Cedar Grove Public Schools

Michael J. Fetherman, Superintendent

520 Pompton Ave. Cedar Grove, New Jersey 07009
(973) 239-1550 www.cedargrove.k12.nj.us

Welcome to the Cedar Grove School District! In order to register your child, we ask that you complete the following paperwork. In doing so, we will work as a team to ensure your child has a safe and nurturing experience in our school system.

Birth Certificate

You must present the original birth certificate at the time of registration.

Health Forms

The following health information is necessary for registration:

1. **Student Health History** (enclosed) – This form is to be completed by the parent/guardian, returned and reviewed with the School Nurse.
2. **Immunization Record** (enclosed) – A copy of the current immunization record signed by the physician. The following immunizations are required by the State of New Jersey for all children entering kindergarten:
   A. DTaP – Four doses, with one dose given on or after the 4th birthday OR any 5 doses.
   B. POLIO – Three doses, with one dose given after the 4th birthday OR any 4 doses.
   C. MEASLES – Two doses of a live Measles-containing vaccine given on or after the first birthday. Intervals between the first and second measles/MMR/MR doses cannot be less than one month. Laboratory evidence of immunity is also acceptable.
   D. RUBELLA AND MUMPS – One dose of live Rubella-containing vaccine and one dose of live Mumps-containing vaccine given on or after the first birthday. Laboratory evidence of immunity is also acceptable.
   E. VARICELLA (Chicken Pox) – One dose given on or after the first birthday. Laboratory evidence of immunity or physician's statement of previous varicella disease is also acceptable.
   F. HEPATITIS B – Three-dose vaccine series given.
3. **Physical Examination** (enclosed) – Each child entering kindergarten must have a physical examination **within 365 days of the first day of school**. If your child is scheduled for an examination in the upcoming months before September, please hold onto the physical examination form, have it completed at that time, and then return it to the School Nurse.

Proof of Residency

Parents/guardians must supply proof of residency in Cedar Grove (see Registration Form for appropriate documents).

Registration Form

The Registration Form is for use by the school office. Please have it completed for registration purposes.

Please remember that all requirements outlined in this letter must be met before your child can be registered. Contact the Registration Office at (973) 239-1550 x 6200 if you have any questions.

Cedar Grove Public Schools

Michael J. Fetherman, Superintendent
520 Pompton Ave. Cedar Grove, New Jersey 07009
(973) 239-1550 www.cedargrove.k12.nj.us

The following residency documents are required for registration:

One from group A

Homeowners

- Current mortgage statement
- Property tax bill
- Deed

Renters (require both)

- Lease
- Landlord affidavit

Three from group B (all bills must be current)

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

Cedar Grove Public Schools
Administrative Office
520 Pompton Ave.
Cedar Grove, NJ 07009
973-239-1550
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. Date of entry to U.S.	Country of Citizenship

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

Is the student proficient is any language other than English _____

Race: White _____ Black _____ Hispanic _____ AsianPacific 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 <u>both</u> 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*

<u>*A copy of the legal document is required for the student's file</u>

<u>Educational History</u>

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 _____ F1Visa _____

<u>Primary Proof of Residency:</u>

Deed _____ Tax bill _____ Lease agreement _____ Mortgage statement _____

<u>Secondary Proof of Residency</u>: Current Bill or Statement _____

<u>ALL proof must be in the name of person registering student and must be current. No Exceptions.</u>

_____ Staff member that received documentation

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:

Health Information:

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):

This student's health information may be shared with pertinent school staff if necessary to maintain well being and safety.

Parent/Guardian will call the school if student will be absent or late.

Signature **Date**

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 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: Intials:

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 aforenamed 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

CEDAR GROVE PUBLIC SCHOOLS
DEPARTMENT OF STUDENT SERVICES
520 Pompton Avenue
Cedar Grove, New Jersey 07009
www.cedargrove.k12.nj.us

Christopher Kinney
Director of Special Services

Telephone:(973)239-1550
Fax: (973)239-8606

Pre-School Only

Dear Parents/Guardians

Your child is attending pre-school in Cedar Grove. Children may have accidents or a physical condition that may require the staff to change their diaper or incontinence product. The staff may also need to assist your child in changing his or her clothing. We are therefore requesting that you sign the statement below.

I hereby authorize the school nurse or teacher of my child_____ to physically change my child's diaper or assist him/her in changing into clean clothing when necessary.

_____

Parent/Guardian Signature Date

Pre-School Only

Cedar Grove Public Schools

Health Services

Dear Parents/Guardians,

The New Jersey Department of Health and Senior Services requires that every child six months through 59 months of age attending any licensed preschool facility shall annually receive at least one dose of influenza vaccine between September 1st and December 31st of each year.

Children who have not received the flu vaccine by December 31st of this year must be excluded from school for the duration of the influenza season (through March 31) or until they receive at least one dose of the influenza vaccine.

Please contact your physician as soon as possible to schedule an appointment so that your child is properly immunized.

Must be Completed by Physician:

Student Name:_____

Date of Birth_____

Received Flu Vaccine On:_____

Physician Signature: _____

Physician Address:_____

Physician Phone Number:_____

CEDAR GROVE PUBLIC SCHOOLS
STUDENT HEALTH HISTORY
To Be Completed by the Parent—Return and Review with the School Nurse

NAME_____ **DOB**_____ **DATE**_____

Address_____ **Phone Contact**_____

Father's Name_____ **Mother's Name**_____

BIRTH HISTORY:

Uncomplicated: _____ **Complicated:** _____

Birthweight: _____**lbs.**_____**oz.**

Age Walked Alone: _____ **Age Said Few Words**_____

Siblings: Age_____ **M/F Age**_____**M/F Age**_____ **M/F Age**_____ **M/F**

PARENT/SIBLING HISTORY:

Are there any significant health concerns we should be aware of?

Father_____

Mother_____

Sibling(s) _____

STUDENT ALLERGY HISTORY: **Reaction to Allergen**

Food_____ _____

Environmental_____ _____

Insect Stings_____ _____

Latex_____ _____

Medications_____ _____

MEDICATIONS:

Does your child take any medication, or need an EpiPen for allergic reactions?

Daily Medication_____

PRN (as needed) Medication_____

EpiPen(Adult)_____ **EpiPen Jr.**_____ **Last Time Epi-Pen Used?**_____

INJURIES/OPERATIONS:

Fractures_____ **Surgery**_____

Head Injuries_____ **Sutures**_____

Has your child ever visited the Emergency Room? Yes___ **No**___ **How often?** _____

If yes, please explain_____

Other_____

ILLNESSES:

Asthma	_____	**Epilepsy/Convulsions**	_____	**Respiratory Infections**	_____
Chicken Pox	_____	**Febrile Seizures**	_____	**Skin Problems**	_____
Diabetes	_____	**Stomach Problems**	_____	**Sleeping Problems**	_____
Ear Infections	_____	**Mononucleosis**	_____	**Strep Throat**	_____
Other	_____	**Comments**_____			

SPECIAL CONSIDERATION:

Hearing Concerns_____ **Hearing Aid**_____ **Vision Concerns**_____ **Glasses**_____

Bowel/Bladder Concerns_____

Physical Therapy_____ **Occupational Therapy**_____ **Speech**_____

Takes a Nap_____ **Breath holding**_____ **Temper Tantrums**_____

Emotional Issues_____ **Other**_____

Attends Pre-School/Nursery School - Yes or No - Name of School: _____

SCHOOL NURSE SIGNATURE: _____

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: STRUCTUAL: _____ 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: _____