Language Survey
# Parent/Guardian Questionnaire

**PLEASE PRINT**

Child's name: ________________________________________ Date of birth: _________
(first) (middle) (last)

Date of school entrance: ________

Person completing the survey: [ ]Mother [ ]Father [ ]Grandparent [ ]Guardian [ ]Other

Please tell us about your child:

1. What language did the child learn when he/she first began to talk? _________________________
2. What language does the family speak at home most of the time? _________________________
3. What language (s) does the primary caregiver (s) speak to the child most of the time? ____________
4. What language (s) does the child speak to his/her primary caregiver (s) most of the time? _________
5. What language (s) does the child speak to his/her brothers and sisters most of the time? __________
6. What language does the child speak to his/her friends most of the time? _______________________
7. Please list any preschool program(s) your child attended before coming to our program:
   ________________________________________________________________________
8. In which language do you wish to receive information from the school? _______________________
9. What name do you use for your child (if different from above)? _____________________________

Sources:
Questions 1 – 8 are based on the *NJ DOE Home Language Survey* that was adapted from the sample survey in *A Manual for Community Representatives of the Title VI Steering Committee*, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

Question 9 was adapted from the Parent Questionnaire in *One Child, Two Languages 2nd Edition published 2/2008* by Patton O. Tabors, Paul H. Brookes Publishing

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**NJ SMART DATA SHEET**
**Required by the N J Department of Education**

**First Name** ________________________ **Middle Name** ___________________ **Last Name**_____________________

**Address** ________________________________________________________________________________________

**City** __________________________________ **State:** _______________________ **Zip Code** __________________

**State ID Number** (obtained from previous school district -10 digit number) ____________________________________

**Date of Birth** ________________________________ **Social Security Number** _______________________________

**Birth City** _______________________ **Birth State** __________________ **Birth Country** ________________________

**Birth Certificate Number** ________________________________ **Country of Citizenship** _______________________

**First Entry in US School** _________________________ **US Entry Date (if born outside of US)** __________________

**Primary Language** _______________________________ **Home Language** __________________________________

**Health Insurance** ☐ Yes ☐ No **Name of Health Insurance Carrier** _______________________________________

**Ethnicity** ☐ White ☐ Black ☐ Hispanic ☐ American Indian/Alaskan ☐ Asian Hawaiian/Pacific Islander

**High School Entry Date** ______Month ______ Date ______ Year **Year of Graduation** _____________________

**Gender** ☐ Male ☐ Female **Special Education** ☐ Yes ☐ No **I&RS** ☐ Yes ☐ No **504** ☐ Yes ☐ No

**Residency** ☐ Kenilworth ☐ Winfield Park ☐ Choice

**Choice Students** ☐Yes ☐ No City of Residency ___________________ School District ______________________

Name of School student should attend if they did not attend Brearley _________________________

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**Student Registration - Military Status**

Effective August 6, 2015, the State of New Jersey requires all public schools to identify students' parent(s) or guardian(s) who are on Active Duty, in the National Guard, or in the Reserve components of the United States military services.

**Name of Student:**

______________________________________________

Please indicate the following military connection status for your child:

☐ **Not military connected** - no active duty, National Guard or Reserve parent/guardian.

☐ **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 – Army, Navy, Air Force, Marine Corps, or Coast Guard.

☐ **Unknown** - It is unknown whether or not the student is military connected.

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**Custody Alert Form**

The legal parent, custodian or court-ordered guardian for

________________________________________ is ____________________________________
(Student Name) (Parent/Guardian Name)

The following people may not have legal access to the child or the child's records without written permission from the custodial person (must be accompanied by a copy of the custody papers or restraining order):

Name ________________________________________________________________________

Relationship to student ___________________________________________________________

Address ______________________________________________________________________

Phone number ____________________________

____________________________________________________
Signature of Parent

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# Record Release Form

Student Name: _______________________________________________ Date:____________________________

Name of School: ______________________________________________ Date of Birth: ____________________
(Former)

School Address: ___________________________________________________________________________________
(Street) (City, State) (Zip)

School Telephone: :___________________________ School Fax: :_____________________________

Last Grade Completed:___________________________ State ID Number: :_______________________

**I hereby authorize you to forward *all* documents pertaining to the above student.**

All documents must have the State ID Number on them.

•Cumulative Records
•Health Records (immunizations, etc.)
•Guidance Records (Standardized test scores, Scholastics evaluations, Attendance records)
•Discipline Records (All information related to disciplinary actions and any notice that the students committed juvenile offenses)
•Free/Reduced Lunch Forms
•I&RS, PAC or Section 504 Plans
•Other: ___________________________

Please forward all official records to:

•Harding Elementary School, 426 Boulevard, Kenilworth, NJ 07033, (908) 276-5936
•David Brearley Middle School, 401 Monroe Avenue, Kenilworth, NJ 07033, (908) 931-9696
•David Brearley High School, 401 Monroe Avenue, Kenilworth, NJ 07033, (908) 931-9696

**I hereby authorize you to forward *all* documents pertaining to the above special education student.**

•Child Study Team Evaluations (IEP's, Social History, Psychological, Learning Evaluations, Annual Reports, etc.)

Please forward all official records to:

•Harding Elementary School, Office of Special Services, 426 Boulevard, Kenilworth, NJ 07033

______________________________ ______________________________
Signature of Parent or Guardian Signature of School Official

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908-276-5936

**Student Health Information Form**

Student Name ______________________________________ DOB ______________ Sex _______ Grade ____________________

| General Health Questions | Yes | No | Comments if "Yes" & date of occurrence |
|---|---|---|---|
| Has the student been under a doctor's care in the past 12 months? | | | |
| Has the student been hospitalized in the last 12 months? | | | |
| Has the student ever had any surgeries? | | | |
| Does the student have any missing organs? (eye, kidney, testicle, etc.) | | | |
| Has the student ever had chest pain during or after exercise? | | | |
| Does the student have trouble with breathing or coughing during or after activity? | | | |
| **Condition** | **Yes** | **No** | **Comments if "Yes" & date of occurrence** |
| Anemia | | | |
| Allergies (**food, insects, medications, latex**) | | | |
| Allergies/Hay fever (seasonal) | | | |
| Asthma<br>**Use of Inhaler?** | | | |
| Attention-Deficit/Hyperactivity Disorder | | | |
| Behavioral problems | | | |
| Bladder problems | | | |
| Bowel problems | | | |
| Bronchitis | | | |
| Cancer | | | |
| Cerebral Palsy | | | |
| Chicken Pox | | | |
| Cystic Fibrosis | | | |
| Dental Problems | | | |
| Developmental problems | | | |
| Diabetes | | | |
| Ear Infections (frequent) | | | |
| Eczema | | | |
| Glasses or contact lenses | | | |
| Head or Spinal injury | | | |
| Headaches (frequent) | | | |
| Hearing Aide(s) | | | |
| Hearing problems or Deafness | | | |
| Heart problems | | | |
| Hemophilia | | | |

| Hepatitis | | | |
|---|---|---|---|
| High Blood Pressure | | | |
| Condition | Yes | No | Comments if "Yes" & date of occurrence |
| Hydrocephalus | | | |
| Immune disorder | | | |
| Kidney problems | | | |
| Lyme Disease | | | |
| Meningitis | | | |
| Migraines | | | |
| Mononucleosis | | | |
| Muscular Dystrophy | | | |
| Muscle problems | | | |
| Orthopedic problems | | | |
| Pneumonia | | | |
| Seizures | | | |
| Sickle Cell Disease | | | |
| Skin problems | | | |
| Skull Fracture | | | |
| Speech problems | | | |
| Stomach problems | | | |
| Strept throat (frequent) | | | |
| Tuberculosis | | | |
| Vision problems | | | |
| Other | | | |

List all prescription and over-the-counter **medications** your child takes regularly:

Describe any other important health-related information about your child:

| Student's Pediatrician or Primary Care Provider: | Medical Specialists or Specialty Clinics caring for this student: |
|---|---|
| Has the student ever seen a Dentist? Yes No (circle one) | Name of Dentist: |

**For Parents/Legal Guardians of Students**

The information on this form is current and correct to the best of my knowledge. I understand that if the medical status of my child changes in any significant way, **I will notify his/her school nurse of the change immediately**. I also understand that my child's health/medical information may be shared with other school staff members in order to ensure my child's health and safety while at school.

By signing below, I am agreeing to the above statements.

| **Signature of Parent or Legal Guardian:** | **Date:** |
|---|---|

**For Nursing Use Only**:

Action Plan Received ☐ IHP ☐ Emergency Response Plan ☐ 504 Plan ☐ Medication Forms ☐

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# Comprehensive Physical Examination Report

To be completed by a licensed physician/licensed nurse practitioner.

Name:______________________________________________
DOB:_______________________________________________
Current Meds:_______________________________________

Ht._________ Wt.__________ BMI__________ Age_________
BP_________ T___________ P__________ R___________
Allergies:_______________________________________________

Past Medical History
Major illness___________________________________________
Hospitalizations/Surgeries______________________________
______________________________________________________
______________________________________________________
______________________________________________________

**Asthma**: No Yes: Intermittent • Moderate • Persistent • Severe • Persistent • Exercise induced
*If yes, please see school Nurse for Asthma Action Plan.*
**Anaphylaxis Allergies:**
No Yes: Food • Insects • Latex • Unknown source
*If yes, please see school Nurse for Emergency Allergy Plan.*
History of Anaphylaxis No Yes Epi Pen required No Yes

**Nutritional Assessment**
Special Diet ________________________
Vitamins/Supplements _______________
Comments:____________________________
_____________________________________

**Dental Assessment**
Any Dental Disease No Yes
Dental Caries No Yes
Brush Teeth Regularly No Yes
Dental Visit in the last year No Yes

**Reproductive**
Menarche age________ LMP ________

**Vision Screen**(if indicated) Not indicted
Subjective: any eye disorder Yes No
Wear eyeglasses/contacts Yes No
Objective: visual acuity R 20/ __ L 20/___
with glasses/contacts Yes No
Muscle balance pass fail
Color perception pass fail

**Hearing Screen** (if indicated) Not indicted
Subjective: response to voices Yes No
Delayed speech development Yes No
Recurrent O.M. Yes No
Hearing 20db HL (pass or fail)
1000Hz 2000Hz 4000Hz
Right ear ______ ______ ______
Left ear ______ ______ ______

**TB:** High-risk Group? No Yes
Positive/Referred ___________ mm

| **Review of System** | **WNL** | **Abnormal** | **Comments** |
|---|---|---|---|
| Constitutional | | | |
| Eyes | | | |
| ENT | | | |
| Cardiovascular | | | |
| Respiratory | | | |
| GU | | | |
| GI | | | |
| Musculoskeletal | | | |
| Neurological | | | |
| Psychiatric | | | |
| Endocrine | | | |
| Hemat./Lymphatic | | | |
| Allergic/Immunological | | | |
| | | | |

<table>
<tr><td colspan="2">Social History/Devel. Assessment<br>(Use additional sheets for more information).</td><td rowspan="5">Anticipatory Guidance<br>Nutritional/Diet ___________________________________________<br>SkinCare/Hygiene ___________________________________________<br>Oral/Dental ___________________________________________<br>Behavioral Devel. ___________________________________________<br>Safety ___________________________________________<br>School Status ___________________________________________<br>Health/Reproduction _______________________________________<br>High Risk Activities ________________________________________</td></tr>
<tr><td>Cognitive Devel.</td><td></td></tr>
<tr><td>Speech/Lang. Devel.</td><td></td></tr>
<tr><td>Social/Emot. Devel.</td><td></td></tr>
<tr><td>Health Beh./Habits<br>(Drugs/ETOH/Tobacco)</td><td></td></tr>
<tr><td colspan="3">Comments:</td></tr>
<tr><td colspan="2">Medical Provider's Name (print) ____________________________<br><br>Phone #: (______) ________________________________________<br><br>Signature of Medical Provider:_______________________________<br><br>Date:_________________________</td><td>Physician Stamp required:</td></tr>
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**K ENILWORTH PUBLIC SCHOOLS**
**S CHOOL ENTRANCE HEALTH FORM**
**Ce rtification of Immunization**
**To be completed by a physician, registered nurse, or health department official.**

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day and year of the required vaccines shall be acceptable in lieu of recording of recording these dates on this form as long as the record is attached this form). Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

**Student's Name:**_______________________________________________ **Date of Birth:** /_______/_______/_______/
*Last* *First* *Middle* *Mo.* *Day* *Year*

| IMMUNIZATION | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | |
|---|---|---|---|---|---|
| *Diphtheria, Tetanus, Pertussis (DTP, DTaP) | 1 | 2 | 3 | 4 | 5 |
| *Diphteria, Tetanus (DT) or Td (given after 7 years of age) | 1 | 2 | 3 | 4 | 5 |
| *Tdap booster (6th grade entry) | 1 | 2 | 3 | 4 | 5 |
| *Poliomyelitis (IPV, OPV) | 1 | 2 | 3 | 4 | 5 |
| *Haemophilus influenza Type b (Hib conjugate) *only children <60 months of age | 1 | 2 | 3 | 4 | 5 |
| *Pneumococcal (PCV conjugate) *only children <2 years of age | 1 | 2 | 3 | 4 | 5 |
| Measles, Mumps, Rubella (MMR vaccine) | 1 | 2 | | | |
| *Measles (Rubeola) | 1 | 2 | Serological Confirmation of Measles Immunity: | | |
| *Rubella | 1 | | Serological Confirmation of Rubella Immunity: | | |
| *Mumps | 1 | 2 | | | |
| *Hepatitis B Vaccine (HBV) | 1 | 2 | 3 | | |
| *Varicella Vaccine | 1 | 2 | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | |
| Hepatitis A Vaccine | 1 | 2 | | | |
| Meningococcal Vaccine | 1 | | | | |
| Human Papillomavirus Vaccine | 1 | 2 | 3 | | |
| Other | 1 | 2 | 3 | 4 | 5 |
| Other | 1 | 2 | 3 | 4 | 5 |

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the **MINIMUM** requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children*.

***Signature of Medical Provider or Health Department Official:*** ___________________________________ **Date (Mo., Day, Yr.):**_____/_____/_____