Oaklyn Public School District

136 Kendall Boulevard
Oaklyn, New Jersey 08107
www.oaklynschool.org

SCOTT A. OSWALD, Ed.D.
Superintendent of Schools
856.962.5700 x1002

Ms. Jennifer Boulden
Principal
856.858.0335 x7226

Mrs. Beth Ann Coleman, RSBA
Business Administrator
856.962.5700 x1004

Proof of Domicile

Student Name: _____ **Gr:** _____

Dear Parent/Guardian:

The Oaklyn Board of Education has policies and procedures related to "Proof of Domicile" for students who attend our schools. The District shall only provide a free education to those students who are domiciled within the District or who otherwise qualify for a free education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 et seq. and N.J.A.C. 6A:22-1.1 et seq. A student shall be domiciled in the District "when he or she is living with a parent or legal guardian whose permanent home is located within the District." N.J.A.C. 6A:22-3.1 The home is permanent if "the parent or guardian intends to return to it when absent and has no present intent of moving from it…" Id. If the District discovers that a student is attending school whose parents are not domiciled within the District and who is not otherwise eligible for a free education, the District may apply for the student's removal and seek tuition reimbursement for the period of ineligible attendance in accordance with the provisions of the N.J.S.A. 18A:38-1(b)(2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense. N.J.S.A. 18A:31-1(c). If the applicant is convicted of such an offense, the applicant may be fined up to $1,000.00 and/or be imprisoned for up to 6 months.

Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C:43-3. If convicted for such a crime, the applicant may be punished by a fine of $10,000.00 and/or be imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understood the contents of this notification.

Printed Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

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Home Language Survey

Student's Name: _____ Date of Birth: _____ Gr: _____

Parent/Guardian Name: _____ Phone #: _____

As required by state and federal law (State Bilingual Education Act of 1974, Federal Lau vs. Nicholas Supreme Court ruling of 1974), all parents must be surveyed as to the home language of their public school children. The child's parent/guardian must complete the form.

This data is used to determine need for language support services. The district offers students English as a Second Language where appropriate and/or if desired by parents.

1. What language did your child learn when he/she first began to speak? _____
2. What language do you use most often when speaking to your child at home? _____
3. What language does your child use most often when speaking to you? _____
4. What language does your child use most when speaking to brothers and sisters? _____
5. What language does your child use most often when speaking to other relatives? _____
6. What language does your child use most often when speaking to friends at home? _____

Was your child born in the United States? (Please circle)

Yes No

If born outside of the United States, please list the Country of Birth and date entered into USA:

_____ _____
Country of Birth Date entered into USA

_____ _____
Parent/Guardian Signature Date

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Parent Authorization for Release of School Records

Name of school previously attended: _____

School Address: _____

_____

School Phone Number: _____ School Fax Number: _____

Student Name	Date of Birth	Grade

In accordance with the New Jersey Administrative Code Inspection of School Records, the above-named school is hereby authorized to release to the school named below all school records, including NJ State ID #, grades, health, medical, psychological, social, educational, developmental and discipline records.

Request for Transcript of School Records

Please send all academic school records to the school below:

Oaklyn Public School
136 Kendall Blvd.
Oaklyn, NJ 08107

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

GENESIS
Student Information System

GENESIS PARENT PORTAL

Our new Genesis Parent Portal is now open for all parents. Please complete this form and return it with our registration packet.

Thank you.

Please Print Clearly

Parent/Guardian Information
Parent/Guardian Name: _____ Relationship to student: _____ Telephone #: _____ Email: _____ I certify that I am the legal guardian of the student(s) listed below and wish to gain access to the Genesis Parent Portal. Parent/Guardian Signature: _____ Date: _____
Student(s) Information
Student Name: _____ Grade: _____ Date of Birth: _____
Student Name: _____ Grade: _____ Date of Birth: _____
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CONFIDENTIAL HEALTH HISTORY
Elementary

Student Name: _____ Gr. _____ D.O.B. _____ Gender: _____

Parent/Guardian Name: _____ Address: _____

Phone Number: _____ Email: _____

Child's Physician: _____ Phone Number: _____

Preferred Hospital: _____

My child is covered by medical insurance provided by:
___ Employer ___ Self ___ NJ Family Care ___not covered
(If not covered, please contact your school nurse for information on NJ Family Care)

I. **Pregnancy & Birth** (check one)

1. Did mother have any illness during pregnancy with this child? ___ Yes ___ No
   If yes, explain: _____
2. Did mother deliver within a week of the date? ___ Yes ___ No
   If not, explain: _____
3. Did mother have any difficulty during deliver? ___ Yes ___ No
   If yes, explain: _____
4. Did the child have any difficulty during or after delivery? ___ Yes ___ No
   If yes, explain: _____
5. Did the baby have any trouble staring to breath? ___ Yes ___ No
6. Did the baby have any trouble in the hospital? ___ Yes ___ No
   If yes, explain: _____
7. Did the baby have any feeding problems? ___ Yes ___ No
   If yes, explain: _____
8. What did the baby weigh at birth? ___ Lbs. ___ Oz.

II. **Family/Social**

1. Are both parents in good health? ___ Yes ___ No
2. Are there any members with serious health problems that we should be aware of? If so, please explain _____ ___ Yes ___ No

_____

III. **Medication**

Is the student on any type of medication at this time? ___ Yes ___ No
If yes, please list medicine, dosage and reason for administration of same: _____

_____

IV. **Infections/Illnesses, and Other Problems**

Had your child:

1. Had more than six (6) colds or throat infections each year? ___ Yes ___ No
2. Had more than three (3) ear infections? ___ Yes ___ No
3. Had trouble hearing? ___ Yes ___ No
4. Had his/her hearing tested? ___ Yes ___ No
5. Had any trouble seeing? ___ Yes ___ No
6. Had his/her eyes tested? ___ Yes ___ No
7. Had any trouble with his/her teeth? ___ Yes ___ No
   Date of last dental visit? _____
8. Had any trouble passing his/her urine? ___ Yes ___ No

CONFIDENTIAL HEALTH HISTORY CONTINUED

Student Name: _____

9. Check any of the following that your child has had:

___ Strep Infection	___ Rheumatic Fever	___ Speech Impediment
___ 10-Day Measles	___ Headaches	___ Bedwetting
___ 3-Day Measles	___ Blackouts	___ Poor Concentration
___ Mumps	___ Epilepsy	___ Concussion
___ Scarlatina	___ Convulsions	___ Over-activity
___ Pneumonia	___ Vision Problems	___ Temper Tantrums
___ Whooping Cough	___ Un-coordination	___ Aggressiveness
___ Chicken Pox	___ Hearing Loss	___ Brain Trauma

10. Has your child had any other diseases or problems? ___ Yes ___ No
    If yes, please list them: _____
    _____
11. Has your child had to stay in the hospital overnight? ___ Yes ___ No
    Age: _____ Hospital: _____
    Reason: _____
12. Has your child had any operations or serious accidents? ___ Yes ___ No
    If yes, explain: _____
    _____

V. Allergies/Asthma (check if applicable)

___ Wheezing	___ Reaction to Penicillin	___ Hives
___ Eczema	___ Reaction to medication	___ Hay Fever
___ Asthma	___ Reaction to insect bites	

Additional information on any of the above: _____
_____

VI. Nutrition

Food allergies: _____
Food likes: _____ Food dislikes: _____
Appetite: ___ Good ___ Fair ___ Poor
Unusual weight gain or weight loss: _____

VII. Summary

Is there anything in regard to your child's health and/or behavior you would like to comment upon?
_____
_____

I hereby give permission for my child to receive the following medical attention as part of the school health program in the Collingswood Public Schools. (Please initial "yes" or "no" for all items listed.)

1. Treatment by the school nurse or designee in case of illness or injuries. ____ Yes ____ No
2. Annual vision and hearing screening. ____ Yes ____ No
3. Scoliosis screening by the school nurse for students ages 10-18. ____ Yes ____ No

May we share this information with the necessary school staff? ___ Yes ___ No
Yes, all but: _____

Parent/Guardian Signature: _____

Date: _____

UNIVERSAL CHILD HEALTH RECORD

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

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 ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

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

OAKLYN PUBLIC SCHOOL

DENTAL EXAMINATION FORM
(To be completed by family dentist)

Name of Child: _____

Address: _____
_____
_____

Date of Dental Checkup: _____

Name of Dentist: _____
(Please Print)

Address: _____
_____
_____

Signature of Dentist: _____