



SCHOOL REGISTRATION PACKET

Mid-Year Entrance

1. School Registration Form – Student / Family / Emergency Information
2. Physical Examination & Immunization Requirements
3. Health History (Completed by Parent/Guardian)
4. Physical Examination Form
5. Immunization Record – Grades K-12
6. Vision Exam Form
7. Official Records Request Form – Transfer Card
8. Dismissal Form



SCHOOL REGISTRATION

School _____ Grade _____ Entry Date _____ Student ID # _____

STUDENT INFORMATION

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

Nickname: _____ Student Email (Grades 6-12): _____ Gender: M ☐ F ☐

Home Address [Street] _____

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 Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐

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

If student was born outside of the US, and has not attended at least three full academic school years in the US (including Pre-K), please provide the following information: 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 (including Pre-K):				
School and Address	Grades Attended	First Date of Enrollment	Last Date of Enrollment	Public or Private

NJ State ID # (if transferring from another NJ Public School): _____

FAMILY INFORMATION

1 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other _____

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

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: (____) _____ Business Phone: (____) _____ Occupation: _____

Employer Name/Address: _____

2 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other _____

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

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: (____) _____ Business Phone: (____) _____ Occupation: _____

Employer Name/Address: _____

* If checked, guardianship papers must be produced for examination

Continued on back...

FAMILY INFORMATION (CONTINUED) FOR:**# 3 – Non-Custodial Parent**No Contact Allowed: ☐ Receives Extra Mailing: ☐Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other _____

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

Home Address [Street]: _____ [City, State, Zip] _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Business Phone: (____) _____

Employer/Address: _____ Occupation: _____

4 – Student Resides at More than One Address: ☐Receives Extra Mailing: ☐Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other _____

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

Home Address [Street]: _____ [City, State, Zip] _____

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

EMERGENCY INFORMATION

In the case of an emergency or early dismissal the parent/guardians will be contacted, Please list the individuals to whom the school may entrust your child if parent/guardians are unreachable. **DO NOT** list a parent or guardian as Emergency Contact. No student shall be released from school unless accompanied by an adult designated by the parent.

Please check if your child may **ONLY** be released to parent: ☐

Contact Name (Not parent/guardian)	Relationship	Address	Home Phone	Work Phone	Cell Phone
1					
2					
3					

PHYSICIAN/INSURANCE INFORMATION

My child's medical care is provided by: _____ (name of Doctor, Clinic, or HMO) _____ (Telephone)

My child has Health Insurance: ☐ Yes ☐ NoIf **Yes**, please provide name of Insurance Company: _____

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

Parent/Guardian Signature: _____ Date: _____

School Official Signature: _____ Date: _____

* If checked, guardianship papers must be produced for examination

NewStuReg/Revised January 2013

RIDGEWOOD PUBLIC SCHOOLS

Ridgewood, New Jersey

PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

Kindergarten – Grades 12

All of the required information must be submitted prior to the first day of school (or starting date). A student can be refused entry until all requirements are met. If registering in the spring for the next school year, the forms are due June 15. If registering during the summer for September entrance, the forms are due prior to September 1. If registering for the current school year, the immunization record and health history are due before entrance. The physical exam form is due within 30 days of entrance. Exceptions may be granted only for religious beliefs or medical recommendations.

All students entering Kindergarten in the State of New Jersey must have documentation of a completed physical examination by their personal physician before entering the school district. We have provided you with the form. This exam must have been performed within 365 days prior to the first day of school (or starting date) and must state what, if any, modifications are required for full participation in the school program. Dental, hearing and eye examinations are also recommended, but not mandatory. A record of the student's medical history, physical and emotional make-up may be very helpful in handling and teaching the student should problems subsequently develop. Families who do not have a personal physician or access to medical care should discuss this with the school nurse.

In addition to the requirements noted above, TB (Mantoux Testing) may be required for a select group of foreign born students and/or students transferring from a high TB incidence country into the Ridgewood Public Schools. Please consult your school nurse for details.

Immunization Requirements for Children Entering Kindergarten & Higher Grades:

DTaP (Diphtheria and Tetanus Toxoids and Pertussis Vaccine)

Age 5-6 years: A minimum of four (4) doses of DTaP are required. One dose must have been administered on or after the fourth birthday or any five (5) doses.

Age 7-9 years: A minimum of three (3) doses of Td or any previously administered combination of DTP, DTaP and DT to equal three (3) doses.

Tdap (Tetanus and Diphtheria Toxoids and Acellular Pertussis Vaccine)

One (1) dose for students entering Grade 6, or comparable age level for special education programs.

OPV (Oral Poliovirus Vaccine) or IPV (Inactivated Polio Vaccine)

Age 5-6 years: A minimum of three (3) doses of poliovirus vaccine is required, providing one dose is given on or after the fourth birthday, or any four (4) doses.

Age 7 and older: Any three (3) doses

MMR (Measles, Mumps, Rubella)

Administered after the first birthday:

Two (2) doses of a live Measles-containing vaccine

One (1) dose of live Mumps-containing vaccine

One (1) dose of live Rubella-containing vaccine

Hepatitis B Vaccine

Three (3) doses are required.

Varicella Vaccine

One (1) dose administered on or after the first birthday for children born after 1/1/1998

PCV (Pneumococcal Conjugate)

Two (2) doses - Ages 2–11 months

One (1) dose - Ages 12-59 months

Meningococcal

One (1) dose for students entering Grade 6, or comparable age level for special education programs

HPV (Human Papillomavirus Vaccine) - Optional

Administer to females, minimum age 9 years, and ages 13 to 18 if not previously vaccinated

1st dose – Age 11 or 12 years

2nd dose - 2 months after first dose

3rd dose - 6 months after first dose (at least 24 weeks after 1st dose)

HIB (Haemophilus Influenza Type B)

One (1) dose annually - Ages 12 months to 59 Months

RIDGEWOOD PUBLIC SCHOOLS
Ridgewood, New Jersey

Students New To The Ridgewood Public Schools – Grades K-5

SCHOOL HEALTH HISTORY ENTRANCE FORM

TO BE COMPLETED BY PARENT.

Please complete the following and return to the school nurse as soon as possible.

Child's Name _____ Sex M ☐ F ☐ Birth Date _____
(Last) (First)

Grade _____ School _____ Home Address _____

Father's Name _____ Mother's Name _____

Home Phone _____ Work Phone Mother _____ Father _____
Cell Phone: _____ Cell Phone _____

Siblings, Names/Ages _____

Language(s) spoken at home (other than English) _____

II. BIRTH & DEVELOPMENTAL HISTORY

Birth Weight: Pounds _____ ounces

Gestation (Duration of Pregnancy) _____ weeks or _____ months

Pregnancy: Illness of Mother Yes ☐ No ☐ If yes, explain: _____

Other areas of concern -- Yes ☐ No ☐ If yes, explain: _____

Problems/labor & deliver-- Yes ☐ No ☐ If yes, explain: _____

Growth and Development: Age child – _____

Sat alone _____ Crawled _____ Walked _____ First Spoke _____ Spoke in sentences _____

Coordination (difficulty) Yes ☐ No ☐ If yes, explain: _____
(fine motor, large muscle, other areas of concern)

II. FAMILY MEDICAL HISTORY (Please specify: Allergies, Respiratory, Heart, Diabetes, Cancer, Other)

Father _____ Mother _____

Siblings _____ Relative _____

III. HEALTH HISTORY (Please check appropriate column, note year, and explain where applicable.)

Allergy Types	Reaction	School Restriction
Bee/Insect		
Drugs		
Food		
Pollen		
Skin		
Other (i.e. latex)		

Other Conditions	No	Yes	Year(s)	Explain
Asthma/Reactive Airway Passage				
Blood Disorder				
Cancer				
Concussion/Head Trauma				
Diabetes				
Digestive/Feeding Disorder				
Diseases, i.e. chicken pox				
Mononucleosis				
Mumps				
Measles				
Dietary Restrictions				
Emotional Problems				
Genitourinary Problems				
Hearing Difficulty				
Heart Disease (defects)				
Hospitalization(s)				
Severe Infections				
Kidney Disease				
Neuro-muscular Disorders or prosthesis				
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes				
Orthopedic Disorder				

Other Conditions	No	Yes	Year(s)	Explain
Central Nervous System Disorder				
Rubella				
Skin Disorder				
Speech Impairment				
Surgical Procedure(s)				
Vision Problems				
Glasses/Contacts				
Other (list and explain) serious illnesses, accident, genetic disorders)				

A. Is the student receiving medication? Yes ☐ No ☐ If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date Prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes ☐ No ☐ If yes, explain: _____

C. Does the student require an special procedures and/or treatments?

Yes ☐ No ☐ If yes, explain: _____

D. Is the student current under treatment for any health conditions?

Yes ☐ No ☐ If yes, complete the following:

<u>Condition</u>	<u>Physician</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

E. Has the student had a vision screening?

Yes ☐ No ☐ If yes, please report results: _____ (date) _____

F. Has the student had a hearing screening?

Yes ☐ No ☐ If yes, please report results: _____ (date) _____

G. Has the student had any special medical examinations?

Yes ☐ No ☐ If yes, complete the following: (i.e., ophthalmologic, neurological, orthopedic, etc.):

Specialty	Physician	Exam Date	Diagnosis	Recommendation

H. Has the student had any experience(s) which you feel may affect his/her physical, mental, and/or social development?

Yes ☐ No ☐ If yes, please explain:

I. Please complete: Last medical examination:

Date:	Reason
Physician:	Findings
Address:	
Phone#:	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As parent/guardian of the above named student, I hereby allow for the sharing of information between the student's health care team and the nurse, to divulge necessary information to necessary staff.

Date
/dc/1/2010

Signature of Parent/Guardian

PHYSICAL EXAMINATION FORM - GRADES K-5

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) (First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <i>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.</i>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

RIDGEWOOD PUBLIC SCHOOLS
Ridgewood, New Jersey

State of New Jersey
IMMUNIZATION RECORD
Kindergarten – Grades 12

		Immunization Registry Number	
Name of Child (Last, First, M.I.)		Date of Birth (Mo/Day/Yr)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian	Name		
	Address		Telephone No.

TO BE COMPLETED BY HEALTH CARE PROVIDER

DISEASE	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr			
DTaP (DIPHTHERIA, TETANUS, PERTUSSIS) or any combination <i>*If Td or DT, indicate in box</i>	/ /	/ /	/ /	/ /	/ /			
Tdap (TETANUS, DIPHTHERIA TOXOIDS, ACELLULAR PERTUSSIS)								
IPV (INACTIVATED POLIOVIRUS) OR OPV (ORAL POLIOVIRUS) <i>If IPV or OPV, indicate in box</i>	/ /	/ /	/ /	/ /	/ /			
MMR (MEASLES, MUMPS, RUBELLA)								
HEPATITIS B								
VARICELLA								
PCV (PNEUMOCOCCAL CONJUGATE)								
MENINGOCOCCAL								
HPV (HUMAN PAPILLOMAVIRUS)								
HIB (HAEMOPHILUS INFLUENZA TYPE B)								

Lead Screening	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

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

RIDGEWOOD PUBLIC SCHOOLS
Ridgewood, New Jersey

VISION EXAMINATION FORM

The Board of Education recommends that all pre-school children have a complete eye examination before entering school in the fall. Good vision is essential to success in school. It is our hope that pre-school eye examinations will help many children to receive the proper vision correction through early detection and/or treatment.

Vision Screening is required for athletic participation at the middle and high schools.

Upon completion of the eye examination, have the examiner indicate his/her findings and recommendations on the form below. This form should be returned to the school nurse.

Student's Name _____ **Date** _____

I have given a complete eye exam with the following diagnosis and recommendations:

		Distance	Near		Distance	Near
Vision Without Correction	O.D.			O.S.		
Vision With Correction						

Muscle Balance _____

Color Test _____

Stereopsis Eye _____

Eye Defects _____

Recommendations/Conclusions

1. Normal Eye Examination Yes ☐ No ☐

2. Corrective lens prescribed Yes ☐ No ☐

3. Re-examine on _____ (Date of Return Visit)

4. Other (Preferential seating, low vision, aides, etc.) _____

Physician's Signature

Date

Please Print:

Name of Physician _____

Address _____

Phone Number _____

RIDGEWOOD PUBLIC SCHOOLS

Ridgewood, New Jersey

OFFICIAL RECORDS REQUEST FORM TRANSFER CARD

Please Print

Student Information			
Last Name	First Name	Middle Name	
Street	City	State	Zip
Date of Birth			
Place of Birth [City, State, Country]		Languages Spoken at Home	
Previous School		Entering School – Send Info to:	
Name of School Public <input type="checkbox"/> Private <input type="checkbox"/>		<ul style="list-style-type: none"> ▪ Hawes ES, 531 Stevens Ave, Ridgewood, NJ 07450 ▪ Orchard ES, 230 Demarest St, Ridgewood, NJ 07450 ▪ Ridge ES, 325 W. Ridgewood Ave, Ridgewood, NJ 07450 ▪ Somerville ES, 45 S. Pleasant Ave, Ridgewood, NJ 07450 ▪ Travell ES, 340 Bogert Ave, Ridgewood, NJ 07450 ▪ Willard ES, 601 Morningside Ave, Ridgewood, NJ 07450 ▪ Benjamin Franklin MS, 335 N. Van Dien Ave, Ridgewood, NJ 07450 ▪ George Washington MS, 155 Washington Place, Ridgewood, NJ 07450 ▪ Ridgewood HS, 627 E. Ridgewood Ave, Ridgewood, NJ 07450 	
Address [Street, City, State, Zip]			
Telephone Fax			
Last Date of Attendance Last Grade Attended			
NJ State ID# (if transferring from a Public School in NJ)			
Records to Be Released			
District Assessments		Is student in an ESL or Bilingual Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Assessments		Has student ever been referred for Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Education Records		Has student ever been referred for Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the specific classification, if any:	
Comments			
Office Use Only			
Requested By	Requested Date	Received By	Received Date

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

Signature of Parent/Legal Guardian (circle one) _____
 Signature of Student (18 or above) _____
 Date _____

* Parental permission is no longer required when records are requested by authorized school personnel. (Family Education Rights and Privacy Act, Final Rule on Educational Records. Federal Register, June 17, 1976, Vol.41, No. 118, page 24673). The prior District may also release the following mandated records: transcript of grades, health records, attendance records, child study team records and disciplinary records pursuant to N.J.A.C. 6:3-6.5

Ridgewood Public Schools
Ridgewood, New Jersey

SCHOOL DISMISSAL FORM

School employees are expected to know and supervise the implementation of parents'/guardians' plans for dismissal. It is the responsibility of parents/guardians to notify the school as to the preferred plan for the dismissal of their children, as well as be familiar with the school calendar and dismissal times.

Please read the choices below in order to let school officials know how your child should be released at dismissal time and indicate your preference.

Child's Name _____ Teacher _____ Grade _____

1. _____ My child is aware of our family plan for leaving school grounds each day. The supervising staff member will dismiss my child from the assigned door at the designated time. My child knows to return to the teacher or main office if there is an unexpected change in our plans. **Please note: This option should be selected if the child walks home, alone or with a group, or if a parent (or other adult/group) meets the child at a designated location other than the dismissal door on a regular basis.

2. _____ My child takes the bus.

3. _____ My child may be released by the supervising staff member ONLY to the following:
**Please note: If this option is selected, make sure to include all care givers, siblings, as well as leaders of any organization in which your child is participating immediately following dismissal from school, i.e. Brownies, Girl Scouts, CCD, Hebrew School, etc.

Name:

Phone:

I understand that school personnel will follow the plan indicated above every day. Changes to this plan may only be made in writing and given to the teacher in advance of the anticipated change. I have received the school calendar (attached) and will plan accordingly.

I also understand that there are no crossing guards at lunch time or at any time other than scheduled morning arrival and afternoon dismissal. In the event that my child will arrive at school or be released from school at any time other than scheduled morning arrival or afternoon dismissal, I will assume responsibility for his or her safe crossing of the street.

Parent Signature

Date

Print Name