

LAUREL SPRINGS SCHOOL DISTRICT  
LAUREL SPRINGS NJ 08021

KINDERGARTEN/PRESCHOOL REGISTRATION

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)  
*Your child must be five (5) years of age on or before October 1 for kindergarten and four (4) years of age on or before October 1 for preschool.*
- 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**  
**KINDERGARTEN/PRESCHOOL 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

Siblings/Others in Household

Name

DOB

Grade

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***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

- |   |   |
|---|---|
| <input type="checkbox"/> Birth Certificate/Legal Proof of Birth | <input type="checkbox"/> Proof of Residency (4 forms)   |
| <input type="checkbox"/> Immunization Records                   | <input type="checkbox"/> Custody Papers (if applicable) |
| <input type="checkbox"/> Signed Request for School Records      | <input type="checkbox"/> Transfer Card                  |

Date registration completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Laurel Springs School

Who cares for your child when not in school? \_\_\_\_\_

Any pregnancy, labor, birth problems? \_\_\_\_\_

\_\_\_\_\_

What responsibilities does your child have at home? \_\_\_\_\_

Was your child hard to care for as a baby? Yes \_\_\_ No \_\_\_

Has it been necessary for you to move frequently? Yes \_\_\_ No \_\_\_

Does your child have a regular bedtime? Yes \_\_\_ No \_\_\_  
If yes, what time? \_\_\_\_\_

Does your child have nightmares? Yes \_\_\_ No \_\_\_

Does your child walk is his/her sleep? Yes \_\_\_ No \_\_\_

Are there neighborhood children his/her age to play with? Yes \_\_\_ No \_\_\_

Does your child prefer playing: Quietly inside \_\_\_ or Outdoors \_\_\_\_\_

Does your child have difficulty separating from you when left with a babysitter? Yes \_\_\_ No \_\_\_

Has your child attended a nursery school, church-related school, etc.? Yes \_\_\_ No \_\_\_  
If yes, specify \_\_\_\_\_

Has your child required special services (speech, physical therapy etc.) Yes \_\_\_ No \_\_\_  
If yes, specify \_\_\_\_\_

Does your child enjoy being read to? Yes \_\_\_ No \_\_\_

Is your child looking forward to going to school? Yes \_\_\_ No \_\_\_

Can your child follow simple instructions? Yes \_\_\_ No \_\_\_

Did your child sit up by himself/herself by 9 months? Yes \_\_\_ No \_\_\_  
If no, please elaborate \_\_\_\_\_

Did your child walk by himself/herself by 15 months? Yes \_\_\_ No \_\_\_  
If no, please elaborate \_\_\_\_\_

Is your child bothered by a noisy environment or loud noise? Yes \_\_\_ No \_\_\_

Does your child have difficulty understanding or speaking? Yes \_\_\_ No \_\_\_  
If yes, describe \_\_\_\_\_

Does your child stutter or have any speech problems? Yes \_\_\_ No \_\_\_  
At this time your child can do things as well as a \_\_\_\_\_-year old.

Is your child potty trained? Yes \_\_\_ No \_\_\_  
If yes, at what age? \_\_\_\_\_  
Bedwetting? Yes \_\_\_ No \_\_\_

Circle the words that describe your child

Large for age	Nervous/anxious	Clumsy	Generally happy
Small for age	High-strung	Loving	Cries easily
Easy to manage	Stubborn	Friendly	Daydreams
Hard to manage	Moody	Energetic	Quiet
Very particular	Shy	Has tantrums	Clingy
Short attention span	Irritable	Bossy	

Any additional information you feel would be of benefit to your child's teacher

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**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)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Epilepsy/Seizures        | <input type="checkbox"/> Eczema/Dermatitis     | <input type="checkbox"/> Sleep Problems          |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Chickenpox            | <input type="checkbox"/> Tonsillectomy           |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Meningitis            | <input type="checkbox"/> Hearing Problems        |
| <input type="checkbox"/> Kidney disorder          | <input type="checkbox"/> ADHD/ADD              | <input type="checkbox"/> Vision Problems         |
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Mononucleosis         | <input type="checkbox"/> Glasses/Contacts        |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Lyme disease          | <input type="checkbox"/> Fractures               |
| <input type="checkbox"/> Anxiety/Depression       | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Speech Problems         |
| <input type="checkbox"/> Frequent Strep Infection | <input type="checkbox"/> Orthopedic problems   | <input type="checkbox"/> Concussions/Head Injury |
| <input type="checkbox"/> 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  
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).

\_\_\_\_\_  
Signature of Parent/Legal Guardian

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**District Use Only**

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

\_\_\_\_\_  
Signature of McKinney-Vento Liaison

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth /      /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (    )    -	
<b><i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i></b>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <b><i>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.</i></b>					
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](http://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](http://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 health 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.

### 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