WOODLAND TOWNSHIP BOARD OF EDUCATION
CHATSWORTH ELEMENTARY SCHOOL
2 John Bowker Jr. Blvd. - P.O. Box 477
Chatsworth, New Jersey 08019
Phone: (609) 726-1230 Fax: (609) 726-9037
www.woodlandboe.org

Misty Weiss – Superintendent
Carolyn Fischl – Supervisor
Laura Archer - Business Administrator

APPROVED PROOF OF RESIDENCY DOCUMENTATION

(4 Proofs Required)

The following forms of documentation may demonstrate a student's eligibility for enrollment in the district. Particular documentation necessary to demonstrate eligibility under specific provisions in law is indicated below.

MANDATORY – MUST PROVIDE AT LEAST ONE OF THE FOLLOWING:

- ☐ Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency.

Provide Three of the Following:

- ☐ Current voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location
- ☐ Court orders, State agency agreements and other evidence of court or agency placements or directives
- ☐ Receipts, bills, cancelled checks and other evidence of expenditures demonstrating personal attachment to a particular location, or, where applicable, to support of the student
- ☐ Medical reports, counselor or social worker assessments, employment documents, benefit statements and other evidence of circumstances demonstrating where applicable, family or economic hardship or temporary residency
- ☐ Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, legal guardian, person keeping an "affidavit student," adult student, person(s) with whom a family is living, or others as appropriate
- ☐ Documents pertaining to military status and assignment
- ☐ Any business record or document issued by a government entity
- ☐ Any other form of documentation relevant to demonstrating entitlement to attend school

The totality of information and documentation you offer will be considered in evaluating an application, and, unless expressly required by law, the student will not be denied enrollment based on your inability to provide certain form(s) of documentation where other acceptable evidence is presented.

You will not be asked for any information or document protected from disclosure by law, or pertaining to criteria which are not legitimate bases for determining eligibility to attend school. You may voluntarily disclose any documents or information you believe will help establish that the student meets the requirements of law for the entitlement to attend school in the district, but we may not, directly or indirectly, require or request:

- Income tax returns
- Documentation or information relating to citizenship or immigration/visa status, unless the student holds or is applying for an F-1 visa
- Documentation or information relating to compliance with local housing ordinances or conditions of tenancy
- Social Security numbers

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CHECK LIST OF ITEMS TO REGISTER YOUR STUDENT:

- ▫ Proof of residency
- ▫ A copy of your child's birth certificate
  (We can make a copy of the original if need be)
- ▫ Up to date physical form filled out by your doctor
  (Physical form is provided in this packet)
- ▫ Up to date immunization record
- ▫ Any special service, IEP or 504 related plans from prior schools
- ▫ Registration packed completed in full

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NEW STUDENT REGISTRATION FORM

Name of Child: _____ Date of Birth: _____

Male **OR** Female Grade: _____ Grade Entering: _____ Home Telephone Number: _____

Child's Home Address: _____

City and State of Birth: _____ Country of Birth: _____

Ethnic Code: _____ **1.** White **2.** Black **3.** Hispanic **4.** Amer. Indian/Alaskan **5.** Asian/Pacific Islander **6.** Hawaiian Native/Other Pacific Islander

FIRST (MAIN) CONTACT:

Name: _____ Relationship to Student: _____

Address (If Different from Child's): _____

Occupation & Employer: _____ Employer Phone Number: _____

Cell Phone Number: _____ E-Mail Address: _____

Home Phone Number: _____

Circle One: Active Military Connected/Not Active Military Connected

SECOND CONTACT:

Name: _____ Relationship to Student: _____

Address (If Different from Child's): _____

Occupation & Employer: _____ Employer Phone Number: _____

Cell Phone Number: _____ E-Mail Address: _____

Home Phone Number: _____

Circle One: Active Military Connected/Not Active Military Connected

Guardian's Information:

Name: _____ Relationship to Student: _____

Address (If Different from Child's): _____

Occupation & Employer: _____ Employer Phone Number: _____

Cell Phone Number: _____ E-Mail Address: _____

Home Phone Number: _____

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PARENT INFORMATION

Parents: Together / Separated / Divorced / Remarried / Single

Deceased: Father: _____ Mother: _____

Child Resides With: Father / Mother / Stepfather / Stepmother

If Other, Please Explain: _____

FAMILY INFORMATION

Please List Other Children in the Family:

1. Name: _____ DOB: _____ Place of Birth: _____
   Name of School & Grade Attending/Attended: _____

2. Name: _____ DOB: _____ Place of Birth: _____
   Name of School & Grade Attending/Attended: _____

3. Name: _____ DOB: _____ Place of Birth: _____
   Name of School & Grade Attending/Attended: _____

4. Name: _____ DOB: _____ Place of Birth: _____
   Name of School & Grade Attending/Attended: _____

What development do you live in?: _____

Do you own or rent your dwelling?: _____

If other, please explain: _____

Is another language besides English spoken in your home?: Yes or No
If yes, what language(s)? _____

Has your child ever received English as a Second Language services (ESL)? Yes or No
If yes, what grade(s)?: _____

Has your child participated in or been recommended for Gifted/Talented Program? Yes or No

Has your child ever repeated a grade? Yes or No

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FAMILY INFORMATION (CONTINUED)

Is your child currently receiving any specialized school program/related services or does your child have an IEP or 504 Plan?

Yes or No

(If yes, please fill out the following information)

Has your child participated in any of the following?:

Speech Therapy / Occupational Therapy / Physical Therapy

I hereby authorize the Woodland Township School District to investigate and confirm any and all statements made by me on this form. I am aware that if any statements contained on this registration form concerning residency are false, I may be assessed the tuition for the aforementioned child and prosecuted to the full extent of the law.

Parents Name: _____
(Please Print)

Parent's Signature: _____
(Please Sign in Ink)

Date: _____

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EMERGENCY CONTACT INFORMATION

In the event of illness or accident, if the parents cannot be reached, please notify the following persons in the order listed until someone is contacted. If the school is unable to reach me or the emergency contacts, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary. The individuals listed below also have my permission to pick-up my child/children from school.

1. NAME: _____ PHONE NUMBER: _____

Address: _____

_____
Relationship to Child

Are there any persons NOT permitted to pick up your child from school?

YES or NO

If yes, please explain: _____

_____

_____

_____

[If there is a court order in existence regarding custody, two copies are required.]

_____
Parent/Guardian Signature

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Does your child have Health Insurance?

Yes ____ If yes, List name of the Insurance Company _____

No ____ If no, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Sign below only if you agree to release your name and address to the NJ FamilyCare Program to contact you about health insurance.

Signature: _____ Printed Name: _____ Date: _____

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

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____

Physician's Name

_____

Physician's Address Physician's Phone Number

_____

Signature of Parent/Guardian Date

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PHYSICAL EXAMINATION FORM FOR NEW STUDENTS

(To Be Completed by Physician)

Child's Name: _____ Birthdate: _____

Immunizations

Please see attached for required immunizations AND also attach an updated copy of the child's immunization record.

Medical History

Allergies? Y or N	Diabetes? Y or N
Asthma? Y or N	Kidney Disorders? Y or N
Cardiac Disorders? Y or N	Neuromuscular Disorders? Y or N
Convulsive? Y or N	Injuries? Y or N
Congenital Defects? Y or N	Surgeries? Y or N

Comments: _____

_____

Physical Examination

[Fill in any abnormalities or check off if normal]

Ears:	Heart:	Posture:
Eyes:	Lungs:	Nervous System:
Nose:	Abdomen:	Nutrition:
Throat:	Hernia:	Speech:
Teeth:	Genito/Urinary:	
Glands:	Skin:	

Height: _____ Weight: _____ Male or Female

Blood Pressure: ____/____ (____/____) Vision: Right 20/____ Left 20/____ Hearing: _____

Is this child cleared for all school activities? (Including physical education): Y or N

If no, please explain: _____

General Overall Appearance: _____

Does this child regularly take medication?: _____

Comments or Recommendations:

_____

_____

Doctor's Signature: _____ **Date:** _____

Doctor's Office Stamp:

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IMMUNIZATION REQUIREMENTS

The following are required by the New Jersey Department of Health and the New Jersey Department of Education before your child may begin school in September. A health care provider's statement with the specific dates (month-day-year) each vaccine was given must be provided as evidence of immunization.

Student's immunizations records:

a. DPT - 4 doses - one dose to be administered after the 4th birthday
b. POLIOVIRUS VACCINE - 3 doses - one dose to be administered after the 4th birthday
c. MEASLES - 2 doses - first dose administered on or after the first birthday and the second dose administered no less than one month after the first
d. RUBELLA - 1 dose - administered on or after the first birthday
e. MUMPS - 1 dose - administered on or after the first birthday
f. HEPATITIS B VACCINE - 3 doses
g. VARICELLA - 1 dose

In addition to the above immunizations, Pre-School students (*up to 59 months of age*) are required to have the following:

a. HIB - 1 dose - administered on or after the first birthday
b. PCV - 1 dose - administered on or after the first birthday
c. INFLUENZA VACCINE - 1 dose administered annually between Sept. 1st and Dec. 31st of each year

Questions relating to immunization and physical examination requirements may be addressed to Ms. Huber, School Nurse, at 609-726-1230 ext. 204 or by email: mhuber@woodlandboe.org

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DEVELOPMENTAL/HEALTH HISTORY

Child's Name: _____ Date of Birth: _____ Grade: _____

Address: _____ Phone Number: _____

_____

Birth Information

1. Did mother have any illness during pregnancy? Y or N
2. Did you carry this child for a full nine months? Y or N
3. Did mother have any difficulty during delivery? Y or N
If yes, please explain:
_____
_____
4. Did child have any difficulty during or after delivery? Y or N
If yes, please explain:
_____
_____
5. Did you baby have any trouble starting to breath? Y or N
6. Did your child have any trouble in the hospital? Y or N
If yes, please explain:
_____
_____
7. What did the child weigh at birth?
____pounds _____ounces

Development

1. Could your child sit alone by age 7 months? Y or N
2. Could your child walk alone by age 1 ½? Y or N
3. Did your child say any words by age 1 ½? Y or N
4. Did your child talk in simple sentences by age 3? Y or N
5. Do others have difficulty understanding what your child is saying? Y or N
6. Does your child learn as quickly as your other children? Y or N
7. Does your child dress himself/herself completely? Y or N
Tie Shoes? Y or N Zippers? Y or N Buttons? Y or N
8. Does your child seem to understand directions? Y or N

Allergies

Has your child had:
1. Eczema or hives? Y or N
2. Wheezing or Asthma? Y or N
3. Allergies or reactions to any medicines or foods? Y or N
If yes, please explain:
_____
_____
4. Many colds, hay fever, or sinus trouble? Y or N

Family-Social History

1. Are both parents in good health? Y or N
2. Are there any family members with a serious health problem? Y or N
If yes, please explain:
_____
_____
_____
3. List brothers and sisters with birth dates:
1. _____ __/__/__
2. _____ __/__/__
3. _____ __/__/__
4. _____ __/__/__
5. _____ __/__/__
4. Does anyone help you take care of your child on a regular basis? Y or N
If yes, please explain:
_____
_____
5. Does Mother work outside of the home? Y or N
Full Time or Part Time

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Illness and Other Problems?

Has your child:

1. Had more than six colds or throat infections each year? Y or N
2. Had more than three ear infections? Y or N
3. Had any trouble hearing? Y or N

If yes, please explain:

_____

_____

4. Had his/her hearing tested? Y or N
5. Had any trouble seeing? Y or N
6. Had his/her eyes tested? Y or N

When?: _____

7. Had any trouble with his/her teeth? Y or N
8. Had any trouble passing his/her urine? Y or N
9. Does he/she wet the bed? Y or N
10. Had a convulsion/fit or fainting spell? Y or N
11. Had a high fever? Y or N
12. Circle any of the following diseases that your child has had:

Chicken Pox Scarlet Fever Pneumonia
Bronchitis Frequent Strep Infections

If any others, please explain:

_____

_____

13. Had to stay in a hospital overnight? Y or N

If yes: Age _____ Hospital _____

Reason for Visit/Stay:

_____

_____

14. Had an operation? Y or N

If yes, please explain:

_____

_____

15. Been on medication other than antibiotics, decongestants, or vitamins? Y or N

Names of Medication:

_____

_____

_____

Accidents

Please circle any serious accidents your child has had:

Burns Poisoning
Cuts (needing a doctor's attention) Broken Bones

If any others, please explain:

_____

_____

_____

Behavior Discipline

Do you have any special concerns about your child? Y or N

If yes, Please Explain:

_____

_____

_____

_____

_____

I understand that pertinent health information about my child may be shared with appropriate staff members to insure my child's welfare at school.

This form has been completed by:

_____

Print Name

_____

Sign Name

_____

Relatonship to Child

_____

Date

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AUTHORIZATION FOR THE RELEASE OF RECORDS

In accordance with the provisions of the Family Education Rights and Privacy Act of 1974, and N.J.A.C. 6:3-2.1 et al.

I, _____ do authorize the transfer of all school records (to include Child
(Parent/Guardian's Name)

Study Team records if applicable) of: _____ to Woodland Township
(Student's Name)

School District, Chatsworth Elementary School, Chatsworth, NJ from: _____
(Name of School)

Please List Address of Previous School:

_____

_____

_____

I hereby attest that I have legal authority to request release of these forms.

_____
Parent/Guardian Signature Date

_____
School Witness

Student Residency Questionnaire

NOTE: PLEASE REMOVE ALL INFORMATION IN THIS BOX BEFORE USING THIS FORM; UPDATE THIS FORM TO REFLECT THE NEEDS AND SPECIFICS PERTAINING TO YOUR DISTRICT. This form is an example of what most districts in Texas have found useful to include in their student enrollment packets to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. This form is adapted from one developed by Cypress Fairbanks ISD.

Name of School _____

Name of Student: _____ Sex: ☐ Male ☐ Female
Last First Middle

Birth Date ____/____/____ Age: _____ Social Security #: _____
Month / Day / Year *(or student identification number)*

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?

_____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (*Check one box.*)

- ☐ In a motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accomodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) _____

Address_____ Zip _____ Phone_____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian_____ Date_____

Please send a copy to _____ **at the Central Office.**
Fax: xxx-xxx-xxxx

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature