Haworth Public School

Ms. Jennifer L. Montesano
Chief School Administrator

Mr. Paul Wolford
Director of Education

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 **OR** 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. 35101.

Sincerely,

Karen Erner

Karen Erner
Administrative Assistant

Haworth Public School

Ms. Jennifer L. Montesano
Chief School Administrator

Mr. Paul Wolford
Director of Education

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
6) _____ NJ SMART State ID Number ***(if coming from another NJ PUBLIC SCHOOL)***

The records above are to be released to:

Ms. Karen Erner
Haworth Public School
205 Valley Road
Haworth, NJ 07641

Thank you for your assistance in this important matter.

Sincerely,
Karen Erner
Karen Erner
Administrative Assistant

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

Ms. Jennifer L. Montesano
Chief School Administrator

Mr. Paul Wolford
Director of Education

PERMANENT RECORD INFORMATION

Date: _____ GRADE ENTERING: _____

Child's Name: _____ Sex: F M

Address: _____ Date of Birth: _____

City/Country of Birth: _____

Home Number: _____ Mom Cell: _____ Dad Cell: _____

Mom Email: _____ Dad Email: _____

	NAME	HOME ADDRESS (if different from above)	OCCUPATION	CITIZENSHIP	BIRTHPLACE
Father					
Mother					
Guardian					

SIBLINGS:

NAME	DATE OF BIRTH	CURRENT GRADE

Former Residence: _____

Former School Name and Phone Number: _____

Former School Address and Grade: _____

Haworth Public School

Ms. Jennifer L. Montesano
Chief School Administrator

Mr. Paul Wolford
Director of Education

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 in the home who would be 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 Public School

Ms. Jennifer L. Montesano
Chief School Administrator

Mr. Paul Wolford
Director of Education

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

205 Valley Road
Ph: 201-384-5526

www.haworth.org

Haworth, New Jersey 07641
Fax: 201-384-8619

HAWORTH SCHOOL DISTRICT
STUDENT CALENDAR
2015-16

H = Half Day

September				
M	T	W	T	F
	1*	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

October				
M	T	W	T	F
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30H

November				
M	T	W	T	F
2	3H	4	5	6
9	10	11	12	13
16	17	18	19	20
23H	24H	25H	26	27
30				

December				
M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23H	24	25
28	29	30	31	

January 2016				
M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18H	19	20	21	22
25	26	27	28	29

February				
M	T	W	T	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29				

March				
M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

April				
M	T	W	T	F
				1
4	5	6	7H	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

May				
M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27*
30	31			

June				
M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24*
27	28	29	30	

First Day for Teachers	Sept 1
First Day for Students	Sept 2
Labor Day (SCHOOL CLOSED)	Sept 7
Rosh Hashanah (SCHOOL CLOSED)	Sept 14-15
Yom Kippur (SCHOOL CLOSED)	Sept 23
One Session Day (PM Staff Development)	Oct 30
One Session Day (Election Day)	Nov 3
Teachers' Convention (SCHOOL CLOSED)	Nov 5-6
One Session Day (conferences)	Nov 23/24
One Session Day (before Thanksgiving)	Nov 25
Thanksgiving (SCHOOL CLOSED)	Nov26-27
One Session Day	Dec 23
Holiday Recess	Dec 24-Jan 1
One Session Day - Martin Luther King Day (PM Staff Development)	Jan 18
February Recess	Feb 15-19
Good Friday (SCHOOL CLOSED)	March 25
One Session Day (conferences)	Apr 7
Spring Recess	April 11-15
Teachers' PD Day (SCHOOL CLOSED)	May 27
Memorial Day (SCHOOL CLOSED)	May 30
Last Day of School for students	June 23
Last Day of School for staff	June 24

GRADUATION WILL BE HELD 6/16/16

*** Staff Only**

Number of Days

	Students	Staff
Sept	17	18
Oct	22	22
Nov	17	17
Dec	17	17
Jan	20	20
Feb	16	16
Mar	22	22
Apr	16	16
May	20	21
June	17	18
	184	187

*** 184 for students; 187 for staff**

(*This number includes 3 built-in snow days)

Adopted:

Three snow days have been built into the calendar. If the snow days are not used, the student calendar will be adjusted as follows: first student give-back day will be Thursday, June 23, the second give-back day will be Wednesday, June 22, and the third giveback day will be Tuesday, June 21. If deemed necessary by unexpected closings beyond the three built in days, the April vacation may be abbreviated in part or in whole. Therefore, plans which cannot be changed should not be made for the April vacation. The Superintendent reserves the right to make adjustment to the school's time schedule when it is deemed necessary.

BELL SCHEDULE

Regular Day		
First Bell	8:25 AM	
Second Bell	8:30 AM	
Period	**BEGINS**	**ENDS**
1	8:25 AM	9:14 AM
2	9:17 AM	10:04 AM
3	10:07 AM	10:54 AM
4	10:57 AM	11:44 AM
Lunch	11:46 AM	12:33 PM
5	12:36 PM	1:23 PM
6	1:26 PM	2:13 PM
7	2:16 PM	3:03 PM
Teacher Dismissal	3:33 PM	
One Session Day		
Period	**BEGINS**	**ENDS**
1	8:25 AM	9:01 AM
2	9:03 AM	9:37 AM
3	9:39 AM	10:13 AM
4	10:15 AM	10:49 AM
Lockers	10:49 AM	10:54 AM
5	10:55 AM	11:29 AM
6	11:31 AM	12:05 PM
7	12:07 PM	12:42 PM
Teacher Dismissal	1:10 PM	
Delayed Opening		
Period	**BEGINS**	**ENDS**
1	10:00 AM	10:36 AM
2	10:38 AM	11:14 AM
3	11:16 AM	11:52 AM
Lunch	11:54 AM	12:34 PM
4	12:36 PM	1:12 PM
5	1:14 PM	1:48 PM
6	1:50 PM	2:24 PM
7	2:26 PM	3:03 PM
Teacher Dismissal	3:33 PM	

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 SCHOOLS

HAWORTH, NEW JERSEY

GRADE: _____ DATE: _____

NAME: _____ ADDRESS: _____

BIRTH DATE: _____ PARENT'S NAME: _____ PHONE NO.: _____

IMMUNIZATION DATES
(Mo/Day/Yr)

DTaP / D.P.T. _____
D. & T. _____
Measles _____
Rubella _____
Mumps _____
Polio - Sabin 1. _____
Mono ☐ 2. _____
IPV ☐ Tri ☐ 3. _____
Booster ☐ 4. _____
Hepatitis B Vaccine _____
_____
_____
_____
Hib _____
_____
Varicella _____
Mantoux Test _____
Date _____ Result _____

PAST HISTORY & LAB
(X) if had – approximate date

Measles _____
Mumps _____
Chicken Pox _____
Rubella _____
Scarlet Fever _____
Pertussis _____
Significant Allergy _____
_____
Injury _____
_____
Operations _____
_____
Hgb. _____
Urine _____ Alb. _____ Sug. _____

EXAMINATION
(✓) if normal – (X) if abnormal, details on back of card)

General Condition _____
Height _____ Weight _____
Eyes - Without glasses 20/ , 20/
Eyes - With glasses 20/ , 20/
Ears _____ Genitalia _____
Hearing _____ Extremities _____
Nose _____ Skin _____
Mouth _____
Heart _____ Neurological Exam _____
B.P. _____ Psychological Exam _____
Lungs _____ Behavioral Pattern _____
Abdomen _____ Speech Development _____
Hernia _____
Scoliosis _____

PLEASE NOTE IMMUNIZATION REQUIREMENTS ON REVERSE SIDE

PLEASE HAVE CURRENT PHYSICAL COMPLETED AND RETURN TO SCHOOL NURSE BY DEC. 31

PHYSICIAN'S REMARKS:

Recommendations for physical activity:

_____ Full Physical Activity

_____ Modified Physical Activity

because of _____

_____

_____

Other special recommendations or modifications in pupil's program:

_____

Date of Examination _____

_____
M.D. Signature

_____
Address / Phone

As mandated by the New Jersey State Department of Health, the minimal immunization requirements are as follows:

DISEASE	VACCINATION
Diphtheria Tetanus Whooping Cough	A minimum of four (4) doses of DTap is required. One (1) does must be on or after the fourth birthday.
Varicella	One (1) dose on or after the 1st birthday if born on or after Jan.1, 1998.
Poliomyelitis	A minimum of three (3) doses of polio vaccine (IPV or OPV) is required. One (1) dose must be on or after the fourth birthday.
Measles	Two (2) doses of measles - containing vaccine given on or after the first birthday (preferably MMR) are required. The two (2) must be separated by an interval of at least one month.
Rubella	One (1) rubella vaccine on or after the first birthday.
Mumps	One (1) mumps vaccine on or after the first birthday.
Hepatitis B	Three doses for all students born on or after Jan. 1, 1990.

NOTE: All new students entering our schools for the first time or from out of the country must show evidence of receiving a tuberculin test within the previous 6 months. Check with the school nurse for certain exemptions.

The Board of Education reserves the right to re-examine all pupils for whom restriction of physical activity is recommended.

NURSE'S OR PARENT'S NOTES (Please note any medications being taken):

_____
Parent / Guardian Signature

8/06