



## Cedar Grove Public Schools

Michael J. Fetherman, Superintendent

520 Pompton Ave. Cedar Grove, New Jersey 07009

(973) 239-1550 [www.cedargrove.k12.nj.us](http://www.cedargrove.k12.nj.us)

### **PRIOR TO ENTERING CEDAR GROVE HIGH SCHOOL, THE FOLLOWING CONDITIONS MUST BE SATISFIED:**

Transfer student must be signed out of previous school with the following:

- Birth Certificate
- Transfer Card
- Copy of Transcript
- Copy of Schedule
- Copy of Report Card
- Immunization (A-45) Health Records (copy is acceptable)

The following residency documents are required for registration:

- Homeowners - one of the following from List A and any three (3) from List B:

List A

- Current mortgage statement
- Property tax bill
- Deed

List B (All bills must be current)

- Phone bill
- Cable bill
- Electricity bill
- Water bill
- Insurance bill
- Bank account statement
- Credit card statement

- Renters - both of the following and any three (3) from List B above:

- Lease
- Landlord affidavit

Thank you for your anticipated cooperation. Please contact the Registration Office at (973) 239-1550 x 6200 if you have any questions.

Cedar Grove Public Schools  
 Administrative Office  
 520 Pompton Ave.  
 Cedar Grove, NJ 07009  
 973-239-1550  
[www.cedargrove.k12.nj.us](http://www.cedargrove.k12.nj.us)

Student Registration Information

Name of Student \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ SID # \_\_\_\_\_

Address \_\_\_\_\_ Home Telephone # \_\_\_\_\_

Fathers Name	Occupation	Work Telephone #
Fathers address if different from above		Fathers Cell #
Mothers Name	Occupation	Work Telephone #
Mothers address if different from above		Mothers Cell #
E-mail address (This is the primary e-mail contact)		

Country of Birth	City and State of birth
Born outside the U.S.	Country of Citizenship
Date of entry to U.S.	

What is the primary language spoken at home: \_\_\_\_\_ Is student proficient in English \_\_\_\_\_

Is the student proficient in any language other than English \_\_\_\_\_

Race: White \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian Pacific Islander or Native Hawaiian \_\_\_\_\_

American Indian/Alaskan \_\_\_\_\_ Other \_\_\_\_\_ (Please specify) \_\_\_\_\_

Please check all that apply:

- \_\_\_\_\_ I am the natural parent
- \_\_\_\_\_ The student being registered is living with both natural parents
- \_\_\_\_\_ The student is residing with natural mother or father (please circle one)
- \_\_\_\_\_ Mother/Father has: \_\_\_sole legal custody\* \_\_\_ joint legal custody\* \_\_\_joint physical custody\*  
(circle one)
- \_\_\_\_\_ I am the step-parent          \_\_\_\_\_ I am the legal guardian\*

**\*A copy of the legal document is required for the student's file**

Educational History

Last School Attended: \_\_\_\_\_

Address: \_\_\_\_\_

Dates Attended: \_\_\_\_\_

Does your child have an IEP (Individual Educational Plan) \_\_\_\_\_

504 Plan \_\_\_\_\_          ISP (Individual Support Plan) \_\_\_\_\_

Has your child received any of the following services? (please circle)

BSI(comp. ed)          ESL classes          Bilingual classes

Related Services: Speech    Occupational Therapy    Physical Therapy

\_\_\_\_\_  
Signature of person registering student

\_\_\_\_\_  
Date

(Office use only)

The following was received at time of registration:

Birth Certificate \_\_\_\_\_          Passport \_\_\_\_\_          F1 Visa \_\_\_\_\_

**Primary Proof of Residency:**

Deed \_\_\_\_\_    Tax bill \_\_\_\_\_    Lease agreement \_\_\_\_\_    Mortgage statement \_\_\_\_\_

**Secondary Proof of Residency:**    Current Bill or Statement \_\_\_\_\_

**ALL proof must be in the name of person registering student and must be current. No Exceptions.**

\_\_\_\_\_ Staff member that received documentation

FOR RENTERS ONLY

CEDAR GROVE SCHOOL DISTRICT  
LANDLORD AFFIDAVIT

STATE OF NEW JERSEY :  
  :      SS  
COUNTY OF \_\_\_\_\_ :

I, \_\_\_\_\_ do swear under oath to the following:

1. (Check A or B below)

(A) I am the owner of the dwelling unit located at \_\_\_\_\_  
(street and/or apartment unit address)

Cedar Grove, Essex County, New Jersey.

(B) I am \_\_\_\_\_ of \_\_\_\_\_  
(name of landlord corporation/partnership)

the owner of the dwelling unit located at \_\_\_\_\_  
(street and/or apartment unit address)

Cedar Grove, Essex County, New Jersey.

2. \_\_\_\_\_ is a tenant residing in the dwelling unit under an  
(name of tenant)

unwritten lease.

3. I am making this Affidavit in connection with the Tenant's claim that

\_\_\_\_\_ is residing with him/her in the dwelling unit and  
(name of student)

that this student is entitled to a free public education in the Cedar Grove School District.

4. I understand that the Cedar Grove School District will rely upon the statements contained herein to permit the aforementioned student to attend school in the Cedar Grove School District.

5. I certify that the statements contained in this affidavit are true, accurate, and complete. I am aware that if any of the foregoing statements are willfully false, I may be liable for criminal and/or civil penalties.

Sworn to and subscribed :  
before me this \_\_\_\_\_ day :  
of \_\_\_\_\_, 20\_\_\_\_ :

\_\_\_\_\_  
Signature of Person Attesting

\_\_\_\_\_  
Notary Public of the State of New Jersey

# Emergency Information Verification Form

Please sign as indicated. Also, please fill in any missing information and make corrections where necessary.

Current School:		Grade:	Homeroom:
Student's Name:		DOB:	Sex:
Residence:	Student Cell:	Mailing Address if different than residence:	
	Student Email:	Court Orders/Legal Restrictions:	
Please include company name for Work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used in the event that we cannot reach at the other numbers listed. The Primary or Home Number will also be used for attendance auto-dialer.			
Guardian:		Primary #:	E-Mail:
Home:	Cell:	Work: x	Work Cell:
Guardian:		Primary #:	E-Mail:
Home:	Cell:	Work: x	Work Cell:
Emergency 1:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:
Emergency 2:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:
Emergency 3:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:

<p><b>Health Information:</b></p> <p>Medical alerts/allergies          Does your child require a EpiPen?          If yes please provide doctors' orders and EpiPen.          Does your child have asthma?          If yes please provide asthma action plan.          Receives daily medication during school hours (Y/N)          Wears glasses and/or contact lenses (Y/N):</p>	<p>This student's health information may be shared with pertinent school staff if necessary to maintain well being and safety.</p> <p>Parent/Guardian will call the school if student will be absent or late.</p> <p style="text-align: right;">             _____  <b>Signature</b> <span style="margin-left: 100px;"><b>Date</b></span> </p>
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**Health care provider information (for emergency treatment when we are unable to contact you):**

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

Please sign here to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency.

\_\_\_\_\_

**Signature** **Date**

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

**NO** My child does not have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me 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).*

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online or call 1-800-701-0710.

**YES** My child has health insurance. If yes, what is the name of the Insurance Company?

Residence:	Student ID:
	Date Filed:
	Initials:

CEDAR GROVE PUBLIC SCHOOLS  
520 Pompton Avenue  
Cedar Grove, NJ 07009  
[www.cedargrove.k12.nj.us](http://www.cedargrove.k12.nj.us)

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL STUDENT INFORMATION**

Student's Name \_\_\_\_\_

Current Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

To: (name of agency or individual) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone/Fax: \_\_\_\_\_

Please release to the Cedar Grove School district the following information

- |  |  |
|--|--|
| <input type="checkbox"/> Permanent File  | <input type="checkbox"/> Standardized Test Results |
| <input type="checkbox"/> Transfer Card   | <input type="checkbox"/> Teachers Grades           |
| <input type="checkbox"/> Educational Records   | <input type="checkbox"/> Health Records            |
| <input type="checkbox"/> Special Education Records (all child study team records including medical requests) |  |

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please send all of the above records to the school circled below

North End School  
122 Stevens Avenue  
Cedar Grove, NJ 07009  
973-256-1454

South End School  
116 Harper Terrace  
Cedar Grove, NJ 07009  
973-239-2116

Memorial Middle School  
500 Ridge Road  
Cedar Grove, NJ 07009  
973-239-2646

Cedar Grove High School  
90 Rugby Road  
Cedar Grove, NJ 07009  
973-239-6400

Cedar Grove Public Schools  
Department of Special Services  
520 Pompton Avenue  
Cedar Grove, NJ 07009  
973-239-1550

## NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION TRANSFER FORM

THE UNDERSIGNED HEREBY CERTIFY THAT THE STUDENT NAMED HEREIN HAS TRANSFERRED TO HIS/HER PRESENT SCHOOL OF ENROLLMENT WITHOUT INDUCEMENT OR RECRUITMENT OR TO SEEK AN ATHLETIC ADVANTAGE. THE PARENTS/GUARDIANS ALSO AGREE TO THE SUBMISSION TO THE NJSIAA OF ANY PERTINENT RECORDS, INCLUDING TRANSCRIPTS, MAINTAINED BY THE SCHOOLS. REFUSAL TO SIGN THE TRANSFER FORM **MAY NOT** BE BASED UPON NONPAYMENT OF FEES, FAILURE TO RETURN SCHOOL PROPERTY AND THE LIKE. **THE TRANSFER FORM IS NECESSARY FOR STUDENTS WHO ARE RESIDING WITH THEIR PARENTS WHO HAVE MOVED TO THE UNITED STATES OR WHO HAVE MOVED FROM ONE SECONDARY SCHOOL DISTRICT TO ANOTHER SECONDARY SCHOOL DISTRICT.**

**STEP 1 – TO BE COMPLETED BY PRESENT SCHOOL AND FORWARDED TO PREVIOUS SCHOOL (PLEASE PRINT LEGIBLY)**

Name of **Present School**: \_\_\_\_\_ City: \_\_\_\_\_  Check if Choice School?

Student's Name: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_

Date of Enrollment at Present School (If enrollment occurs after the beginning of the school year, Month, Day, Year, student first attended class: \_\_\_\_\_)

Principal's Name: \_\_\_\_\_ Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athletic Director's Name: \_\_\_\_\_ Athletic Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian **PRESENT** complete Address: \_\_\_\_\_

**STEP 2 – TO BE COMPLETED BY PREVIOUS SCHOOL IMMEDIATELY AND RETURNED TO PRESENT SCHOOL**

Name of **Previous School**: \_\_\_\_\_ City: \_\_\_\_\_

Date of Withdrawal: \_\_\_\_\_ Student first entered 9<sup>th</sup> grade/school: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian **PREVIOUS** Address: \_\_\_\_\_

A. List all sports in which the student participated on a varsity level in a sports season during the calendar year prior to the transfer:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

*Student is ineligible for thirty (30) calendar days from the start of the Present School's regular schedule for each sport listed above.*

B. Has the student participated in a 9-12 program while in the 6, 7, 8<sup>th</sup> grade? \_\_\_\_\_ Yes \_\_\_\_\_ No (See Bylaws, Art.V, Sec.4.I)

ATTENTION: If the student is from a high school in a foreign country which does not sponsor interscholastic athletics, the adult(s) with whom the student is domiciled must attach a summary of the sports in which the student participated in a non-school community and/or national team/program for participants 14 years old or above. Said participation will be evaluated in "non-school" play to determine varsity status.

Check box if there is evidence that the student transferred for athletic advantage

Check box if there is evidence that the student was recruited.

**IF EITHER BOX IS CHECKED, WRITTEN EVIDENCE OF SUCH MUST BE SENT DIRECTLY TO NJSIAA FOR REVIEW.**

(If either of the two boxes is checked, or the form is not signed by the Principal and/or Athletic Director of the previous school, the transfer student is not eligible for regular season interscholastic competition until a hearing is held by NJSIAA.)

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athletic Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If unsigned, please state reason(s): \_\_\_\_\_

**PLEASE FORWARD ALL FORMS/DOCUMENTS TO LARRY WHITE AT THE NJSIAA OFFICE:**

**lwhite@NJSIAA.org OR Fax to: 609-259-3047 OR Mail to: P. O. Box 487, Robbinsville, NJ 08691**

CEDAR GROVE PUBLIC SCHOOLS PHYSICAL EXAMINATION

DATE OF EXAM: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M F GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CEDAR GROVE, NJ 07009

HISTORY OF ILLNESS AND/OR SURGERIES: \_\_\_\_\_

VISION R 20/ L 20/ CORRECTED: YES NO GLASSES: YES NO CONTACTS: YES NO HEARING: R L

HEIGHT: \_\_\_\_\_ % WEIGHT: \_\_\_\_\_ % BP: \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_ BPM

ALLERGIES: \_\_\_\_\_

ALLERGY CARE PLAN ATTACHED: YES NO

ASTHMA: \_\_\_\_\_ ASTHMA TREATMENT PLAN ATTACHED: YES NO

EARS: \_\_\_\_\_ EYES: \_\_\_\_\_ LYMPH GLANDS: \_\_\_\_\_

THYROID: \_\_\_\_\_ NOSE: \_\_\_\_\_ THROAT: \_\_\_\_\_

TEETH: \_\_\_\_\_ MOUTH: \_\_\_\_\_ GENITO-URINARY: \_\_\_\_\_

HEART: \_\_\_\_\_ MURMUR: YES NO LUNGS: \_\_\_\_\_

ABDOMEN: \_\_\_\_\_ HERNIA: YES NO

ORTHOPEDIC: STRUCTURAL: \_\_\_\_\_ POSTURE: \_\_\_\_\_ FEET: \_\_\_\_\_ SCOLIOSIS: \_\_\_\_\_

SKIN: \_\_\_\_\_ NUTRITION: \_\_\_\_\_ NERVOUS SYSTEM: \_\_\_\_\_

SPEECH: \_\_\_\_\_ GENERAL APPEARANCE: \_\_\_\_\_

PSYCHO-SOCIAL CONCERNS: \_\_\_\_\_

WHAT IF ANY RESTRICTIONS ARE NECESSARY FOR FULL PARTICIPATION? \_\_\_\_\_

IS THE CHILD RECEIVING MEDICATION? \_\_\_\_\_ OTHER THERAPY: \_\_\_\_\_

IF YES, WHAT ARE THE SIDE EFFECTS WITH REGARD TO HIS/HER ACADEMIC PROGRESS? \_\_\_\_\_

HEALTH CARE PROVIDER'S NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

IMMUNIZATIONS:

DTP/DTaP/Td	POLIO	MMR	HEPATITIS B	HIB	PREVNAR	VARICELLA
1 _____	1 _____	1 _____	1 _____	1 _____	1 _____	1 _____
2 _____	2 _____	2 _____	2 _____	2 _____	2 _____	2 _____
3 _____	3 _____	3 _____	3 _____	3 _____	3 _____	3 _____
4 _____	4 _____		4 _____	4 _____	4 _____	
5 _____	5 _____				5 _____	

Tdap	MENINGOCOCCAL	HEPATITIS A	ADDITIONAL IMMUNIZATIONS:
1 _____	1 _____	1 _____	_____
2 _____		2 _____	_____

MANTOUX: PLANTED \_\_\_\_\_ READ \_\_\_\_\_ RESULT \_\_\_\_\_ BLOOD LEAD LEVEL: \_\_\_\_\_