EDGEWATER SCHOOL DISTRICT

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251 Undercliff Avenue
Edgewater, New Jersey 07020
(201) 945-4106

GRADES 1 - 6

Please be advised you must bring the following information in order to register your child in the Edgewater School District. 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:
   Original birth certificate ***or***
   A passport is acceptable if born outside the United States
2. Proof of Edgewater residency:
   If homeowner: mortgage statement, property tax bill, or a copy of your deed
   If renting: your original current lease, signed and dated **AND** notarized landlord affidavit
3. One utility bill, e.g., PSE&G, water bill, cable/phone bill
4. Registration form
5. Health records:
   a. Current immunization record (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)

Edgewater Board of Education Registration Form (Grades One through Six)

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 place 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

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 _____

EDGEWATER SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM (Page 1 of 2)
TO BE COMPLETED AND SIGNED BY A PHYSICIAN

_____ _____
Student's Name (Last, First, M.I.) Date of Examination

_____/_____/_____ ☐ Male ☐ Female _____
Date of birth Grade/Teacher

Height: _____ Weight: _____ BP: _____ Pulse, resting _____

Vision: R 20/_____ L 20/_____ (without correction) Hearing: Right ear _____

R 20/_____ L 20/_____ (with correction) Left ear _____

	NORMAL	ABNORMAL	DESCRIPTION
Appearance, Nutrition			
Head, Neck (masses, ROM)			
Eyes (conjunctiva)			
Ears (infection, perforation, tubes)			
Nose (obstruction), Throat			
Mouth, Teeth			
Lymph nodes			
Chest and Lungs			
Cardiac (murmurs, clicks)			
Abdomen (scars, liver, spleen, masses)			
Back, Spine (deformity, ROM, scoliosis)			
Extremities (muscle weakness, injuries)			
Testes (presence, descent)			
Genitalia (hernia)			
Level of Maturation			
Neurological (reflexes, balance)			

GENERAL CONDITION: _____

MAY _____ MAY NOT _____ participate in all physical activities.

OTHER MEDICAL CONDITIONS OR RESTRICTIONS: _____

_____

EDGEWATER SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM (page 2 of 2)
TO BE COMPLETED AND SIGNED BY A PHYSICIAN

_____ ____/____/____

Student's Name (Last, First, M.I.) Date of birth

IMMUNIZATIONS

VACCINE TYPE	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diptheria, Pertussis, Tetanus, DPT, Tdap (if DT or TD please indicate)					
Polio Vaccine (indicate OPV or IPV)					
Measles, Mumps, Rubella (MMR)					
H Influenzae, Type, HIB					
Hepatitis B					
Varicella					
Pneumococcal					
Influenza					
Meningococcal					

Mantoux Test Date: _____ Mantoux Test Results: _____

HEALTH HISTORY-DATES

Asthma _____ Measles _____ Mumps _____ Chicken Pox _____ German Measles _____

Convulsions _____ Rheumatic Fever _____ Diabetes _____ Epilepsy _____

Tuberculosis _____ Fractures _____ Operations _____ Emotional Problems _____

Allergies (food and drug) _____

Lead Levels _____ Results _____

_____ _____

Print Physician's Name Physician's Signature

_____

Print Physician's Address

_____ _____

Physician's Telephone Number Physician's Fax Number

EDGEWATER SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM
NON-PRESCRIPTION and PRESCRIPTION DRUGS

Dear Parent/Guardian,

In accordance with school policy and state mandates, if your child **needs to take any prescription or over the counter medications during school,** the following procedure must be followed before the school nurse will administer medication to your child. **The four necessary requirements are:**

A. Provide **written physician statement** identifying the type, dosage and purpose of the medication.
B. Provide **written parent/guardian permission** for nurse to give the medication prescribed by physician.
C. Provide medication in **original labeled pharmacy container** (pharmacies will provide an extra labeled container) with the child's name, date, name of medication, dosage schedule and physician's name. Nonprescription drugs are to be in original container.
D. **Parent/guardian (not the child) must bring in all medication to the school nurse.**

PHYSICIAN AUTHORIZATION

I request that the Edgewater School District's School Nurse administer the following medication as prescribed to:

_____ Grade: _____
(Print name of pupil)

MEDICATION: Please print below:	DOSAGE	HOURS OF ADMINISTRATION	DATE TO START	DATE TO DISCONTINUE

Diagnosis/reason medication is being administered: _____

Special instructions: _____

Possible side effects: _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME & ADDRESS STAMP: _____

DR'S FAX: _____ **DR'S PHONE:** _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the Edgewater School Nurse administer the above medication as prescribed.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email address: _____

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 SCHOOL DISTRICT

251 UNDERCLIFF AVENUE
EDGEWATER, NJ 07020
www.edgewaterschools.org

Phone (201) 945-4106
FAX (201) 945-4104

Request of Records

STUDENT INFORMATION

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____ Circle: Female / Male

PREVIOUS SCHOOL

Name of School _____ Circle: Public / Private

Address _____ City _____ State _____ Zip _____

Phone _____ FAX _____

Last Day Student Attended _____

I, _____, hereby give permission for release of the following records and for the school district to contact my child's former district for further information.

_____ _____

Signature of Parent/Guardian Date

OFFICIAL RECORDS TO BE RELEASED

Grades/Transcript - District/State Assessments - Health Records - Records/Reports completed by professional persons, agencies, Child Study, etc. - Disciplinary Records

NJ State ID: _____ Is the student in an ESL/Bilingual Program? Yes / No

Does the student have an IEP? Yes / No

Please send the school records to: George Washington School Attn: Records
801 Undercliff Ave., Edgewater, NJ 07020
Phone: 201-886-3480 ext. 1200
FAX: 201-224-0735

Requested By: _____ Received By: _____

Date Requested: _____ Date Received: _____

Parental permission is not required when the following mandated records are requested by authorized school personnel: transcript of grades, health records, attendance records, child study team records, and disciplinary records pursuant to N.J.A.C. 6:3-6:5.