Alpine Public School

500 Hillside Ave
Alpine, NJ 07620
(201) 768-8255, Fax: (201) 768-7855

Registration Packet

Only a parent or *guardian may register a student for the Alpine Public School

Children must be 5 years of age on or before October 15th to enter kindergarten and 6 years of age by October 15th to enter first grade from a private school.

Please call for an appointment

Registration information: Mrs. Nancy Smith (201) 768-8255 Ext. 1110

Registration Location: Alpine School-Main Office
500 Hillside Ave, Alpine, NJ 07620

*Guardian - An adult who has assumed financial and legal responsibility for a minor child. The Guardian must provide notarized guardianship papers.

Alpine School District
Office of the Principal
www.alpineschool.org

500 Hillside Avenue
Alpine, New Jersey 07620

Phone (201)768-8255 ext 1110
Fax (201) 768-7855

NEW STUDENT CHECKLIST

______1. **Proof of Residency Requirements: Must submit all, main office will make copies:**

a) Current deed/lease
b) Parent driver's license
c) Utility bill or bank statement
(If living with a family must have notarized letter from legal Alpine resident attesting that the family is related to the resident and is living rent-free with the legal resident, plus acceptable current lease or deed for the resident.)

______2. **Kindergarten:** Proof of child's immunization against measles, German measles, polio, mumps, tuberculosis (tuberculin test) and hepatitis B.
Transfer: Original A45 from current school.

______3. School medical form including proof of a complete physical examination including tests of vision and hearing.

______4. Copy of child's birth certificate.

______5. Enrollment Card filled out completely, including any cell numbers.

______6. Custody papers if applicable.

______7. Within four weeks, return dental exam form.

______8. Currently has an IEP. ______NO ______YES

______9. Currently has ESL Program. ______NO ______YES

Alpine Public School
Registration Form

Today's Date: ___/___/___ Entry Date: ___/___/_____

Student Information

Last Name____________________ First Name: __________________ Middle Initial: ____

Home Address: ____PO Box__________

Former Place of Residence _______________If renting, date lease expires: ____/____/______

Home Phone: (__) ____________________Email address ___________________________

Birth City/State: ______________________________D.O.B _____________________

If outside U.S. – City and Country of Birth _______________ Date of Entry to U.S.__________

Date of Entry to School (other than Alpine School)_____________________________________

Name & Address of Prior School____

Grade Last Attended __________ Citizenship: _________________________

Ethnicity:
___White ___African-American ___Hispanic ___ American Indian
___Asian ___ Hawaiian Native/Other Pacific Islander ___Other

Student's Primary Language (first or native language spoken):___________________________

Home Language (language spoken most frequently at home):_____________________________

Father Full Name ____
Place of Birth ____
Occupation ____
Bus. Address ____
Bus Phone __________________________ Cell __________________________________

Mother Full Name
Place of Birth____
Occupation ____
Bus. Address____
Bus Phone __________________________ Cell __________________________________

Phone # at which a parent can <u>always</u> be reached during school hours _______________

Emergency/Evacuation
List two relatives/neighbors who will assure temporary care of your child(ren) in the event you cannot be reached, child's illness or emergency.

1. Name __________________________________Address___________________________
Telephone________________________________Relalationship______________________

2. Name __________________________________Address___________________________
Telephone________________________________Relalationship______________________

HEALTH INFORMATION

Date_______________________________

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact the physician, the school may take whatever arrangements that is necessary.

Parent/Guardian ____

Health Care Provider Information

Contact	Contact Name	Contact Phone number
Hospital		
Doctor		
Dentist		

Does your child have health care coverage? ___Yes ___No

If yes, name of provider:____

Please sign here to indicate that we have your permission to call the above contacts when you are not available or in an emergency.

_________________________________ _________________________________

Signature Date

I give the school nurse permission to release and exchange pertinent medical information to all appropriate school staff members.

___ I do consent

___ I do not consent

_____________________________ ___________________________

Signature Date

NJ Family Care 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.

___ Yes, you may release my name and address to NJ Family Care program to contact me about health insurance.

___No, do not release my name and address to NJ FamilyCare to contact me about health insurance.

_________________________________ _________________________________

Signature Date

Allergies ___________________________ Medications Taken: __________________

Other Conditions ____

Alpine Public School

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Alpine, NJ 07620
(201) 768-8255, Fax: (201) 768-7855

Certificate of Residency

This form must be notarized by a Alpine Board of Education employee at the time of registration.

This registration Form is submitted for the purpose of inducing the Alpine Board of Education to accept my/our child/children as a student in the Alpine Public School on a tuition-free basis. I/We state that the information contained in this Form is true and accurate and acknowledge the Alpine Board of Education's reliance upon the truthfulness and accuracy of this information. If any of the statements contained in this Registration Form are willfully false, I/We are aware that I/We are subject to criminal penalties provided by law for perjury and/or false swearing, and I/We will be personally liable for the payment of tuition for the child retroactive for the period of ineligible attendance of said child/children in the Alpine Public School as well as any related costs and/or fees, including attorneys fees, incurred as a result of such ineligible attendance.

I, ____, parent guardian of
(Name of Parent/Guardian – please print clearly)

Full Name of Child*	Current Age	Grade Entering in Alpine School	Name of School

____
(Alpine Street Address – please print clearly)

Signature of Applicant(s): ____

Date: ____

Signature of Applicant(s): ____

Date: ____

SWORN AND SUBSCRIBED BEFORE ME THIS __________ DAY OF ________________________

____
NAME OF OFFICAL ADMINISTERING OATH

____
TITLE OF OFFICAL

*A Certificate of Residency form must be completed for each child in the district.

Alpine Public School

Medical History

Child's Name________________________ Nickname__________________________________

Address_____________________________ Home phone_______________________________

Date of Birth ________________________ Male_____ Female______

Mother's Name____________________________ Cell phone____________________________

Father's Name ____________________________ Cell Phone___________________________

Pediatrician ______________________________ Phone________________________________

Address____

Nursery School (Name and Address)____

Dates Attended_______________ Length of Sessions__________________________________

Siblings:

Name________________________________ Age____________

Name________________________________ Age____________

Name________________________________ Age____________

FAMILY MEDICAL HISTORY

Please indicate family member:

Seizure disorder__________________ Diabetes____________________________________

Scoliosis_________________________ Cardiac/Hypertension_________________________

Other____

CHILD'S BIRTH HISTORY

Hospital/Facility___________________________ Address_____________________________

Child's birth weight____

Birth Defects (if any) ____

Other noteworthy information____

____

Motor Development — Approximate Age

Crawls ______________

Walks ______________

Speech ______________

Illness or Injury Hospitalization – Reason and dates)

____

Accidents (broken bones, sprains, sutures, ect.)

____

Known Allergies

Foods (List) ____

Medication required ____

Explain ____

Asthma ____

Medication required ____

Explain ____

Bee Sting ____

Medication Required ____

Explain ____

HEALTH HISTORY

Has your child had any of the following? Please supply dates.

Bronchitis______________ Fever greater than 104 degrees

Strep Throat______________ Convulsions/Seizures

Sinus Infection______________

Eye Function

Glasses______________

Other______________

Ear Problems

Frequent Infections______________

Other______________

Is there any other medical information you would like to supply to enable us to better service your child's needs? ____

____

REPORT OF FAMILY DENTIST

Please sign this notice when treatment started. This is to certify that

____

Child's Name

Has had a dental examination and that necessary corrections will be made.

Remarks____

____

Signature of Dentist ____

Address ____

Date ____

ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date __________

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PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ______

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
[b]Consider GU exam if in private setting. Having third party present is recommended
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________
  - Reason ______________________________

Recommendations ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician, APN, PA ______________________________

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

____

____

____

____

____

EMERGENCY INFORMATION

Allergies ______________________________

____

____

____

____

____

Other information ______________________________

____

____

____

____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ______________________________
(Date)

Approved ______ Not Approved ______

Signature: ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ______________________________ Date __________

Address ______________________________ Phone __________

Signature of physician, APN, PA ______________________________

Completed Cardiac Assessment Professional Development Module

Date ______________ Signature ______________________________

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

K-8

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M I)	Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Fem

PARENT OR GUARDIAN	NAME	TELEPHONE NO
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted: ______ ☐ Medical exemption attached ☐ Religious exemption attached