Edgewater School District
Building a Better World, One Student at a Time

Edgewater School District
251 Undercliff Avenue Edgewater, NJ 07020
201-945-4106

Siobhan Tauchert
Superintendent of Schools
stauchert@edgewaterschools.org

7-12 GRADE REGISTRATION
For Edgewater Residents Only
At the George Washington School Main Office
801 Undercliff Ave, Edgewater

Please be advised you must bring the following information in order to register your child for Kindergarten in the Edgewater School District for the 2022-2023 school year. Only a parent or legal guardian may enroll the child. Your child does not need to be present for registration.

1) Proof of child's date of birth
    a) Original birth certificate ***or***
    b) Passport (**if born outside the US**)
2) Proof of Edgewater residency:
    a) If homeowner: mortgage statement, property tax bill, or a copy of your deed
    b) If renting: your current lease, signed and dated AND a notarized landlord affidavit
3) One utility bill, e.g., PSE&G, water bill, cable/phone dated within the last 60 days
4) Registration forms
5) Health Records
    a) Current immunization records (up-to-date immunization records must be submitted before a child can attend school)
    b) Physical examination completed by a physician
    c) Medical authorization form (if your child is required to take prescription or non-prescription medication during school hours)
6) Home Language Survey
7) If applicable
    a) IEP and/or Evaluations
    b) Review income eligibility guidelines
    c) Free and Reduced Price School Meals Household Application (available on the website)

Leonia Board of Education
Residency Check List

☐ **Deed**
Or
☐ **Lease**

☐ **Birth Certificate**
Or
☐ **Passport**

☐ **Utility Bill**

☐ **Immunization Records/Physical (within 1 year)**

☐ **Transfer Card**

☐ **Special Needs**

☐ **Guardianship Case**

☐ **Custody Issues**

☐ **Home Language Survey - https://tinyurl.com/LeoniaHLS**

ACS (Pre K-5)_____**LMS (6-8)** _____ **LHS (9-12)** _____

COMMENTS:_____

_____

Residency Officer – Best Time_____

LEONIA PUBLIC SCHOOLS

570 GRAND AVENUE
LEONIA, NJ 07605
(201) 302-5200
Fax (201) 947-4782

Name of Guardian____

Address: ____

Home Telephone # : ____

Business Telephone # : ____

Cell Phone #: ____

- A **lease**, effective during the current school year, showing residence within the Borough of Leonia;

  OR

- A **recorded deed** showing ownership of residence within the Borough of Leonia.

  AND

- A **current utility bill**

  AND

- **Student Birth Certificate or Passport**

  AND

- **Transfer Card and Documentation** from prior schools including **Immunization records.**

>>>

- If you do not have a lease or deed **in your name**, **OR** you **do not have** an updated lease, you must provide a **current signed Landlord Affidavit form or Resident Affidavit/Lessee form (available on our website or in the Board of Education Office.)**

- A **current signed affidavit form** stating that the student(s) listed above reside(s) with you and is/are financially dependent upon you even though you are not his/her/their parent or legal guardian. **[Documentation of financial dependency must be attached]**

I, ______________________________, affirm that I am the natural parent/legal guardian of the student(s) listed above. I further state that this form and the attached documentation constitute true and accurate proof that the student(s) listed above reside with me within the Borough of Leonia. If any student listed above stops living with me, or if I move my residence out the Borough of Leonia, I will notify the Leonia Board of Education in writing within thirty (30) days.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to penalties as per N.J.A.C.6A:22-4.2.

Signed: ______________________________

Dated: ______________________________

LEONIA PUBLIC SCHOOLS

Leonia, New Jersey

SCHOOL REGISTRATION

School _____ Grade _____ Entry Date _____ Student ID# _____

STUDENT INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

Nickname:_____Student Email (Grade 6-12): _____Gender: M ____F____X_____

*Student Cellphone Grade 9-12_____

Home Address_____

If Renting, Date Lease Expires_____ Home Telephone: (___) _____

***Ethnicity** (must check one): Hispanic _____ Non-Hispanic _____

***Race** (must check at least one, or all that apply): White ____ Black/African American ____

Asian ____ Native American/Pacific Islander ____ American Indian/Alaskan Native ____

Date of Birth: _____ City, State and Country of Birth: _____

*US Entry Date: _____ *US School Entry Date: _____

1st Language Spoken: _____ Primary Language Spoken at Home: _____

Proficient in English: Yes ____ No ____ All Languages Spoken: _____

Names, Dates and Grades of Previous Schools of Attendance

School & Address	Grades Attended	First Date of Enrollment	Last Date of Enrollment	Public or Private

*Receiving free/reduced lunch in previous district: _____Yes _____No

FAMILY INFORMATION FOR THE HOME WHERE THE CHILD LIVES

Guardian # 1 – Home Where the Child Lives

Relationship to Student: Mother ____ Father ____ Guardian* ____ Affidavit ____ Other _____

Last Name: _____ First Name: _____

Title: Mr.____Mrs.____Ms.____Dr.____ Email Address: _____

Cell Phone: (___)_____Business Phone:(___)_____Occupation:_____

Employer Name/Address: _____

Guardian # 2- Home where the Child Lives

Relationship to Student: Mother ____ Father ____ Guardian* ____ Affidavit ____Other_____

Last Name: _____ First Name: _____

Title: Mr.____ Mrs. ____Ms. ____ Dr. ____ Email Address: _____

Cell Phone: (___)_____Business Phone: (___)_____Occupation:_____

Employer Name/Address: _____

Guardian # 3 – Non Custodian Parent **No Contact Allowed ___Receives Extra Mailing ___**

Relationship to Student: Mother____Father____Guardian*____Affidavit____Other_____

Last Name:_____ First Name:_____

Home Address (Street)_____(City, State, Zip)_____

Title: Mr. ____Mrs. ____Ms. ____Dr.____ Email Address_____

Home Phone: (___)_____Cell Phone(___)_____Business Phone:(___)_____

Employer/Address:_____Occupation:_____

*If checked, guardianship papers must be produced for examination

 # 4 – Student Resides at More than One Address: _____ Receives Extra Mailing: _____

Relationship to Student: Mother____Father____Guardian*____Affidavit____Other_____

Last Name:_____ First Name_____

Home Address (Street)_____(City, State, Zip)_____

*If checked, guardianship papers must be produced for examination

Title: Mr.____Mrs.____Ms.____Dr.____ Email Address:_____

Home Phone (___)_____Cell Phone: (___)_____Business Phone:(___)_____

Employer/Address:_____Occupation: _____

SIBLING INFORMATION

Name	Birthdate	Grade	Gender	Relationship	School	Resides w/Student

*My child has Health Insurance: Yes____ No____
If yes, please provide name of Insurance Company:_____

I acknowledge that the above information is accurate and all provided documentation is valid and current.

Please sign and date:

Parent/Guardian Signature:_____Date:_____

*Should it be determined that my child(ren)'s primary domicile is not in Leonia or Edgewater, I agree to pay tuition for the time my child(ren) has (have) been educated in the Leonia Public Schools.

Parent/Guardian Signature:_____Date:_____

Edgewater Board of Education Registration Form

PLEASE PRINT

Directions to Parent/Guardian: The questions on this form must be completed at the time of enrollment. Some responses are optional to protect the privacy of student or family, however, the parent or 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 or guardian declines to respond to a question, leave the item blank.

STUDENT INFORMATION

Date of Enrollment _____ Gender of Child ☐ Male ☐ Female

First Name of Child _____ Last Name of Child _____

Middle Name of Child _____ Generation Code/Suffix (Jr., Sr., III) _____

Birth Date (MM-DD-YYYY) _____ Nickname _____

Authenticity of Birth (office use only) _____

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

Date of entry in U.S. _____ Date student started school in U.S. _____

Number of siblings: Older Sisters _____ Younger Sisters _____ Older Brothers _____ Younger Brothers _____

Race Check one or more boxes to indicate the race/ethnicity that you consider your child to be:

☐ American Indian or Alaska Native ☐ Black or African American ☐ White

☐ Asian ☐ Native Hawaiian or other Pacific Islander

Ethnicity of Child ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Native Language of Child. The language or dialect first learned by an individual or first used by the parent/guardian with the child. The term is often referred to as the first language spoken. A representative sample of languages in New Jersey is listed below. Select the box to indicate the native language of the child.

☐ Albanian	☐ Gujarati	☐ Polish
☐ Arabic	☐ Hebrew	☐ Russian
☐ Armenian (Hayeren)	☐ Hindi	☐ Sindhi
☐ Bengali (Bengabhasa, Bangala, Bangla)	☐ Italian	☐ Spanish
☐ Cantonese (Yue, Toishan, Taishan)	☐ Japanese	☐ Tagalog
☐ Dari (Afghan, Persian)	☐ Korean	☐ Telugu
☐ English	☐ Malayam	☐ Turkish
☐ Farsi	☐ Mandarin (Chin, Kuoyu, Pekingese, N. Chinese, Putongua)	☐ Urdu
☐ Greek	☐ Panjabi (Punjabi)	☐ Other (please specify):

NOTE: Please read the following definitions pertaining to resident status carefully before answering the questions.

Is the student eligible for migrant education services? A "migratory child" means a child who is, or whose parent or spouse is, a migratory agricultural worker, including a dairy worker or a migratory fisher, and who in the preceding 36 months, in order to obtain, or accompany such parent or spouse, in order to obtain temporary or seasonal employment in agricultural or fishing work -- has moved from one school district to another or resides in a school district of more than 15,000 square miles, and migrates a distance of 20 miles or more to a temporary residence to engage in a fishing activity.

☐ Yes ☐ No

Is the student homeless? A student shall be considered homeless if any of the following conditions apply:

1. Resides in a supervised publicly or privately operated shelter designed to provide temporary living accommodations.
2. Resides in an institution that provides a temporary residence of individuals intended to be institutionalized.
3. Resides in a public or private placed not designed for or ordinarily used as a regular sleeping accommodation for human beings.
4. Lives with a parent in a domestic violence shelter.
5. A runaway living in a shelter.
6. A school-aged mother residing in a home for adolescent mothers.
7. A sick or abandoned child residing in a hospital and would otherwise be released if he or she had a permanent residence.
8. The child of a homeless family, which is out of necessity living with relatives or friends.
9. The child of a migrant family, which lacks adequate housing.
10. Finally, a child or youth shall be considered homeless when a dispute occurs regarding the determination of homelessness, the involved districts shall immediately notify the county superintendent of schools (regional assistant commissioner), who shall decide the status of the child within 48 hours.

☐ Yes ☐ No

Is the student qualified to receive federal support as an immigrant? An immigrant is a student who is age 3 to 21 and was NOT born in the US, and has not been attending one or more schools in one or more states for more than three full academic years.

☐ Yes ☐ No

Is the student a dependent of a member of the **Active Duty Forces** (full-time) - Army, Navy, Air Force, Marine Corps, Coast Guard or National Guard?

☐ Yes ☐ No

FOR OFFICIAL USE ONLY

EFFECTIVE ENTRANCE DATE_____ TEACHER/GRADE_____

STUDENT ID _____ NJSMART ID _____

BUS ASSIGNMENT AND STOP_____ **ADMINISTRATOR'S APPROVAL:**_____

FAMILY INFORMATION

Please provide the legal residence and phone number of:

Student's Name: _____ Home tel. number _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

	PARENT 1		PARENT 2
Name		Name	
Gender		Gender	
Address		Address	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
Email Address		Email Address	

Marital status of parents (optional): ☐ Single ☐ Married Is there a court order on file? ☐ Yes ☐ No

Are there custody issues? ☐ Yes ☐ No If so, who has legal custody of the student? _____

STEP-MOTHER		STEP-FATHER		OTHER LEGAL GUARDIAN	
Name		Name		Name	
Address		Address		Address	
Work Phone		Work Phone		Work Phone	
Cell Phone		Cell Phone		Cell Phone	

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

1. EMERGENCY CONTACT: _____ Relationship to student: _____

Address: _____

Home telephone number: _____ Cell/ work number: _____

2. EMERGENCY CONTACT: _____ Relationship to student: _____

Address: _____

Home telephone number: _____ Cell /work number: _____

I certify that the information given above is true to the best of my knowledge and belief.

Date _____ Parent Signature _____

HEALTH INSURANCE INFORMATION

Does your child have Health Insurance?

YES _____ Name of insurance company: _____

NO _____

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents.
For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

YES _____ You may release my name and address to the NJ Family Care Program to contact me about health insurance.

NO _____ You may not release my name and address to the NJ Family Care Program to contact me about health

SIGNATURE OF PARENT/GUARDIAN : _____

PRINTED NAME: _____ DATE: _____

Written consent required pursuant to 20 U.S.C. § 1232g (0)(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child has received during the past year:

_____

Dental Exam (Date): _____ Braces: ☐ Yes ☐ No

Eye Exam (Date): _____ Contacts: ☐ Yes ☐ No Glasses: ☐ Yes ☐ No

Please list any medications taken, disease or condition which the student has e.g., allergies, diabetes, seizures, asthma, heart condition, orthopedic problems., etc. Please advise if there are any medical/other measures which are necessary to ensure the health and welfare of your child.,

_____

_____

Doctor: _____ Telephone number: _____

Dentist: _____ Telephone number: _____

Hospital: _____ Address: _____ Tel. number: _____

I, the undersigned, do hereby authorize officials of the Edgewater School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.
In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby Authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

SIGNATURE OF PARENT/GUARDIAN: _____

PRINTED NAME: _____ DATE: _____

Educational Information

What is the name and location of the institution which provided care, education, and/or services to the student prior to this enrollment?

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Please list other previously attended schools: (start with Kindergarten)

Name of School	Location	Grade	Year Attended

What was the last grade completed by the student?

☐	Preschool	☐	First Grade	☐	Third Grade	☐	Fifth Grade
☐	Kindergarten	☐	Second Grade	☐	Fourth Grade	☐	Sixth Grade

Is (was) your child a classified student eligible to receive special education and related services?

☐ YES ☐ NO

If yes, does your child have (or had) an Individual Education Plan (IEP)?

☐ YES ☐ NO

If yes, have you submitted a copy of the IEP to our school?

☐ YES ☐ NO

Date of Receipt: _____ Signature confirmation of receipt by district personnel: _____

Check all services your child received(s):

SERVICE	DATE OF SERVICE	LOCATION OF SERVICE
Early Intervention ☐ Yes ☐ No	_____	_____
Pre-School Disabled ☐ Yes ☐ No	_____	_____
Speech/Language ☐ Yes ☐ No	_____	_____
ELL/ESL/Bilingual ☐ Yes ☐ No	_____	_____
Extra help in the form of Remedial/Basic Skills/Supplemental ☐ Yes ☐ No	_____	_____

If Yes, which area(s) ☐ Language Arts ☐ Math ☐ Other: _____

****

Parent/Guardian Permission to Release and Exchange Confidential Information

I hereby authorize an exchange of all school related information between the Edgewater Child Study Team, Student Health Services, Administration and previous school district as needed.

Student's Name: _____ Date of Birth: _____

Telephone Number: _____ Previous School: _____

Address: _____

_____ _____

Parent/Guardian Signature Date

For Official Use Only

EFFECTIVE ENTRANCE DATE _____ TEACHER/GRADE _____

STUDENT ID _____ NJSMART ID _____

BUS ASSIGNMENT AND STOP _____ ADMINISTRATOR'S APPROVAL: _____

CC: CST ____ ELL ____ Speech ____ Remedial ____ Test Coordinator ___

NURSE ____

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 _____

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 _____

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

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 _____

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 _____

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 _____

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

EDGEWATER SCHOOL DISTRICT
251 UNDERCLIFF AVENUE
EDGEWATER, NJ 07020

LANDLORD AFFIDAVIT

Full Name of Landlord:
(print clearly)

Name of Tenant(s):
(print clearly)

Address of Tenant(s):
(print clearly)

Names of Child/Children residing with Tenant
(print clearly)

I, the owner of the property listed above, hereby affirm that the parent(s)/guardian(s) of the child/children listed above, do reside at the above address in the Town of Edgewater. This is a _____ month to month, _____ yearly rental (check one).

I understand that if the residency information that I am providing is found to be false, I will be responsible – along with the person(s) named as the tenant(s) – for all the tuition costs and fees paid by the Edgewater Board of Education, in addition to any legal fees that may be incurred.

Further, I understand that any person – including landlords – who fraudulently allow a child of another person to use his or her residence or address and is not the primary financial supporter of that child, and/or any person who fraudulently claims to have given up custody of his or her child to a person in Edgewater commits a CRIMINAL OFFENSE which is punishable under the law.

LANDLORD'S SIGNATURE MUST BE NOTARIZED BY A NOTARY PUBLIC

Landlord's Signature: _____

Sworn & Subscribed to me on this day of: _____

Signature of Notary Public: _____

Edgewater Schools
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 schools 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)? _____