Public Schools of Edison Township

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

Richard O'Malley, Ed. D.
Superintendent of Schools

Richard Benedict
Manager

January, 2017

KINDERGARTEN 2017-2018 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 or online at www.edison.k12.nj.us/enrollment.) 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 special kindergarten pre-registration 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 completing 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 #16: 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
11/15

KINDERGARTEN REGISTRATION 2017-2018

Children **must** be 5 years of age **on or before October 1, 2017** to be eligible for Kindergarten

SCHOOL	REGISTRATION DATES
MENLO PARK	February 6 through Feb 10, 2017
WASHINGTON	February 13 through February 17
JAMES MADISON PRIMARY	February 21 through February 24
LINDENEAU	February 27 through March 3
BEN FRANKLIN	February 27 through March 3
LINCOLN	March 6 through March 10
JOHN MARSHALL	March 13 through March 17
WOODBROOK	March 20 through March 24
JAMES MONROE	March 27 through March 31
M L KING	March 27 through March 31

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 and click "Kindergarten registration packet 2017-2018" under site shortcuts on the left hand side of the page or you can pick up a Kindergarten registration packet at the Enrollment Center *beginning January 13, 2017*. 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.

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TELEPHONE (732) 452-4570 FAX (732) 452-4576
Monday through Friday 9:00 am - 3:00 pm

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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 with current address (Driver's License, Permanent Resident Card, 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

11/14
RB/kk

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STUDENT ENROLLMENT FORM: DATE: _____/ _____ / _____

Enrolled by: _____ Date: __/__/____ OFFICE USE ONLY (Rev. 11/16/16) ***Input By: _____ Date: __/__/____***

NEW ENROLLMENT: YES | NO **RE-ENROLLMENT:** YES | NO **CHANGE OF ADDRESS:** YES | NO

SSID# _____ LOCAL ID# _____ PCC CODE _____ FAMILY CODE _____

Affidavit of Residency: _____ Affidavit of Domicile: _____ Change of Custody: _____ Homeless: _____

Edison School: _____ Grade: _____ Previous School: _____ Grade: _____

Previous School Address _____ School Records Submitted: YES | NO

Custody Document Submitted: YES ____ NO ____ Basic Skills: ____ Speech: ____ ESL: ____

SPECIAL EDUCATION: YES | NO [**IEP Submitted:** YES | NO] **Copy sent to Special Services:** YES ___ NO ___

_____ **Does Qualify under McKinney-Vento Act** _____ **Does NOT Qualify under McKinney-Vento Act**

First Name_____Last Name _____

Middle Name _____Birthdate: _____ / _____ / _____ Gender: Male | Female
MM DD YYYY (Circle one)

Ethnicity

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ American Indian / Alaskan
- ☐ Asian
- ☐ Hawaiian native/other Pacific Islander

Birth City: _____

Birth State: _____

Birth Country: _____

U.S. Citizen: YES / NO - If no, citizen of _____
Country of origin

Original Entry in U.S.: ____ / ____ / _____ (MM DD YYYY)

First Entry in U.S. School: _____ / _____ / _____ (MM DD YYYY)

Student's Primary Language: _____ Home Language: _____

SPECIAL EDUCATION: YES | NO [**IEP Submitted:** YES | NO] **Basic Skills: ____ Speech: ____ ESL: ____**

Nothing Less Than Excellence

Student's Current Legal Home Address in Edison _____

_____ Apt#: _____
Street Address / Zip Code

Home Phone Number (_____) _____ - _____ Email: _____

Mother/Guardian 1 Mobile: (_____) _____ - _____ Father/Guardian 2 Mobile: (_____) _____ - _____

Parent/Legal Guardian Information (PLEASE PRINT CLEARLY)

Previous Legal Address: _____ Apt #: _____
Street Address /City/ Zip Code

CHECK HERE IF CURRENT ADDRESS IS THE SAME AS THE STUDENT ADDRESS: _____

Parent/Legal Guardian Information

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.

==========

Mother/Legal Guardian 1 Name _____ Relation to Student:_____

_____ Apt #: _____
Street Address / Zip Code

Home Phone Number (_____) _____ - _____ Mobile (_____) _____ - _____

Work Phone (_ _____) _____ - _____ Email: _____

Language Spoken: _____This parent/legal guardian has residential custody: ____ YES ____ NO

Father/Legal Guardian 2 Name _____ Relation to Student: _____

_____ Apt #: _____
Street Address / Zip Code

Home Phone Number (_____) _____ - _____ Mobile (_____) _____ - _____

Work Phone: (_____) _____ - _____ Email: _____

Language Spoken: _____This parent/legal guardian has residential custody: ____ YES ____ NO

Emergency Contact (NOT parent/legal guardian)

Name _____ Name _____

Relation to Student _____ Relation to Student _____

Phone Number (____) _____ - _____ Phone Number (____) _____ - _____

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

NAME	GENDER	BIRTHDATE	CURRENT SCHOOL	GRADE

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

HS FORM #16D

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

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 Infection	_____
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

8196, 5/98,6/99,3103,1/05

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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, 2017.

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, 2017.

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HS FORM #16

HEALTH CARE PROVIDER EXAMINATION (Grades Pre K-12, Excluding Sports or Intramurals)
RETURN TO THE SCHOOL NURSE

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: _____ BMI Percentile: _____ Blood Pressure: _____ Pulse: _____

Vision R: _____ L _____ Vision correction (glasses/contacts): _____
Hearing/Ears (tubes/hearing aides): _____
Skin and scalp: _____ Abdomen: _____
Rashes _____ Jaundice _____ Infection _____ Hepatomegaly _____ Splenomegaly _____ Mass _____
Head and neck: _____ Lymph nodes: _____
Nose and throat: _____ Teeth: _____
Extremities: _____ Inguinal area (hernia): _____
Mobility _____ Deformity _____ Joint Instability _____
Lungs: _____ Spine (scoliosis,etc.): _____
Neurological: _____ Reflexes Balance Coordination
Females: Normal Menstruation Males: Hernia: Testes Descended
Heart (any irregularity? If yes, please explain): Murmurs _____ Rhythm/Rate _____
Injuries, operations? Explain: _____
Chronic Illness Condition or Disease:

_____
Orthopedic defects: Yes _____ No _____ Accommodations 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, 8108, 9/10
file:NHSM Form 16

(over)

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08337

HEALTH HISTORY
(TO BE COMPLETED BY PARENT OR GUARDIAN)

Student's Name:_____ **Grade/Section:** _____ **School:** _____

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

14. Explain any YES answers (include dates): _____

_____

_____

_____

Signature of Parent/Guardian: _____ DATE:_____

Revised:12/03,4/04, 8/08
file: NHSM Form 16

PUBLIC SCHOOLS OF EDISON TOWNSHIPHS FORM #15
EDISON, NEW JERSEY 08837
HEALTH SERVICES

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 theft 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

SC:mpl
file:NHS form 15