Kenilworth Public Schools
Office of the Superintendent
www.kenilworthschools.com
426 Boulevard
Kenilworth, New Jersey 07033
908-276-5936

Student Registration Checklist

- Registration Information Form (3 pages)
- Home Language Survey
- Record Release Form
- Student Health History Form (completed by parent/guardian)
- Comprehensive Physical Examination Form (completed by physician)
- Immunization Form (completed by physician or attach separate immunization record)
- NJ SMART Data Sheet
- Military Status Form
- Custody Alert Form (attach court documents if applicable)
- Documents Required:
    1. Student's Birth Certificate
    2. Current tax bill, mortgage statement or lease
    3. Two current utility bills
    4. Student's Report Card
    5. Student's Test Scores
    6. Transfer Card (from previous school district)

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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 ☐ Migrant ☐ Immigrant	Ethnicity ☐ Native American/Eskimo ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Hispanic/Latino ☐ Caucasian/European	☐ Asian/ Middle Eastern ☐ African/African American	
Date of Birth		Birth Place	

Mother/Guardian Information

Mother/Guardian		Marital Status	☐ Single ☐ Married ☐ Divorced ☐ 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
If yes, please explain:

Is your child or has your child ever been classified for special education? YES NO
If yes, provide a copy of your child's IEP

Is your child currently eligible for Section 504? YES NO
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
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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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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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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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 <u>special education</u> 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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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 **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			

Social History/Devel. Assessment (Use additional sheets for more information).		**Anticipatory Guidance** Nutritional/Diet _____ SkinCare/Hygiene _____ Oral/Dental _____ Behavioral Devel. _____ Safety _____ School Status _____ Health/Reproduction _____ High Risk Activities _____
Cognitive Devel.		
Speech/Lang. Devel.		
Social/Emot. Devel.		
Health Beh./Habits (Drugs/ETOH/Tobacco)		
Comments:		
Medical Provider's Name (print) _____ Phone #: (_____) _____ **Signature of Medical Provider:_____** **Date:_____**		**Physician Stamp required:**

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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.):**____/____/____