



Haworth Public School

Dear Parents/Guardians:

Welcome to the Haworth Public School.

In order to enroll your child(ren), please provide the School Office with the following paperwork:

- 1.) **Three (3) forms of proof of Haworth residence:**
 - a. Deed/Lease papers
 - b. PSE&G or Rockland Electric bill
 - c. Drivers License and one other utility bill
- 2.) School Records from previous school
- 3.) Health Records from child(ren)'s physician
- 4.) Birth Certificate **OR** Passport

We appreciate your supplying the above information as soon as possible so that we may expedite the registration process. If you have any questions, please do not hesitate to contact the main office at (201) 384-5526, ext. 35100 or 35101.

Sincerely,

Patricia Voigt

Patricia Voigt
Principal



Haworth Public School

**SCHOOL REGISTRATION FORM &
PERMANENT RECORD INFORMATION**

Today's Date: _____ Entry Date _____ GRADE ENTERING: _____

Child's Name: _____ Ethnicity: _____ Gender: F M X

Date of Birth: _____ City & Country of Birth: _____

Permanent Address/Address of Domicile: _____

Is this Student a dependent of a full-time active duty member of the Armed Forces? Yes No

Home Phone: _____ Mom Cell: _____ Dad Cell: _____

Mom Email: _____ Dad Email: _____

Guardian's Home & Cell Number: (H): _____ (C): _____

	NAME	HOME ADDRESS <small>if different from above</small>	OCCUPATION	CITIZENSHIP	BIRTHPLACE
FATHER					
MOTHER					
*GUARDIAN					

****(If legal guardian is someone other than the child's parents, please complete the appropriate Domicile Affidavit Document on file in the school's Main Office).***

SIBLINGS' NAMES (if any)	DATE OF BIRTH	CURRENT GRADE

Former Residence: _____

Former School Name and Phone Number: _____

Former School Address and Grade: _____



Haworth Public School

REQUEST FOR SCHOOL RECORDS

Date: _____

Dear Colleague:

_____, a student formerly registered in your school, has enrolled in

Grade _____ in the Haworth Public School.

I would greatly appreciate your forwarding copies of the following to my attention:

- 1) _____ Standardized Achievement Test Scores
- 2) _____ Report Cards
- 3) _____ Health Records (please include original A45)
- 4) _____ Attendance Information
- 5) _____ Child Study Team Records (including most current IEP)
- 6) _____ 504 Records
- 7) _____ NJ SMART State ID Number (*if coming from another NJ Public School*)

The records above are to be released to:

Mrs. Patricia Voigt
 Haworth Public School
 205 Valley Road
 Haworth, NJ 07641

Thank you for your assistance in this important matter.

Sincerely,

Patricia Voigt

Patricia Voigt
Principal

I hereby grant permission for the release of the above records to the Haworth Public School.

Parent/Guardian Signature and Date: _____

Name, Address and Phone # of School releasing records: _____

Phone: _____

Home Language Survey

Date:

Student's Name:

Grade:

1. What was the first language used by your child?

2. At home does your child hear or use a language other than English more than half of the time?

3. Does the child understand a language other than English?

4. When interacting with parents or guardians, does your child use a language other than English more than half of the time?

5. When interacting with caregivers other than parents or guardians, does your child use a language other than English more than half of the time?

6. Has your child recently moved from another school district where he/she was identified as an English language learner?

7. What are the home languages spoken?

8. How long has your child lived in the United States?

Parents/Guardians: Is there a parent/guardian in the home who is comfortable receiving school notices in English? Yes No



Haworth Public School

ALLERGY & MEDICATION SURVEY

Child's Name: _____ Grade: _____

1. Allergy Information: Does your child have any allergies?

	<u>Please Specify</u> YES	NO
Medications (i.e. antibiotics)	<input type="checkbox"/>	<input type="checkbox"/>
Food (i.e. milk, eggs, wheat, yeast, peanuts)....	<input type="checkbox"/>	<input type="checkbox"/>
Environmental (i.e. grass, dust, animal)	<input type="checkbox"/>	<input type="checkbox"/>
Insect Bites (i.e. bees, spiders, mosquito).....	<input type="checkbox"/>	<input type="checkbox"/>
Food Dyes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Others.....	<input type="checkbox"/>	<input type="checkbox"/>

If yes, what kind of reaction does your child experience?

Does your child take medication for an allergic reaction?

2. Medication Information: Please list below all medications, supplements, complementary therapies, etc., that your child is taking.

Medication/Therapy	Dosage	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**APPROVED SCHOOL PHYSICAL EXAMINATION FORM
HAWORTH PUBLIC SCHOOLS**

(K - 8)

**UNIVERSAL
CHILD HEALTH RECORD**

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

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

HAWORTH SCHOOL STUDENT INFORMATION CARD

In case of accident or sudden illness, it is imperative that we have the following information on file:

Name LAST FIRST MIDDLE Gender: M F Grade/Teacher
Address Date of Birth (M/D/Y)
Home phone

ALLERGIES (LIST ALL)
ALLERGIC REACTION(S)

Name of Parent/Guardian 1: Cell phone
Address
Email: Work phone

Name of Parent/Guardian 2: Cell phone
Address
Email: Work phone

List 2 neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:
Name Relationship Name Relationship
Home phone Cell Home phone Cell

I give my permission to share necessary medical information with my child's teachers:

Parent/Guardian Signature

Does your child have health insurance?
Yes. If yes, name of insurance company
No. NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information, please call 800-701-0710 or visit www.njfamilycare.org to apply online.

Signature Printed name Date
Written consent required pursuant to 20 U.S.C. - 1232g (b)(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child has received during the past year
Dental exam date Braces Eye exam date Contacts Glasses

MEDICATIONS (LIST ALL)

Immunizations/Tetanus (date & type)
Restrictions:
Doctor Phone
Dentist Phone
Hospital Address & Phone

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforementioned child. I will not hold the school district financially responsible for the emergency care and/or transportation to a care facility for said child.

Signature of Parent/Guardian & date