LAUREL SPRINGS SCHOOL DISTRICT
LAUREL SPRINGS NJ 08021

DOCUMENTS NEEDED FOR REGISTRATION

When all the required documentation is gathered and all forms are complete, please contact Jane DiOrio at 856-783-1086 X110 to schedule an appointment to complete the registration process.

****Registration is not complete until all information is received****

- Student Registration Packet
- Birth Certificate (original with raised seal)
- Custody Documentation (if applicable)
- Health/Immunization Record
- Transfer Card – with report card, standardized test results, school health card
- IEP or 504 Plan (if applicable)

Proof of Residency
A pupil whose parents/guardians are currently domiciled in Laurel Springs will be admitted to the school district after the parents/guardians have produced proper proof of residency as follows:

A. **Residency Documentation (one of the following):**
   - **Homeowners must provide:** Current Property Tax Bill, Mortgage Statement or Settlement papers (new Homeowners)
   - **Apartment or Rental must provide:** Current signed Lease- with all occupants listed
   - **Residing with someone who is a Homeowner:** Please call 856-783-1086 X110 to request a Sworn Statement Form that will need to be completed and notarized by the homeowner. Homeowner will also have to provide the following:
     Current Property Tax Bill or Mortgage Statement and Current Utility Bill
     Parent/Guardian: Three forms from the list below
   - **Residing with Someone who is Renting:** Please call 856-783-1086 X110 to go over paperwork

B. **Residency documentation as listed above, plus three (3) of the following:**

Auto Insurance ID Card	Driver's License	Bank Statement
Utility Bill (gas/electric/water/sewer/cable/cell phone		Voter Registration

LAUREL SPRINGS SCHOOL
STUDENT REGISTRATION FORM

Date: _____

Student Information: Age: _____ Grade: ____

Last Name: _____

First Name: _____ Middle Name: _____

Date of Birth: ____/____/____ Age: _____ Male Female

Birth City: _____ Birth State: _____ Birth Country: _____

Address: _____

Home#: (____)- ____- _____

Phone Number to use for school closing announcements: _____

Ethnicity: Please check all that apply

Hispanic/Latino ___ Asian___ Black ___ American Indian ___ White ___ Pacific ___

Previous School Information (This section does not apply to kindergarten registration)
Name of School _____

Address _____

Check off any services that the student was currently receiving at previous school:

Basic Skills _____ Speech _____ 504 Plan _____ Special Education _____ (please provide us with a copy of IEP) ESL ____ English as Second Language

Is student a military dependent?

Active Duty ____ (Active Duty Forces, Full-time, in the Army, Navy, Air Force, Marine Corps or Coast Guard)

National Guard or Reserve ____ (Member of the National Guard or Reserve Forces: Army, Navy, Air Force, Marine Corps, or Coast Guard

Not Military Connected ____

Laurel Springs School

Parent/Guardian Information:

Name: _____

Address: (if different than student) _____

Email: _____

Employer: _____ Occupation: _____

Work Phone: _____

Name: _____

Address: (if different than student) _____

Email: _____

Employer: _____ Occupation: _____

Work Phone: _____

Marital Status of Parents: Married ____Separated ____Divorced ____ Single ____ Civil Union ____

Mother Deceased ____ Father Deceased ____

Student Resides with: (Please Circle All That Apply)

Both Parents Mother Father Stepmother Grandparents Guardian

Are there any custody issues or restraining orders against family or others pertaining to this student?

Yes _____ No _____ if YES, please attach a copy to this form

Doctor Emergency Information

Physician's Name: _____ Phone Number: _____

Do you have health insurance? Yes _____ No _____

If yes what is the name of your provider? _____

LAUREL SPRINGS SCHOOL

This information will remain confidential and is required for your child's health file

Student's Name _____Date of Birth: _____/_____/_____ Sex: Male Female

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Health History (past or present- check all that apply)

_____ Epilepsy/Seizures	_____ Eczema/Dermatitis	_____Sleep Problems
_____Diabetes	_____ Chickenpox	_____ Tonsillectomy
_____Asthma	_____ Meningitis	_____ Hearing Problems
_____ Kidney disorder	_____ ADHD/ADD	_____ Vision Problems
_____ Heart disease	_____ Mononucleosis	_____ Glasses/Contacts
_____ Arthritis	_____ Lyme disease	_____ Fractures
_____ Anxiety/Depression	_____ Constipation/Diarrhea	_____ Speech Problems
_____ Frequent Strep Infection	_____ Orthopedic problems	_____ Concussions/Head Injury

_____ Other _____

Food Allergies: Is your child allergic to any food? Yes No

Food & Reaction/ Explain: _____

Sting Allergies: Is your child allergic to any insect stings? Yes No

Insect & Reaction/Explain: _____

Drug/Medication Allergies: Is your child allergic to any medications? Yes No

Medication & Reaction/Explain; _____

Does your child keep an EPI-Pen in school? Yes No

Does your child take medication daily? Yes No

Name of Medication Dose Time(s)

_____

_____

_____

_____

Will your child require medication at school? Yes No

Parent/Guardian Signature: _____Date: _____

Laurel Springs School

Siblings/Others in Household Name	DOB	Grade

I certify that the information provided in this registration form is true and accurate. My signature verifies that I am in compliance with the District's residency requirements and that the district has the right to perform a residency investigation. If said investigation reveals that false information is contained in this registration, the student will be ineligible to attend school in the district and penalties may be assessed to collect tuition.

_____ ____/____/____

Signature Date

District Use Only

The following information has been received and verified. Copies of items noted below must be attached to this registration. Check appropriate

- ☐ Birth Certificate/Legal Proof of Birth
- ☐ Immunization Records
- ☐ Signed Request for School Records
- ☐ Proof of Residency (4 forms)
- ☐ Custody Papers (if applicable)
- ☐ Transfer Card

Date registration completed: ____/____/____

Laurel Springs School
Student Residency Questionnaire

Student's Name: _____
Last name First name

Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No

2. Is this a temporary living arrangement due to the loss of housing or economic hardship>
   ☐ Yes ☐ No

If you answered YES to the above questions, please complete the remainder of this form.

If you answered NO, you may stop here.

Where is the student presently living? (Check only one box)

☐ 1= Shelters, transitional housing, awaiting foster care

☐ 2= Doubled up; sharing the housing of other persons due to economic hardship, loss of housing, or other reasons (such as domestic violence)

☐ 3= Unsheltered; includes cars, parks, campgrounds, temporary trailers including FEMA trailers or abandoned buildings

☐ 4= Hotel or Motel

I certify that the information provided here is true and correct. I understand that falsifying records is an offense under Section 37.10, Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition and/or other costs TEC Sec 25.002(3)(d).

_____ Date: _____/_____/_____
Signature of Parent/Legal Guardian

District Use Only

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ Date: _____/_____/_____
Signature of McKinney-Vento Liaison

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: _____ Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

_____

2.) Was the first language used by the student a language other than English?

_____ **No** _____ **Yes**

3.) Does the student speak or understand a language other than English?

_____ **No** _____ **Yes**

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ **No** _____ **Yes**

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ **No** _____ **Yes**

Laurel Springs School
623 Grand Avenue
Laurel Springs NJ 08021
856.783.1086
856.784.0474 fax

Date: _____

Name of School: _____

Fax#: _____

To Whom it May Concern:

Laurel Springs has recently enrolled the following student(s):

Name Grade

_____

_____

_____

_____

Please forward the scholastic, health, and any Basic Skills, ESL and/or Child Study Team (IEP) records of the above listed student(s) to the address above

Thank you for your cooperation in responding to this request.

****

AUTHORIZATION TO RELEASE PUPIL RECORDS

I have enrolled my child(ren) in the Laurel Springs School District and authorize the release of scholastic, health, and other pertinent records.

_____

Parent/Guardian Name (please print)

_____

Parent/Guardian Signature

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.