

# Millbridge Elementary School

"Delran's Future Begins Here"

282 Conrow Road

Delran, NJ 08075



Jennifer M. Lowe

Principal

John Karakashian

Assistant Principal

To the Parents of a Prospective Kindergarten Student,

Welcome to Millbridge Elementary School! Each spring we register students for our kindergarten program in the fall. To be eligible for kindergarten, your child must be five years old **ON OR BEFORE SEPTEMBER 30, 2018**.

As part of the registration process, all incoming kindergarten students are screened by our school personnel. This helps our staff to provide the appropriate service for students in September. The screening process will take approximately 30 minutes. During this time, parents will register their child by presenting completed paperwork with the required documentation. An interview with our school nurse will also be included to be sure that all required health and medical information is on file. Please make arrangements for younger brothers or sisters to remain at home. Your full attention to the registration process will be necessary.

**\*\*\*Please bring the original and one (1) copy of the documents listed below\*\*\***

**A. Birth Certificate**

**B. A recent photograph** that can be attached to the child's cumulative folder and remain with the school district (no larger than 3x5 please/no copy necessary).

**C. Proof of residency**

One **PRIMARY** Proof of Residency- examples include current lease agreement, property mortgage bill, property tax bill (within 60 days), housing agreement **AND**

One **SECONDARY** Proof of Residency: Examples: Utility Bill- electric, gas, cable (within 60 days)

**D. Custody papers, if applicable.**

**E. Proof of immunizations.**

**F. Physical examination.**

**G. Completed registration paperwork.** Forms may be printed out at home or picked up at either 52 Hartford Road or at 282 Conrow Road.

A healthy-child physical examination is required. This physical should be done around your child's fifth birthday so his/her shots can be completed; however, if completed after Sept. 1, 2017 it will be accepted. It is advisable to make your child's appointment as soon as possible. Your child's immunizations and physical must be completed before he/she attends kindergarten. Following this letter is a one-page overview outlining the minimum immunization requirements for New Jersey's schools.

If you and your child are unable to attend your screening appointment, we ask you to contact the school office at (856) 461-2900 as soon as possible. If you have any questions, please call the school.

Sincerely,

Jennifer M. Lowe, *Principal*

John Karakashian, *Assistant Principal*

# STUDENT REGISTRATION FORM - Delran Township School District

Start Date: \_\_\_\_\_

504    CST    LEP

## STUDENT INFORMATION

Student Gender:  Male    Female   Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_   Student Grade: \_\_\_\_  
(M) (D) (Y)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Intl: \_\_\_\_

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

City of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

\* Has student ever been registered in the Delran School System before?  Yes    No  
\* Has student attended any school previously?  Yes    No

Student NJ State ID # (if known): \_\_\_\_\_ Grade last attended: \_\_\_\_\_

### **If born outside of the U.S:**

When did your child first enter the United States? \_\_\_\_\_

When did your child first enter the U.S school system? \_\_\_\_\_

## PRIOR SCHOOL DISTRICT & PRIOR HOME ADDRESS INFORMATION

Previous Home Address: \_\_\_\_\_

Previous School Name: \_\_\_\_\_ Previous School City: \_\_\_\_\_

Previous School County: \_\_\_\_\_ Previous School State: \_\_\_\_\_

### **Ethnicity of Student: (Check all that apply)**

- American Indian/Alaskan Native:** a person having origins in any of the original people of North and South America including Central America and who maintains a tribal affiliation or community attachment.
- Asian:** a person having origins in any of the original people of the Far East, Southeast Asia, or the Indian Subcontinent, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black:** a person having origins in any of the original people of Africa.
- Hawaiian:** a person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.
- Hispanic:** a person having origins in any of the original people of Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race.
- White:** a person having origins of the original people of Europe, the Middle East or North America.
- Multiracial:** a person who has a mixed ancestry of two or more races.

PARENT(S)/GUARDIAN(S) INFORMATION

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child Lives with:  Single Parent  Married Parent  Guardianship  Foster/Adoptive Parent

Is there a custody agreement in place for this student?  Yes  No

If Yes: A copy of custody/guardianship papers MUST be provided to the school to be kept on file.

Custody granted to:  Mother  Father  Joint

Is either parent currently active in the Military?  Yes  No

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other Custodial Parent/Guardian

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship \_\_\_\_\_ Email: \_\_\_\_\_

Other Children in the family

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School:  Millbridge  DIS  DMS  DHS Other: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School:  Millbridge  DIS  DMS  DHS Other: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**ACADEMIC INFORMATION**

1. Was the student ever classified by a Child Study Team? 1.  Yes  No  
If yes, does your child receive any of the following services? (*check all that apply*)

Occupational Therapy

Physical Therapy

Speech Therapy

Counseling

2. Does the student have a current Individual Education Plan (IEP)? 2.  Yes  No

3. Does the student have a current 504 Accommodation Plan? 3.  Yes  No

4. Is the student classified as eligible for Speech/Language services? 4.  Yes  No

5. Is the student currently placed in Basic Skills Language Arts? 5.  Yes  No

6. Is the student currently placed in Basic Skills Math? 6.  Yes  No

7. Was the student ever retained? 7.  Yes  No

If yes, what grade level(s) \_\_\_\_\_

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**PARENT/GUARDIAN VERIFICATION**

I, \_\_\_\_\_, understand that my child may be tested in Language Arts, Reading, Math, and/or English as a Second Language, before he/she is properly placed in a classroom in the Delran Township Public School District.

**I further attest that all information provided on this registration form is true and accurate and may be investigated by the School Resource Officer or the Delran Township Board of Education.**

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

\_\_\_\_\_  
Date

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**HOME LANGUAGE SURVEY**

Dear Parent/Guardian:

We are required by the New Jersey State Department of Education to determine the home language of all public school students. Collecting this information will help us to know more about the language diversity of our community, and to provide support for students who are in need of English language services.

1. What language did your child speak first?

\_\_\_\_\_

2. What language do you speak most often to your child?

\_\_\_\_\_

3. Does the *student* speak a language other than English at home?  Yes  No

If yes, what language? \_\_\_\_\_

4. Does the student have a *parent* whose native language is not English?  Yes  No

If yes, what language? \_\_\_\_\_

5. Does the student live with a relative or guardian whose native language is NOT English?  Yes  No

If yes, what language: \_\_\_\_\_

6. What is the primary language spoken at home? \_\_\_\_\_

7. Has the student received English as a Second Language instruction:  Yes  No

If yes, what grade level? \_\_\_\_\_

8. Do you/did you read to your child in his/her first language?  Yes  No

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

\_\_\_\_\_  
Date

## New Jersey Minimum Immunization Requirements

	<u>Preschool</u>	<u>Kindergarten</u>
<b>DTP</b>	Minimum 4 doses	4 doses, with one dose given on or after the 4 <sup>th</sup> birthday, OR any 5 doses
<b>Polio</b>	Minimum 3 doses	3 doses, with one dose given on or after the 4 <sup>th</sup> birthday, OR any 4 doses
<b>MMR</b>	Minimum 1 dose; MUST be given on or after the 1 <sup>st</sup> birthday	2 doses; MUST be given on or after the 1 <sup>st</sup> birthday
<b>Varicella</b>	Minimum 1 dose; MUST be given on or after the 1st birthday	Minimum 1 dose; MUST be given on or after the 1st birthday
<b>HIB</b>	3 doses AND the last dose MUST be given on or after the 1 <sup>st</sup> birthday	Not required for Kindergarten
<b>Pneumococcal</b>	3 doses AND the last dose MUST be given on or after the 1st birthday	Not required for Kindergarten
<b>Influenza</b>	MUST be given between September 1 <sup>st</sup> and December 31 <sup>st</sup> annually	Not required for Kindergarten
<b>Hepatitis B</b>	3 doses must be given at specific intervals: <ul style="list-style-type: none"> <li>• 1st dose at birth (or shortly after)</li> <li>• 2nd dose at least one month after 1st dose</li> <li>• 3rd dose must be 4 months from the 1st dose <u>and</u> 2 months after the 2nd dose <u>and</u> the child must be at least 6 months of age when receiving the 3rd dose or the dose will be considered invalid</li> </ul>	

**PLEASE NOTE:** Your child will **NOT** be permitted to start school in September unless the school has written proof that all immunizations are complete!

**Also required for admittance:** A Physical Examination Form, which must be completed by your child's doctor. Please bring this completed form with you to registration.

Please remember that all of the above are requirements by the State of New Jersey and are mandated by law. Any student who is not compliant in all of the above (immunizations and documented physical exam) will be **EXCLUDED** from school until all such requirements are met per the following:

### **N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL**

Thank you for your cooperation. If you have any questions, please do not hesitate to call me.

Sincerely,

Cecilia Fedore BSN, RN, CSN  
 School Nurse  
 856-461-2900 ext. 2316

# STUDENT HEALTH INVENTORY

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)

Student Gender: Male  Female

Date of last:  
 \_\_\_\_\_  
 physical exam

\_\_\_\_\_  
 dental exam

\_\_\_\_\_  
 last eye exam

<i>Does your child:</i>	NO	YES (if yes, please explain)
Take any medication at home?		
Have any allergies?		
Have any breathing difficulties/concerns? (Including asthma, reactive airway disease, etc.)		
Have any difficulty hearing or any ear issues? (including frequent ear infections or tubes in the ear)		
Have any difficulty seeing? (including use of glasses or contacts)		
Have any restrictions on physical activity?		
Have any speech difficulties?		

### Health Conditions

Asthma  Diabetes  Heart  Disease  Seizures/Convulsions

Has your child ever had chickenpox?  Yes  No When? \_\_\_\_\_

Hospitalizations (date/reason) \_\_\_\_\_

Other Medical

Conditions/concerns \_\_\_\_\_

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

\_\_\_\_\_  
 Date

## Delran Township Schools

### Physical Examination Record

Student Gender:  Male  Female Student Grade: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Address \_\_\_\_\_

Examining Physician/Provider \_\_\_\_\_ Address \_\_\_\_\_

**IMMUNIZATIONS:** Completed immunization records **MUST** be attached in order for this form to be valid. See attached sheet for Minimum Immunization Requirements in New Jersey.

If born outside of the USA, you must have a Mantoux test if country of origin is deemed to have a high risk of TB exposure by the NJ Department of Health (Brazil, Turkey, India, Pakistan, etc.)

Tested on \_\_\_\_\_ Read on \_\_\_\_\_ Result (mm) \_\_\_\_\_

**EXAMINATION:** Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected  Y  N  
 Hearing: R  Pass  Fail L  Pass  Fail  
 Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_

Ears (otoscopic)		Hernia	
Eyes		Genito-urinary	
Lymph Glands		Scoliosis	
Thyroid		Posture	
Nose		Feet	
Throat		Skin	
Teeth-mouth		Nutrition	
Heart		Nervous System	
Lungs		Speech	
Abdomen		General appearance	

Other \_\_\_\_\_



**PHYSICAL EXAMINATION RECORD**

**MEDICAL HISTORY**

Allergies		Heart Disease	
Congenital Defects		Otitis Media	
Drug Sensitivities		Strep Infections	
Hepatitis		Mononucleosis	
Neuromuscular		Operations	
Asthma		Fractures	
Chicken Pox		Injuries	
Diabetes		Hospitalizations	

Other \_\_\_\_\_

Medications \_\_\_\_\_

**PHYSICIAN'S FINDINGS PERTINENT TO SCHOOL**

Classification of Physical Activity \_\_\_\_\_

Full Academic Work Program \_\_\_\_\_

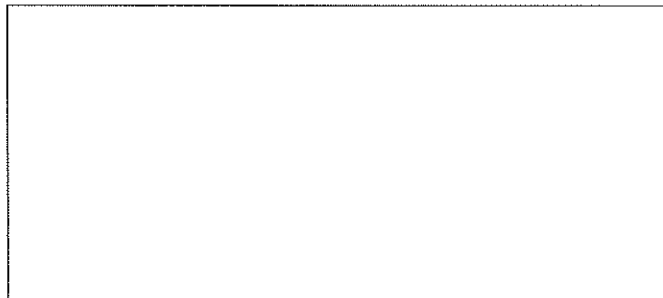
Follow-up and Notes \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician/Provider

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Exam

\_\_\_\_\_

Print Physician/Provider Name



Physician/Provider Stamp Here