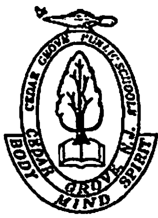

Cedar Grove Public Schools

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 your school system.

Birth Certificate
Board of Education policy requires that a child must be five years old on or before October 1st to be eligible for kindergarten. You must present the original birth certificate at the time of registration.

Health Forms
The following health information is necessary to present at kindergarten 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

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

List A	List B (All bills must be current)
Current mortgage statement	Phone bill
Property tax bill	Cable bill
Deed	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

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*

***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 ________ F1Visa ________

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 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

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:

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: ______________________