January, 2014

KINDERGARTEN 2014-2015 REGISTRATION

Dear Parent/Legal Guardian:

Welcome to Edison Township Public Schools! We are pleased to offer you the opportunity to begin your child’s enrollment process at your convenience. The following forms, which make up the Kindergarten packet, should be filled out neatly and accurately in black ink. (Packets are available at the Enrollment Center, online at www.edison.k12.nj.us/enrollment and at Edison’s public elementary schools.) You will need to bring your completed packet to the Enrollment Center to complete the enrollment process. See enclosed schedule for list of schools and dates.

Please note: Your child will not need to be present for this portion of the enrollment process. At a later date, you and your child will report to the school to meet with the nurse and possibly the Reading Specialist.

On the designated enrollment date, please bring the completed forms and all required documents (see enclosed list of requirements) to the Enrollment Center. At that time, all documentation will be reviewed and the enrollment process completed.

NOTE: Kindergarten Registration will take place at the Enrollment Center – not at the school – on the designated dates. Hours are from 9:00 AM – 3:00 PM.

Below are instructions for the parent/guardian to complete the forms. If you have any questions, please feel free to call 732-452-4570 for assistance.

Student Enrollment Data Form: Leave the top portion of the form blank. Start with the student’s Name. Complete all of the items on the front and back of the form. Please remember to sign and date the form.

Health History, Form #16D: This form needs to be completed by the parent/guardian, not the doctor. Please read each item on the front carefully and indicate yes or no on the lines provided. Be specific with any “yes” answers, providing dates and details when possible. Complete the back of the form and sign.

RB/kk
11/13
**KINDERGARTEN REGISTRATION 2014-2015**

Children **must** be 5 years of age **on or before October 1, 2014** to be eligible for Kindergarten.

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>REGISTRATION DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENLO PARK</td>
<td>February 4 through Feb 7</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>February 10 through Feb 14</td>
</tr>
<tr>
<td>JAMES MADISON PRIMARY</td>
<td>February 18 through February 21</td>
</tr>
<tr>
<td>LINDENEAU</td>
<td>February 24 through February 28</td>
</tr>
<tr>
<td>BEN FRANKLIN</td>
<td>February 24 through February 28</td>
</tr>
<tr>
<td>LINCOLN</td>
<td>March 3 through March 7</td>
</tr>
<tr>
<td>JOHN MARSHALL</td>
<td>March 10 through March 14</td>
</tr>
<tr>
<td>WOODBROOK</td>
<td>March 17 through March 21</td>
</tr>
<tr>
<td>JAMES MONROE</td>
<td>March 31 through April 4</td>
</tr>
<tr>
<td>M L KING</td>
<td>March 31 through April 4</td>
</tr>
</tbody>
</table>

Registration will take place at the Enrollment Center, 312 Pierson Ave., Edison, NJ 08837, **NOT** at the school.

Registration hours are from 9:00 AM and 3:00 PM.

Only the parent or legal guardian may enroll the child. The child does **NOT** need to be present for this special registration. Please go to the district website at [www.edison.k12.nj.us/enrollment](http://www.edison.k12.nj.us/enrollment) and click “Kindergarten registration packet 2014-2015” under site shortcuts on the left hand side of the page or you can pick up a Kindergarten registration packet at any of the elementary schools listed above or at the Enrollment Center beginning January 2, 2014. The packet contains a requirement sheet and the forms that can be filled out prior to coming in for the scheduled registration date.

**Please call the Enrollment Center at 732 452-4570 if you need any further assistance.**
ENROLLMENT REQUIREMENTS

* PARENT OR GUARDIAN MUST ENROLL A STUDENT (UNLESS STUDENT IS AN ADULT)
* STUDENT MUST LIVE IN EDISON
* STUDENT MUST BE PRESENT IN ORDER TO ENROLL OR RE-ENROLL

THE FOLLOWING DOCUMENTS SHOULD BE PRESENTED AT THE TIME OF ENROLLMENT:

PREFERRED PROOFS OF RESIDENCY:
FOUR (4) OF THE FOLLOWING PROOFS OF RESIDENCY MAY BE SUBMITTED:

Current property tax bill, deed, lease, lease renewal or signed letter from landlord, indicating residency
Current utility bill with name and address
Photo ID of parent/guardian (Driver’s license, passport, etc.)
Paid rent receipts or cancelled rent checks
Current automobile registration or insurance card
Bank or credit card statement
Documents pertaining to military status and assignment
Court orders, State agency agreements and other evidence of court or agency placements or directives

(Note: Alternate documentation of residency will be considered.)

PROOF OF STUDENT’S DATE OF BIRTH
Birth Certificate / Passport / Other Official Document Indicating Age

UPDATED IMMUNIZATION RECORD
Document in English, with student’s name, doctor or clinic name, and month, date & year of shots

SCHOOL RECORDS (if available) – Transfer Card / Withdrawal or Leaving Certificate / Report Card / Letter from previous school, confirming attendance and grade level / Test Scores / IEP

PROOF OF CUSTODY, if applicable, may be requested.

FOR MORE INFORMATION, VISIT US ON THE WEB AT: http://www.edison.k12.nj.us/enrollment
Public Schools of Edison Township

ENROLLMENT CENTER
312 PIERSON AVENUE * EDISON, NEW JERSEY 08837
TELEPHONE (732) 452-4570   FAX (732) 452-4576

Richard J. O’Malley, Ed. D.
Superintendent of Schools

Richard Benedict
Manager

STUDENT ENROLLMENT FORM: DATE: _____ / _____ / ______

For Office Use ONLY
NEW ENROLLMENT: YES | NO RE-ENROLLMENT: YES | NO CHANGE OF ADDRESS: YES | NO
SSID# __________________________ LOCAL ID# __________________________ PCC CODE _________________


Edison School: ___________ Grade: _______ Previous School: ______________________ Grade: _______

Previous School Address __________________________________________________________
School Records Submitted: YES | NO

Special Education: YES | NO [IEP Submitted: YES | NO] Basic Skills: _____ Speech: _____ ESL: _____

Student Information (PLEASE PRINT CLEARLY)

First Name ____________________________ Last Name ____________________________

Middle Name ____________________________ Birthdate: _____ / _____ / ______ Gender: Male | Female

___ White
___ Black
___ Hispanic

Birth City: ____________________________________________

Ethnicity: ___ American Indian / Alaskan
___ Asian
___ Hawaiian native/other Pacific Islander

Birth State: __________________________________________

Birth Country: _______________________________________

U.S. Citizen: YES / NO - If no, citizen of ______ Original Entry in U.S.: _____ / _____ / ______

Country of origin MM DD YYYY
First Entry in U.S. School: _____ / _____ / ______

MM DD YYYY Student’s Primary Language __________________________

Special Education: YES | NO [IEP Submitted: YES | NO] Basic Skills: _____ Speech: _____ ESL: _____
Previous Home Address ____________________________ Apt #: __________

Street Address / Zip Code

PLEASE LIST ANY CHILD RESIDING AT THIS ADDRESS ELIGIBLE TO ATTEND SCHOOL

<table>
<thead>
<tr>
<th>NAME</th>
<th>GENDER</th>
<th>BIRTHDATE</th>
<th>CURRENT SCHOOL</th>
<th>GRADE</th>
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</tbody>
</table>

Nothing Less Than Excellence
Current Student Address Information (PLEASE PRINT CLEARLY)

Student Legal Home Address ____________________________________________ Apt #: __________

Street Address / Zip Code

Legal Home Phone Number (_____ ) _____ - ___________ Cell Phone (_____ ) _____ - ___________

Parent/Legal Guardian Information (PLEASE PRINT CLEARLY)

Who has legal custody of the student? ____________________________________________

Note: If the parents are divorced or separated, or someone other than the parents has legal custody of the child, you are required to submit legal proof of residential custody.

Legal proof of custody submitted? _____ YES _____NO

Parent/Legal Guardian Address Information (Complete address only if different from the student)

Parent/Legal Guardian Name ___________________________ Language Spoken: ___________

Street Address / Zip Code

Apt #: __________

Home Phone Number (_____ ) _____ - ___________ Cell Phone (_____ ) _____ - ___________

Occupation ___________________________ Work Phone (_____ ) _____ - ___________

Parent/Legal Guardian Email: ________________________________________________

Other Parent Address Information (Complete address information only if different from above)

Name ___________________________ Language Spoken: ___________

Street Address / Zip Code

Apt #: __________

Home Phone Number (_____ ) _____ - ___________ Cell Phone (_____ ) _____ - ___________

Other Parent Email: _________________________________________________________

Other Phone: (_____ ) _____ - __________

Emergency Contact (Other than parent/legal guardian)

Name ___________________________ Relation to Student ___________________________

Street Address / Zip Code

Apt #: __________

Phone Number (_____ ) _____ - ___________ Email _______________________________________

I/we fully understand that the Edison School District retains the full right to verify any information contained in this application at any time during the period for which enrollment is pending or after enrollment has actually taken place. If at any time the pupil registered no longer qualifies as an Edison pupil, I/we shall forthwith advise the office of the Superintendent of Schools, 312 Pierson Avenue, Edison, NJ 08837. I/we fully understand that failure to do so shall hold me/us legally responsible for all tuition costs, legal costs, and any other expenses incurred by the Edison School District during that period of time for which the pupil was not so qualified for enrollment. I/we understand that no documents or pupil records, awards, or diplomas shall be issued to the pupil or to his parent/guardian or be forwarded to any other school district or school until such costs have been settled with the Edison School District. I/we swear that the information contained herein is true. Any false information concerning residency shall be penalized according to N.J. Statute 18A:38-1.

_________________________________________  _______________________
Parent/Legal Guardian Signature  Date

Enrolled by: _______ Date: ___/___/_______  Input by: ______ Date: ___/___/_______

(Rev. 12/2011)

Nothing Less Than Excellence
KINDERGARTEN PHYSICAL EXAM FORM (#16)

The front of the next form is to be completed by your child’s doctor, following a physical exam.

Exam date must be within 365 days of the child’s first day of school in September, 2014.

The back of the form is to be completed and signed by the parent.

If the Physical Exam Form is completed before your kindergarten enrollment date, please bring the form with you to the Enrollment Center.

If the Physical Exam Form is completed by the first week of June, please return it to the nurse at your child’s school as soon as possible so that your child’s file may be completed before schools close for the summer.

DENTAL HEALTH FORM (#15)

This form should be completed by the child’s dentist, and returned to school in September, 2014.
REGISTRATION HEALTH HISTORY

Student’s Name: _______________________________  Date of Birth: __________

School: ______________________________________  Grade: __________

IMMUNIZATION RECORD

Immunization Document Received  Date ________________

Requested from parents/guardian  Date ________________

CHILDHOOD ILLNESSES, INJURIES, OPERATIONS, ORTHOPEDIC CONDITIONS:
Please give age of child when illness, injury, occurred explain:

- Asthma ____________  Measles ____________
- Chicken Pox ____________  Mononucleosis ____________
- Diabetes ____________  Ear Infections ____________
- Heart Condition ____________  Pneumonia/Bronchitis ____________
- Kidney/Bladder Condition ______  Rheumatic Fever ____________
- Strep Infection ____________  Seizure(s) ____________

Other

- Any known speech/hearing problem: ________________________________
- Any known Visual Problem: ________________________________
- Allergies or Eczema: ________________________________
- Behavioral Difficulties: ________________________________
- Gastrointestinal Problem: ________________________________
- Toileting Difficulties: ________________________________
- Neurological Disorders: ________________________________
- Muscle or Bone Problems: ________________________________
- Other Medical Conditions: ________________________________
- Previous Injuries/Accident: ________________________________
- Sleeping Problems: ________________________________
- Significant or Frequent Illness: ________________________________
- Surgery: ________________________________
- Breathing Difficulties: ________________________________
- Nutritional/Eating Problems: ________________________________
- Other difficulties: ________________________________

Has the child ever had prolonged use of medication, or is any medication or therapy being given at this time? If so, please explain: ____________________________________________

(over)
Physical Limitations:

______________________________________________________________________
______________________________________________________________________

Has your child ever been confined to a hospital? If so, please explain:

______________________________________________________________________
______________________________________________________________________

Has your child ever been advised not to participate in a sport or to reduce activity? If so, please explain:

______________________________________________________________________
______________________________________________________________________

Has your child had a loss of, or serious impairment of a paired organ such as a kidney, eye, lung, etc. If so, please explain:

______________________________________________________________________
______________________________________________________________________

List additional health information.

______________________________________________________________________
______________________________________________________________________

I/we give permission for the nurse to share any health-related information with principal, guidance counselors & teachers on a “need to know” basis for as long as my child is a student in Edison Public Schools.

My child is covered by health insurance ___ yes   ___ no

My child receives his/her health care at: __________________________________

                                          Name of health care provider or clinic

Signature of Parent/Guardian                            Date

8/96, 5/98,6/99,3/03,1/05
N.J.A.C. 6A:16-2.2 requires all medical examinations **must be done by the student’s family physician or clinic where the student receives his/her healthcare.**

If you do not have a family physician or clinic who provides medical care for your child, please contact the school nurse for a school physician exam request form.

**Student:** ____________________________________  **Grade:** __________  **School:** __________  **Male/Female (circle one)**

**Date of Birth:** ______________

**IMMUNIZATIONS ADMINISTERED**

**LABORATORY TESTS DONE**

**T.B. Mantoux Test:** (date) ______________ Result _______-mm.

**RECORD OF PHYSICAL EXAMINATION:**

- **Hearing:** R: _______ L _______
- **Height:** _______  **Weight:** _______  **Blood Pressure:** _______  **Pulse:** _______  **Vision R:** _______  **L:** _______

- **Vision correction (glasses/contacts):** ______________
- **Hearing/Ears (tubes/hearing aids):** ______________

- **Skin and scalp:** ______________  **Abdomen:** ______________  **Mass:** ______________
- **Rashes:** _______  **Jaundice:** _______  **Infection:** _______  **Hepatomegaly:** _______  **Splenomegaly:** _______  **Lymph nodes:** _______
- **Head and neck:** ______________  **Teeth:** ______________  **Inguinal area (hernia):** ______________
- **Mobility:** ______________  **Deformity:** ______________  **Instability:** ______________
- **Lungs:** ______________  **Balance:** ______________  **Coordination:** ______________
- **Neurological:** ______________  **Reflexes:** ______________  **Other:** ______________

- **Females: Normal Menstruation:** _______  **Males:** _______  **Hernia:** _______  **Testes Descended:** _______

- **Heart (any irregularity? If yes, please explain):** Murmurs _______  **Rhythm/Rate:** _______

- **Injuries, operations?** Explain: __________________________________________________________________________

- **Chronic Illness/Disease:** ________________________________________________________________________________________________

- **Orthopedic defects, e.g., scoliosis:** Yes _______  **No:** _______.  **Treatment necessary?** _______

- **Mobility:** ______________  **Instability:** ______________  **Deformity:** ______________

- **Medications being taken by the student?** No _______  **Yes:** _______.  **If yes, please list:** ________________________________________________________________

- **Assessment of Physiologic Maturation:** ____________________________________________________________________________________

- **General condition of student:** ____________________________________________________________________________________________

- **Are there any health findings which might have an effect on the educational management of the student?** If yes, please explain: __________________________________________________________________________

- **In your opinion, is the student capable of carrying a full program in physical education, and field trips?** Yes _______  **No:** _______.  **Explain:** __________________________________________________________________________

- **Restrictions of Activity Recommended:** __________________________________________________________________________________

**Name of Healthcare Provider (please print)** ______________  **Signature of Healthcare Provider** ______________  **Telephone Number** ______________

**Address** ____________________________________________________________________________________________  **Date of Exam** ______________

Revised: 12/03, 4/04

file:NHSM Form 16

(over)
## HEALTH HISTORY
**(TO BE COMPLETED BY PARENT OR GUARDIAN)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has student ever been hospitalized or had surgery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a. Significant illness or injury in past year or less? (sprain, mononucleosis, etc.)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. Is student presently taking any medication? (daily or occasionally)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3. Does student have any severe allergies to (medicines, foods, or insects)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3a. Does student have an EpiPen for severe allergic reaction?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4. Has student ever passed out during or after exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has student ever been dizzy during exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has student ever had chest pain during or after exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has student ever had high blood pressure?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has student ever been told you had a heart murmur?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has student ever had racing of your heart or skipped beats?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Has anyone in your family died of heart problems or sudden death before the age of 50?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5. Does student have any skin problems under treatment (itching, rashes, acne)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6. Has student ever had a head injury or concussion?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7. Has student ever been dizzy or passed out in the heat?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>8. Does student have any problems with hearing loss?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9. Does student have trouble breathing during or after exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9a. Does student have asthma?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9b. Does student use asthma inhaler(s)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>10. Has student had any problems with eyes or vision?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>10a. Does student wear contact lenses or glasses during sports?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>11. Does student have any medical conditions (diabetes, seizure disorder, severe headaches, etc.)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>12. Has student ever fractured or dislocated any of the following?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Skull Neck Shoulder Arm Elbow Wrist Hand Thigh Leg Knee Ankle Foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Does student wear orthodontic braces or retainer?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>14. Explain any YES answers (include dates):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Parent/Guardian: _________________________  DATE: ________________

Revised: 12/03/04

file: NHSM Form 16
DENTAL HEALTH FORM

Dear Parent/Guardian:

An important part of your child's total well-being is the care of the teeth and prevention of decay. In order to promote positive dental health maintenance at an early age, we are asking you to have your family dentist complete the dental form below and return it to the school. This dental form then becomes an essential part of your child's school and health records.

The condition of a child's teeth often affects not only attendance at school but also performance including speech development, in school. Statistics demonstrate that many children have not achieved as well as their capabilities indicate because of discomfort and pain due to cavities and discomfort, pain and illness from teeth that are abscessed.

All parents are interested in the scholastic achievement, health and welfare of their children. In order to improve the dental health of the children of our township, especially those who will be entering kindergarten in September, you are urged to arrange for dental examination of your child's teeth by your family dentist without appreciable delay. The preventive measure of determining tooth defects and decay and obtaining early corrective treatment will help protect permanent teeth and assist in their proper development.

Following the dental examination, please ask your dentist to complete the attached form and return it to school as soon as possible.

Respectfully,

____________________________   ________________________  ______________________
School Nurse            School Phone

========================================================================

TO BE COMPLETED BY FAMILY DENTIST

I have examined _________________________________________  D.O.B. ______________

Please check one:  _____  Patient under treatment.

_____  Dental treatment completed.

_____  No treatment necessary.

Remarks:  _________________________________________________________________

__________________________________________________________________________

______________________________
Signature of Dentist

______________________________
Date