Haworth Public School

July 2019

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

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: ______________________________

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 If different from above	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

HOME LANGUAGE SURVEY

Date: ____________________________

STUDENT'S NAME: ____

HOMEROOM/GRADE: ____

1. What language did your child first learn to speak?

   ____

2. What language does your child use most often when speaking to parents at home?

   ____

3. What language does your child use most often when speaking to brothers and sisters?

   ____

4. What language does your child use most often when speaking to relatives?

   ____

5. What language does your child use most often when speaking to friends?

   ____

6. How long have you lived in the United States?

   ____

7. What is the DATE your child entered the United States?

   ____

PARENTS'/GUARDIANS' LANGUAGE: Is there a parent/guardian in the home who is comfortable receiving school notices in English? ☐ ***Yes*** ☐ ***No***

205 Valley Road
Ph: 201-384-5526
www.haworth.org
Haworth, New Jersey 07641
Fax: 201-384-8619

HAWORTH SCHOOL STUDENT INFORMATION CARD

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

Name ______________________________ Gender: M F Grade/Teacher ______________
LAST FIRST MIDDLE

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 ______________________________

Haworth Public School

ALLERGY & MEDICATION SURVEY

Child's Name:______________________________ Grade: __________

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

	Please Specify YES	NO
Medications (i.e. antibiotics)	☐	☐
Food (i.e. milk, eggs, wheat, yeast, peanuts)	☐	☐
Environmental (i.e. grass, dust, animal)	☐	☐
Insect Bites (i.e. bees, spiders, mosquito)	☐	☐
Food Dyes	☐	☐
Asthma	☐	☐
Others	☐	☐

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 ☐ 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		

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