GARWOOD PUBLIC SCHOOL

www.garwoodschools.org

- An **original** and a copy of child's birth certificate and current immunization records are required for registration.

- The following are required proofs which may be used to establish residency and/or domicile in Garwood:
  1. Mortgage, lease or rental agreement with Garwood address; **AND**
  2. Two or more of the following:
     a) Utility bill in your name with a Garwood address
     b) Credit card bill in your name at a Garwood address
     c) Voter Registration Card in your name with a Garwood address
     d) Driver's License in your name with a Garwood address
     e) Vehicle Registration in your name with a Garwood address
     f) Bank Account in your name with a Garwood address
     g) Federal or State Income Tax Returns indicating domicile in Garwood
     h) Child Custody Order placing the child with a Garwood resident

  You will NOT be asked for any information or documents protected from disclosure by law, or pertaining to criteria that are not legitimate bases for determining eligibility to attend school.
  If living in a residency where there is no established rental agreement, i.e., living with a relative or under an oral lease,
  - the most recent tax bill and notarized letter of domicile from the person whose name appears on the tax bill; or
  - a notarized statement from your landlord indicating his/her name, address & telephone number and affirming that you live at the Garwood address on a month-to-month basis under an oral lease.

  The Garwood Board of Education reserves the right to make a bona fide request for additional and/or alternative documentation of residency on a case by case basis.

- Proof of Immunization (most recent record) as per NJ State Administrative Code 8:57-4
  Diphtheria, Pertussis and Tetanus vaccine (DPT Series) – 4 doses with 1 dose given on or after the fourth birthday, or any total of 5 doses.
  Poliomyelitis vaccine – 3 doses of oral poliovirus vaccine (OPV) or enhanced inactivated polio vaccine (IPV), with 1 dose given on or after the fourth birthday, or any 4 doses spaced by a minimum of 1 month.
  Rubeola (Measles) vaccine – 2 doses given on or after the first birthday separated by at least a month, or laboratory documentation of immunity.
  Rubella (German Measles) vaccine – 1 dose given on or after the first birthday or laboratory documentation of immunity.
  Mumps vaccine – 1 dose given on or after the first birthday, or laboratory documentation of immunity.
  Hepatitis B vaccine – 3 doses or laboratory documentation of immunity.
  Varicella vaccine - one dose of varicella vaccine on or after the first birthday or proof of disease or immunity is required for children 19 months of age or older who attend a child care center, or are entering Kindergarten or Grade 1.

Please note: State law will not permit any child to be admitted to a public school unless immunizations have been completed and documented by an M.D., D.O., or Nurse Practitioner, specifically indicating a day, month and year administered.

- 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.

PUPIL REGISTRATION FORM

REGISTRATION DATE_____
START DATE _____
GRADUATION YEAR _____
GRADE _____

GARWOOD PUBLIC SCHOOLS
GARWOOD, NEW JERSEY 07027

Pupil's Name: _____

Pupil's DOB: _____/_____/_____ Verified: _____BC _____Passport/Visa _____Other

Birth city/state/country:_____

Pupil's address/telephone: _____ _____
(number and street) (home phone)

cell phone _____ e-mail address _____

Residency proof: See attached list _____

School pupil last attended: _____

Address: _____

PARENT/GUARDIAN INFORMATION

Name of parent/guardian:
Mother _____
Highest level of education: _____
Occupation: _____
Business address: _____
Business telephone: _____
Father _____
Highest level of education: _____
Occupation: _____
Business address: _____
Business telephone: _____
Pupil's brothers (names, DOB): _____
Pupil's sisters (names, DOB): _____

ETHNIC GROUP (please circle appropriate box):

White Non-Hispanic	Black Non-Hispanic	Hispanic	American Indian	Asian	Hawaiian native/other Pacific Islander
02-M 03-F	04-M 05-F	06-M 07-F	08-M 09-F	10-M 11-F	12-M 13-F

Language spoken in home: _____ Native language: _____

Marital Status of Parents:

_____Married/living together _____Separated _____Divorced _____Widowed _____Remarried

Has the child been receiving Special Services? Please check appropriate box(es):

____Speech/Language _____OT _____PT _____Other

Is there an IEP in place? _____ Yes _____No

Other information:_____

CUSTODY: Is there an issue of child custody (court decree or other)?

_____ yes If yes, state the custodial parent _____
_____ no

If your answer above was "yes", please fill in the information below:

Court decree: Have you brought the original court decree to the main office this school year so that the school may photocopy it to place in the pupil's folder _____ yes _____ no

Affidavit: If child has been given informal custody to a responsible adult, perhaps due to illness or domestic issue, you should have filed an affidavit to that effect this school year so that it may be placed in the pupil's folder. Is this applicable? _____ yes _____ no

In the absence of one of the above forms, either parent will have the right to receive school correspondence regarding the child, to pick up the child, and to authorize emergency actions.

I hereby grant permission to the school district regarding my child in the following areas:

1. to exchange student information with the student's high school district prior to and after graduation;
2. to participate in school screenings performed by the School Nurse;
3. to have my child appear in school publicity items including press releases, school website, photographs, and videotaping.

I AFFIRM THAT TO THE BEST OF MY KNOWLEDGE ALL INFORMATION CONTAINED ABOVE IS ACCURATE. I AM AWARE THAT DELIBERATELY FALSIFYING A PUBLIC DOCUMENT MAKES ME LIABLE FOR PROSECUTION (cf. N.J.S. 2 C:24-4 and N.J.S. 2 C:20-8). I FURTHER UNDERSTAND THAT MY CHILD'S REGISTRATION WILL NOT BE AUTHORIZED UNTIL I RETURN THE COMPLETED PUPIL MEDICAL FORM. I AUTHORIZE THE GARWOOD PUBLIC SCHOOLS TO TAKE PRUDENT ACTION IN AN EMERGENCY. MY SIGNATURE ALSO VERIFIES THAT I HAVE RECEIVED THE PUPIL/PARENT HANDBOOK, REVIEWED IT WITH MY CHILD AND WILL SEE THAT THE GUIDELINES ARE FOLLOWED.

_____ _____

Signature of parent/guardian Date

Reviewed by Building Principal _____ _____
Signature Date

Revised: 01/25/2017

Comments:_____
_____

NEW STUDENT HEALTH AND PHYSICAL EXAM FORM

HEALTH HISTORY (to be filled out by PARENT/GUARDIAN)

Student's Name: _____ Birth Date: _____ Sex ____M ____F

Grade: _____ Languages Spoken at home: _____

Parent / Guardian Name: _____

HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

_____
_____
_____
_____
_____

Operations or Serious Hospitalizations:

_____
_____
_____

Current Medications (Name, Dose, Frequency and Reason used):

_____
_____
_____

Allergies: (Name, reaction to exposure)

Drug: _____
Food: _____
Environmental: _____

Any Other Additional comments or information that you would like to provide:

_____
_____
_____

Student's Name: _____ Exam Date: _____

PHYSICAL EXAM

Height:	**Weight:**	**Pulse:**	**B/P:**
Vision:	**Uncorrected**	**Right:**	**Left:**
Vision:	**Corrected**	**Right:**	**Left:**
Hearing Screen:		Right:	Left:

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

_____
_____
_____

Any Limitation of Activity or other Recommendations? □ No □ Yes (Please define):

_____
_____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: _____ Date: _____
Name and Address Stamp:

GARWOOD PUBLIC SCHOOLS
Garwood New Jersey 07027

Pupil Medical Form for Entering Garwood Schools

Name :_____ Date of Birth: _____

Address: _____

Current Immunizations: Mandated by New Jersey State Law and/or required by the Garwood Board of Education. Please provide written documentation on separate paper.

Has your child had any known developmental delays? _____

Has your child ever had a learning disability? _____

Is there a family history of a learning disability? _____

HEALTH HISTORY

Familial Diseases (indicate relationship):

Heart Disease _____

Diabetes _____

Asthma, Allergies _____

Mental Illness _____

Metabolic/Chemical Dependence _____

Other _____

Parent Signature: _____ Date: _____

Garwood Public School
Emergency Notification Sheet

In the event of an emergency, the Garwood Public Schools need to have the following information for each student. Please fill out as thoroughly as possible. **Emergency calls will be made in the order these names are listed unless otherwise stated.**

Child's Last Name: _____ Child's First Name: _____ Primary Phone#_____
e-mail address _____

Mother or female guardian _____ (Last name) _____ (First) _____ (Employer/place of work) _____ (Work phone-extension) _____ (cell phone)

Father or male guardian _____ (Last name) _____ (First) _____ (Employer/place of work) _____ (Work phone-extension) _____ (cell phone)

Names and relationship of 2 other adults if the above cannot be contacted for illness or emergency

_____ (Last Name/Relationship) _____ (First) _____ (Phone)

_____ (Last Name/Relationship) _____ (First) _____ (Phone)

Does child have Health Insurance?
Yes _____ If yes, name of insurance company _____
No _____ NJ Family Care 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 Family Care Program to contact me about health insurance. Written consent required pursuant to 20 U.S.C. 1232g(b)(1) and 34 C.F.R. 99.30(b).
Signature: _____ Printed Name _____ Date:_____

Family Doctor _____ (Name) _____ (Phone) Dentist _____ (Name) _____ (Phone)

Wears eyeglasses: ___yes ___no Wears contact lenses ___yes ___no

Allergies/medication needs/medical restrictions_____

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.
AUTHORIZATION IS GRANTED FOR THE GARWOOD PUBLIC SCHOOLS TO TAKE PRUDENT ACTION IN AN EMERGENCY.
Our Pupil/Parent Handbook is on the school website, www.garwoodschools.org. If you would like a hard copy, please let the office know. My signature below verifies that I have reviewed the Pupil/Parent Handbook with my child and will see that the guidelines are followed.

Parent/guardian signature_____ Date_____