Hasbrouck Heights Public Schools
Student Information

First Name: _____ Address: _____ Birthplace City: _____

Middle Name: _____ City/State/Zip: _____ Birthplace State: _____

Last Name: _____ Gender: _____ Birthplace Country: _____

Birthdate: _____ Ethnicity: _____ Secondary Language: _____

Home Phone: _____ Siblings: _____ _____ _____

Mother's Information	Father's Information
Salutation: _____	Salutation: _____
First Name: _____	First Name: _____
Middle Name: _____	Middle Name: _____
Last Name: _____	Last Name: _____
Marital Status: _____	Marital Status: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Email: _____	Email: _____

Additional Emergency Contact: Name: _____ Relation: _____ Cell Phone: _____
Work Phone: _____ Home Phone: _____

Additional Emergency Contact: Name: _____ Relation: _____ Cell Phone: _____
Work Phone: _____ Home Phone: _____

Additional Emergency Contact: Name: _____ Relation: _____ Cell Phone: _____
Work Phone: _____ Home Phone: _____

Are there any restraining orders and/or divorce agreements that apply to this child? YES NO (if yes, please attach)

Student Lives With: Both Parents Mother Father Guardian

Parent/Guardian Signature: _____

HASBROUCK HEIGHTS PUBLIC SCHOOLS

REGISTRATION FORM

Student's Name: _____

_____ SECTION A: If the student is living with a parent or guardian whose permanent home is the address listed on page 1 of this application and is located in the district.

_____ SECTION B: If the student is living with a person domiciled in the district, other than the parent or guardian. ("Affidavit Student")

_____ SECTION C: If the student is living with a parent or guardian temporarily residing within the district.

_____ SECTION D: If the student's situation is not addressed by Section A,B or C or if any of the circumstances in Section D apply (Special Circumstances)

Please check the appropriate section A,B,C or D, according to the situation best matching the student's circumstance.

If you have any questions regarding the completion of the attached forms kindly contact:

Mrs. M. Klenk - High School 201-393-8155
Ms. D. Sisco - Lincoln School 201-393-8182
Mrs. L. Mason - Middle School 201-393-8170
Mrs. P. Hone - Euclid School 201-393-8176

REGISTRATION FORM

Date:_____ School:_____

Student: _____
Last Name First Name Middle Name

Age: _____ Date of Birth: _____ Male: _____ Female: _____

City of Birth: _____ State of Birth: _____

Country of Birth (if other than the USA): _____

If not born in the United States, date child first entered the U.S.: _____

Ethnicity: Hispanic _____ Non-Hispanic _____

Race (please check): White _____ American Indian _____
Asian _____ Pacific Islander _____
Black _____

Name of Parent(s)/Guardian(s): _____

Person Enrolling Student:_____

Relationship to Student If Other Than Parent:_____

Child Lives With (circle one): Both parents Mother Father Guardian

Student's Physical Address: _____

Mailing Address (if different):_____

Home Telephone (Including Area Code):_____

Other Phone or Fax (if any):_____

Parent(s)/Guardian(s) Physical Address: _____

Mailing Address (if different): _____

Are you and your child currently homeless? _____

Home Telephone (including area code):_____

Other Phone or Fax (if any):_____

Native Language of Parent/Guardian/Person Enrolling Student: _____

Is English Spoken and Understood By Parent/Guardian/Person Enrolling Student? Yes _____ No _____

Native Language of Student: _____

Is English Spoken and Understood By Student? Yes_____ No _____

Is either parent connected to the Military? Not Military Connected _____ Active Duty _____

Civilian living off post – working at Ft. Dix _____
Civilian living off post – working at McGuire _____
Civilian living off post – all other Federal Properties _____
Military living off post – working at Ft. Dix/McGuire _____
Military living ON POST – working at Ft. Dix/McGuire _____
Federal Prison Employee _____
Coast Guard Reserve _____

Is your child currently covered by Health Insurance? Yes _____ No _____

If yes, who is his/her health care provider? _____

NO My child **does not** have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Child's Name: _____

Signature (Parent): _____

Printed Name (Parent): _____

Date: _____

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

Date of your child's last medical examination (attach proof): _____

Date of your child's last dental examination (attach proof): _____

Date of your child's last lead test: _____

Lead Level: _____

Date of your child's polio immunization: _____

Proof of Residency: (**Original** of one document required; #6 requires additional documentation)

1. Property Tax Bill _____
2. Deed _____
3. Contract of Sale _____
4. Lease _____
5. Mortgage _____
6. Signed Letter From Landlord (Notarized) _____

How long have you lived in this residence? _____

Please bring **four original** forms of proof as evidence of personal attachment to the address given as your residence. The following will be accepted for consideration: Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to the address given:

1. _____
2. _____
3. _____
4. _____

Student Information (**all originals**):

Birth Certificate _____

Transfer Card _____

Immunization Record _____

Most Recent Report Card _____

Name & Address of Previous School :_____

_____

Educational Services — Previous School

Classified Student _____

504 Student _____

Speech/Language _____

Basic Skills Instruction _____

ESL Program _____

PAC Program _____

Other Program Offerings _____

Explain:_____

_____

If High School student, list athletic teams in which you have participated:

1. _____
2. _____
3. _____
4. _____

Signature of person enrolling student: _____

(For Administrative Use Only)

School Placement & Grade

Euclid School Grade _____

Lincoln School Grade _____

Middle School Grade _____

High School Grade _____

Out of District Placement _____

Pre-School _____

Special Services (Explain): _____

_____

_____

Application Processed by: _____ Date: _____

Principal's Signature: _____ Date: _____

Superintendent of Schools: _____ Date: _____

Hasbrouck Heights School District
Department of Curriculum and Instruction

Home Language Survey

Introduction:

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Demographic Information:

Student Name:_____ Student Birthdate:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

<u>Survey Questions</u>

1. What was the first language used by the student?

_____

(If a language other than English, proceed to question 2a. If English, continue to question 2b)

2a. At home, does the student hear or use a language other than English more than half of the time?

Yes No

(If yes, go to question 7 and list home language(s) spoken. HLS is complete. Proceed to step 2: Records Review Process. If no, continue to question 4.)

2b. At home, does the student hear or use a language other than English more than half of the time?

Yes No

(If yes, continue to question 4. If no, continue to question 3.)

Hasbrouck Heights School District
Department of Curriculum and Instruction

Home Language Survey

3. Does the student understand a language other than English?

Yes No

(If yes, continue to question 4. If no, do not proceed to Step 2: Records Review Process. HLS is complete. Student is not an ELL.)

4. When interacting with his/her parents or guardians, does this student use a language other than English more than half of the time?

Yes No

(If yes, go to question 7 and list home language(s) spoken. HLS is complete. Proceed to Step 2: Records Review Process. If no, continue to Question 5.)

5. When interacting with caregivers other than his/her parents or guardians, does the student use a language other than English more than half of the time?

Yes No

(If yes, go to question 7 and list home language(s) spoken. HLS is complete. Proceed to Step 2: Records Review Process. If no, continue to Question 6)

6. Has the student recently moved from another school district where he/she was identified as an English language learner?

Yes No

(If yes, go to question 7 and list home language(s) spoken. HLS is complete. Proceed to Step 2: Records Review Process. If no, do not proceed to Step 2: Records Review Process. HLS is complete. Student is not an ELL.)

7. List home languages spoken.

HASBROUCK HEIGHTS PUBLIC SCHOOLS

THE OFFICE OF THE ELEMENTARY PRINCIPALS
379 Boulevard
Hasbrouck Heights, New Jersey 07604
Phone (201) 288-6150

JOSEPH COLANGELO
Lincoln School Principal

MICHAEL SICKELS
Euclid School Principal

Date: _____

Students Name: _____ **Grade:** _____

Parents Name: _____ **DOB:** _____

Parent/Guardian Cell Number: _____ **Home Number:**

_____

Parent/Guardian Email: _____

Are there any medical conditions the nurse needs to be aware about?

_____

- ☐ **Some medical forms were submitted. (The school nurse will review all forms to determine if anything is missing.)**
- ☐ **NO forms were submitted at this time.**

**** Please note, proof of all mandatory immunizations are required in order to start school.**

Heather Meli
School Nurse, Lincoln Elementary School
Office # 201-393-8178
Fax # 201-288-0753

Jadira Ortega
School Nurse, Euclid Elementary School
Office # 201-393-8184
Fax # 201-393-0365

HASBROUCK HEIGHTS PUBLIC SCHOOLS
PHYSICAL EVALUATION FORM

(PARENTS TO FILL OUT) **-STUDENT INFORMATION-**

Student's Name: _____ Sport: _____
Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
Address: _____
City/State/Zip:_____ Home Phone: _____
School: _____ District: _____
Parent/Guardian's Full Name: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Examination Date:
Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip:_____

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse:

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N Hearing:R_____L_____

Indicators	**Normal? (Circle One)**		**Abnormal Findings/Comments**
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: _____
Recommendations: _____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation:(CHECK ALL THE APPLY)

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

_____

_____

Conditions requiring clearance before sports participation include, but are not limited to: *Atlantoaxial instability; Bleeding disorder; Hypertension;Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.*

EXAMINED BY:
Family Physician/Provider_____
School Physician_____
____MD ____DO____NP____PA

Physician's/Provider's Stamp:

NOTE TO SCHOOL PHYSICIANS: Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Hasbrouck Heights, NJ, 07604

Name:_____ Date:_____

School:_____ DOB:_____ Grade:_____

Dear Parent / Guardian:

According to the New Jersey State Sanitary Code, Chapter 14: Administrative Code 8:57-4:17, no pupil may enter in a school who has not submitted acceptable evidence of immunization against disease to the School Health Office.

THE RECORD MUST CONTAIN THE NAME, ADDRESS & PHONE NUMBER OF THE PHYSICIAN

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON REGISTRY NUMBER	

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	LEAD SCREENING *(Not Required)* TEST DATE	RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)							
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)					[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history		
HAEMOPHILUS B (HIB) [2]							
HEPATITIS B [3]					Hepatitis B	DATE:	TITER:
VARICELLA [4]					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE [2]					Measles	DATE:	TITER:
INFLUENZA [6]					Mumps	DATE:	TITER:
OTHER, SPECIFY:					Rubella	DATE:	TITER:

☐Provisional Admission Attached - Date Granted: _____ ☐Medical Exemption Attached ☐Religious Exemption Attached

[1] REQUIRES MEDICAL EXEMPTION.
[2] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
[3] REQUIRED FOR K-GRADE 1 (whichever Is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
[4] REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
[5] MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
[6] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Hasbrouck Heights, New Jersey 07604

Dental Visit Form

Student Name: _____ Date of Birth:_____

School:_____ Class/Grade:_____

The above named student was seen in this office on _____ for a dental exam. His/her teeth are:

____ In good health
____ In need of further treatment

_____ _____
Dentist's signature Telephone Number

_____
_____
_____
Address or stamp

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of _____

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

_____

_____

_____

_____

_____

2. Is he/she on medication? If yes, pleas list medication(s):

_____

_____

3. Are there any restrictions? If yes, please list restrictions:

_____

_____

4. Does your child have any allergies to food or medication? If yes, what:

_____

_____

This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature:_____ Date: _____

UPDATED 1/23/09

(PARENT)

Hasbrouck Heights Public School
School Health Services

AUTHORIZATION

FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT_____ DATE OF BIRTH_____

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medications and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid while your child attends school in the Hasbrouck Heights Public School and is intended to allow the staff to better serve your child. If you have any questions or concerns, please contact my office at the telephone number noted above.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print name of Parent / Guardian Telephone Number

Thank you,

The Nursing Department
Hasbrouck Heights Public School

updated 1/23/09