North Brunswick Twp. Public Schools Registration

North Brunswick Twp. Public Schools
308 Old Georges Road
North Brunswick, NJ 08902
Phone 732-289-3040

STUDENTS ARE ELIGIBLE TO REGISTER FOR NORTH BRUNSWICK TOWNSHIP SCHOOLS IF THEY LIVE WITH A PARENT OR GUARDIAN WHO IS A LEGAL RESIDENT OF THE DISTRICT OR WITH ANOTHER LEGAL RESIDENT WHO PROVIDES FULL FINANCIAL SUPPORT OF THE STUDENT

Registration Checklist

REGISTRATIONS ARE BY APPOINTMENT ONLY

Please complete the online pre-registration process available on our website at www.nbtschools.org *BEFORE* scheduling an appointment. Call 732-289-3040 to schedule your appointment.

☐ **Completed Registration Forms:** May be obtained on our website or picked up at the Board of Education and completed before your scheduled appointment

☐ **Proof of Residency - Must present EACH of the following:**

- **Homeowners:** deed, current property tax, current mortgage statement
- **Renters:** current lease
- **Additional documentation (at least two (2) items) which include the parent's name and reflect the North Brunswick address such as:** Utility bill, cable bill, passport, current medical bills, bank statement, voter registration card, state agency documents, etc.
  - **All bills/statements must be dated within 30 days of registration date**
- **Affidavit of Residency Forms (if applicable)** These forms are for parents who do not rent or own property in North Brunswick but are residing in the home of a North Brunswick resident.
  For appointment or questions concerning Residence Requirements call (732) 289-3000, ext 53067

☐ **Original Birth Certificate of your child(ren) (translated to English if in another language)**

☐ **Proof of custody (if applicable) - Legal document for divorce, separation, single parent or guardianship**

☐ **Complete Immunization Record, translated to English on your physician's letterhead if in another language.**

☐ **Physical Exam completed within 365 days of the first day of school. The Universal Health Record must be completed in full and signed by the physician and parent.**

☐ **Student Health Assessment**

The student cannot be admitted without health records

☐ **Previous School Records if applicable:**

- **For all students:** copy of transfer card, report card, test scores and previous school phone number, mail and email addresses
- **For High School students:** an unofficial transcript
- **For Special Education students:** a current IEP

Pupil's Name _____ _____

Last First Middle Grade (as of September)

Student ID #: _____ *School:* _____ *Family Code:* _____

North Brunswick Township Public Schools Registration Form

Child's Name: _____
Last First Middle

Child's North Brunswick Address:

Address: _____ City/State/Zip: _____

Rent: _____ *Exp. Date* _____ Own: _____ Lot # _____ Block # _____ Housing Type: _____ Affidavit: Yes ☐ No ☐

Previous Address: _____ City/State/Zip: _____

If applicable, what was the last grade completed by your child? _____

Previous School Attended: _____ Previous Grade: _____ Phone Number: _____

Address: _____ City/State/School: _____

PARENT / FAMILY INFORMATION SECTION

Parent Status: Married ☐ Divorced ☐ Separate ☐ Single ☐ Remarried ☐ Custody/Child Lives with: _____

CUSTODIAL RIGHTS: Name _____ Relationship: _____ has *LEGAL CUSTODY* of the child.

Legal documents must be on file at the school the child is attending. The other parent/guardian ☐ *May* ☐ *May Not* speak with the child and/or sign the child out of school. Identification is required for parent/guardian.

Children in family (including pupil) in order of age, oldest first...

	Name	Gender M/F	Birth date	School Name, City, State	Grade
1.		○ ○			
2.		○ ○			
3.		○ ○			
4.		○ ○			

Does your child have an IEP? Yes ☐ No ☐ If yes, did you provide a copy of the IEP? Yes ☐ No ☐ Is your child homeless? Yes ☐ No ☐

Are there any educational problems that your child has which you feel the school should be aware of? Yes ☐ No ☐ If yes, please specify. _____

Does your child qualify to receive federal support as an immigrant? Yes ☐ No ☐ Is your child an immigrant? Yes ☐ No ☐

An immigrant is a student who is age 3 to 21 and was NOT born in the U.S. and has not been attending one or more schools in any one or more states for more than three full academic years.

US Entry Date: _____ First Entry Date into a U.S. School: _____

List any allergies: _____ List any medications your child is currently taking: _____

List any present or past physical conditions or special disabilities which might interfere with the normal function of your child in the classroom: _____

Special health recommendations you wish the school to consider: _____

Family Doctor _____ Address _____ Phone _____

Circle where applicable: · Child wears contact lenses: Yes / No Hard / Soft Child has allergies Yes / No Child wears dental appliance Yes / No

EMERGENCY INFORMATION:

If none of the above can be contacted, what do you wish the school to do if the child is sick or injured? _____

In case emergency room treatment becomes necessary, which medical facility do you prefer?
Circle One: Robert Wood Johnson Hospital or St. Peter's University Hospital.

Parent/Guardian Signature: _____ Date: _____

I certify that the foregoing statements made by me are true. I am aware that if any of them are willfully false, I will be subject to legal action. As per State Law and Board Policy, if it is discovered that my child (children) is (are) illegally attending the North Brunswick Schools and not living in North Brunswick, I will be responsible for payment of accrued tuition fees. In addition, I acknowledge that I will be responsible for any legal expenses incurred by North Brunswick Board of Education in relation to the situation.

Important:

I understand that in the final disposition of an emergency the judgement of the school authorities will prevail. The recommendation of the parent/guardian, as indicated here will be respected whenever possible.

North Brunswick Township Schools

STUDENT HEALTH ASSESSMENT

TO BE FILLED OUT BY PARENT

School: ☐JA ☐JD ☐LP ☐Prsns ☐LMS ☐NBTHS Date:

Student (Last, First) _____ Birth Date _____ Grade _____

◯Parent/◯Guardian _____

Address _____

Home Phone # _____ Work # _____ Mobile # _____ Other Day# _____

Physician _____ Phone # _____

Address _____

Dentist Name _____ Phone # _____

LIST OTHER CHILDREN IN THE FAMILY:

Name _____ Birth Date _____ Name _____ Birth Date _____

Name _____ Birth Date _____ Name _____ Birth Date _____

HEALTH HISTORY

FOR ***ALL YES*** RESPONSES: PLEASE GIVE DETAILED INFORMATION ON REVERSE SIDE

	Yes	No		Yes	No		Yes	No
Pregnancy Problems	☐	☐	Birth was premature	☐	☐	Mother has Chronic or Serious Illness	☐	☐
Delays in Walking	☐	☐	Labor & Delivery Problems	☐	☐	Father has Chronic or Serious Illness	☐	☐
Delay in Talking	☐	☐		☐	☐		☐	☐

DOES YOUR CHILD HAVE:						HAS YOUR CHILD *EVER* HAD):					
	Yes	No		Yes	No		Yes	No		Yes	No
Frequent Colds	☐	☐	Vision Problems	☐	☐	Convulsions	☐	☐	Nervous Habits	☐	☐
Frequent Sore Throat	☐	☐	Eyeglasses	☐	☐	Epileptic Seizures	☐	☐	Serious Illness	☐	☐
Life Threatening Allergies (Submit Medical Documentation)	☐	☐	Hearing Problems	☐	☐	Coordination Problems	☐	☐	Chicken Pox	☐	☐
	☐	☐	Hearing Aid	☐	☐	Operation (explain)	☐	☐	Other (explain)	☐	☐
Allergies (explain)	☐	☐	Emotional Problems	☐	☐	Serious Injury	☐	☐		☐	☐
Asthma	☐	☐	Poor Eating Habits	☐	☐	Frequent Stomachaches	☐	☐		☐	☐
			Poor Sleep Patterns	☐	☐	Frequent Headaches	☐	☐		☐	☐

Presently, is your child under medical treatment? (Yes? Explain)	◯	◯
Does your child take any medication? (Yes? Explain)	◯	◯
Has your child been *ever* been referred to a physician for further care for VISION, HEARING, and/or SCOLIOSIS?	◯	◯

PLEASE USE THE REVERSE SIDE TO NOTE ANYTHING ABOUT YOUR CHILD THAT MIGHT PRESENT A SPECIAL PROBLEM

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of health information to occur between my child's physician(s), the School Health Services Nursing Staff and all Staff Members who are in contact with my child.

Parent/Guardian Signature _____ Relationship to Child _____ Date _____

Parent/Guardian Signature _____ Relationship to Child _____ 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 ☐ 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	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

GRADES 9-12 ONLY

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

STUDENT-ATHLETE RESIDENCY AFFIDAVIT

Print Student's Full Name	School	Date

I, _____, of full age, being duly sworn to law, upon my oath depose and say:

1. I am the parent/legal guardian of the above listed student. (circle)
2. I currently reside at: _____

   I have resided at the above address since: _____
3. The above-named student moved with me at my new address on: _____
4. Prior to moving to the new residence address listed above, I resided at the following address:

   _____
5. Prior to moving to the new address listed in #2 above, the student resided at the following address:

   _____

   with named parent/legal guardian_____
6. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.
7. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.
8. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Parent/Guardian Signature	Print Parent/Guardian Full Name

STATE OF NEW JERSEY, COUNTY OF _____. The above-named affiant appeared before me, a notary public of the State of New Jersey, on the _____day of _____, 20_____and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

Notary Public: _____

Copies of this Affidavit must be sent to the New Jersey State Interscholastic Athletic Association upon request

EC Approved 4/1/20