# 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<br>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 _____

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## 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** _____

*APPENDIX H*

# UNIVERSAL CHILD HEALTH RECORD

*Endorsed by:* *American Academy of Pediatrics, New Jersey Chapter*
*New Jersey Academy of Family Physicians*
*New Jersey Department of Health*

## SECTION I - TO BE COMPLETED BY PARENT(S)

| Child's Name *(Last)* | *(First)* | Gender ☐ Male ☐ Female | Date of Birth / / |
|---|---|---|---|

| Does Child Have Health Insurance? ☐Yes ☐No | If Yes, Name of Child's Health Insurance Carrier |
|---|---|

| Parent/Guardian Name | Home Telephone Number ( ) - | Work Telephone/Cell Phone Number ( ) - |
|---|---|---|
| Parent/Guardian Name | Home Telephone Number ( ) - | Work Telephone/Cell Phone Number ( ) - |

***I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.***

| Signature/Date | This form may be released to WIC. ☐Yes ☐No |
|---|---|

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

| Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No |
|---|---|

| Abnormalities Noted: | Weight *(must be taken within 30 days for WIC)* | |
|---|---|---|
| | Height *(must be taken within 30 days for WIC)* | |
| | Head Circumference *(if <2 Years)* | |
| | Blood Pressure *(if ≥3 Years)* | |

| **IMMUNIZATIONS** | ☐ Immunization Record Attached<br>☐ Date Next Immunization Due: _____ |
|---|---|

## MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ Special Care Plan Attached | Comments |

## PREVENTIVE HEALTH SCREENINGS

| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note if Abnormal |
|---|---|---|---|---|---|
| Hgb/Hct | | | Hearing | | |
| Lead: ☐ Capillary ☐ Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

| Name of Health Care Provider (Print) | Health Care Provider Stamp |
|---|---|
| Signature/Date | |



Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

K-8

# STATE OF NEW JERSEY
# HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

| Name of Child (Last, First, MI) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female |
|---|---|---|
| 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