

Hamilton Township School District

Dear Parent/Guardian:

This package includes all documents necessary to register your child/children in the Hamilton Township School District.

Please sign below to attest that all the information you provide on these documents is accurate and that you are aware that falsification on your part will be considered falsifying a government document.

(Signature – Parent/Guardian)

Date:

HAMILTON TOWNSHIP SCHOOL DISTRICT
Mays Landing, NJ 08330

Grade Entering: _____
Student's Name: _____

STUDENT REGISTRATION CHECKLIST

ONLY THE PARENT / LEGAL GUARDIAN CAN REGISTER THE CHILD

PROOF OF RESIDENCY –

YOU MUST HAVE 1 OF THE FOLLOWING IN ORDER TO REGISTER AT THIS TIME

- _____ (OWNER) Deed, Mortgage, or Tax Bill in parent's/guardian's name
- _____ (RENTER) Lease or Tenant Agreement in parent's/guardian's name
- _____ (LIVES W/OWNER) Deed/Tax Bill of owner with whom you reside & Resident's Affidavit
- _____ (LIVES W/RENTER) Renter's Lease with who you reside with & Resident's Affidavit

**2 FORMS OF IDENTIFICATION IN THE PARENT'S / LEGAL GUARDIAN'S NAME
WITH CURRENT MAYS LANDING ADDRESS LISTED**

- _____ Driver's License/ Auto Registration/ Insurance Card
- _____ Utility Bill
- _____ Voter Registration Card
- _____ Paycheck Stub/ Employer Verification on Letterhead Stating Change of Address
- _____ Bank Statement
- _____ Any Formal/Legal Documentation with Name and Current Address

CHILD'S DOCUMENTATION

- _____ Birth Certificate (original)
- _____ Court documentation of guardianship*
- _____ Custody documentation if divorced*
- _____ State Agency placement document of guardianship*

GRADE PLACEMENT DOCUMENTATION

- _____ Transfer Card from previous school
- _____ Report Card
- _____ IMMUNIZATION / HEALTH RECORDS (**MUST** PRESENT A COPY)
- _____ Physical Form (Filled out by doctor) **Mandatory** for K and PreK

* If applicable

Any questions please call 476-6147 prior to registration.
The student may begin school 3 school days after registration.

TOWNSHIP OF HAMILTON SCHOOL DISTRICT REGISTRATION CARD

Name of Pupil: _____
Last First Middle Initial

Address/P.O. Box: _____

Exact Location of Home (Nearest Intersection): _____

Home Telephone: _____ Cell Phone: _____

Emergency Name: _____ Emergency Phone: _____

Grade: _____ Sex: _____ Date of Birth: _____

Country of Birth: _____ City of Birth: _____

Language Spoken @ home: _____ State of Birth: _____

Migrant: Yes/No (circle one) Years in American Schools: _____ Date entered U.S. (if applicable): _____

From City/State: _____ Last Grade Attended: _____
Name, Address, and Phone # of Previous School: _____

Documented Legal Custody/Court Related issues: Yes/No (circle one) If yes, date of documents: _____

Person(s) with whom child is living with: Person registering the student must be: Parent _____ or Legal Guardian _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Occupation: _____ Occupation: _____

Place of Employment: _____ Place of Employment: _____

Work Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

E-mail Address: _____ E-mail Address: _____

Names of children in family/other children in home:

Name	Date of Birth	Name	Date of Birth
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Did your child participate in:
_____ Speech _____ Bilingual/ESL/ELL
(How many years? _____)
_____ 504 Plan
_____ Basic Skills
_____ Special Education/Resource/Self Contained

Office Use Only

Registration Date: _____
Start Date: _____
Bus Number: _____
State ID #: _____
I.D. #: _____
Lunch Pin #: _____

Hamilton Township School District Emergency Contact Information

ID# _____ D/O/B (Mo/Day/Year): _____

Last Name: _____ First: _____ Initial: _____

Address: _____ School: _____

City: _____ Zip: _____ Grade: _____

Home Telephone: (____) _____ Male: Female:

Cell Phone: (____) _____ Teacher/H.R. _____

To Parent/Guardian: To serve your child in case of an accident or sudden illness, it is necessary that you give the following information for emergency calls:

<u>Name</u>	<u>Address</u>	<u>Telephone</u>
Mother/Guardian: _____	Home: _____	Home: _____
E-Mail: _____	Work: _____	Work: _____
		Cell: _____
Father/Guardian: _____	Home: _____	Home: _____
E-Mail: _____	Work: _____	Work: _____
		Cell: _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name: _____	Name: _____
Address: _____	Address: _____
Home# _____	Home# _____
Work# _____	Work# _____
Cell# _____	Cell# _____
Relationship _____	Relationship _____

Please list other children attending New Jersey Public Schools (Name, School)

Name: _____ School: _____

Name: _____ School: _____

Please check this box if there has been a name change of parent/guardian, address or telephone number.

STUDENT HEALTH INSURANCE INFORMATION
(This form is to be submitted to the School Nurse by Office personnel)

Student's Name: _____ Date of Birth: _____ Grade: _____

Does your child have Health Insurance?

Yes _____ If yes, name of insurance company: _____

No: _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

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: Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Eye Exam:	Date: _____	Contacts: <input type="checkbox"/> Glasses: <input type="checkbox"/>
Allergy:	Kind: _____	Medications: _____
Allergic Reaction:	Date: _____	Medications: _____
Immunizations/Tetanus:	Date: _____	Type: _____
Restrictions:	Type: _____	

Doctor: _____ Telephone: _____

Dentist: _____ Telephone: _____

Hospital: _____

Address: _____ Telephone: _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly 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 judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Hamilton Township School District Student Health History

Please answer the questions listed below. This form will provide us with valuable information concerning your child. It will also alert the staff to any health issues regarding your child. All information will be held strictly confidential. Your child's health and welfare is our primary concern. Please feel free to contact your child's School Nurse if you have any questions or concerns. Thank you!

Child's Full Name: _____

School _____ Last _____ Grade _____ First _____ Initial _____
Teacher _____

Date of Birth: _____

Has your child had any of the following?

	Yes	No		Yes	No
Chicken Pox	_____	_____	Strep Infection	_____	_____
Scarlet Fever	_____	_____	Hepatitis	_____	_____
Rheumatic Fever	_____	_____	Meningitis	_____	_____
Kidney Problems	_____	_____	Seizures	_____	_____
Ear Infections	_____	_____	Nosebleeds	_____	_____
Diabetes	_____	_____	Asthma	_____	_____
Pneumonia	_____	_____	Lymes	_____	_____
Neurological problems	_____	_____	Heart Disease	_____	_____
Mononucleosis	_____	_____			

Allergies (List all):

Medication Allergies _____

Food Allergies _____

Environmental Allergies (Latex, bees, seasonal, etc) _____

Has your child	Yes	No
1. Had more than six colds or throat infections each year?	_____	_____
2. Had more than three ear infections?	_____	_____
3. Had trouble hearing?	_____	_____
4. Ever had tubes inserted in ears surgically? Year _____	_____	_____
5. Ever worn hearing aids?	_____	_____
6. Ever had trouble seeing?	_____	_____
7. Ever worn contact lenses?	_____	_____
8. Ever worn glasses?	_____	_____
9. Had any trouble with his/her teeth?	_____	_____
10. Seen a dentist recently? Last Visit _____	_____	_____
11. Inability to control bowel or bladder?	_____	_____
12. Ever had a convulsion or fainting spell?	_____	_____
13. Had any other diseases or illnesses? If so, name them _____		

14. Had to stay in the hospital overnight? Yes _____ No _____
Age _____ Reason _____

15. Has your child ever had any serious accidents?
Burns _____ Poisoning _____ Broken Bones _____
Cuts requiring a Doctor _____
Comments _____

OVER

16. Has your child ever been diagnosed as having a heart problem or heart murmur?

Yes _____ No _____

If yes please submit a doctor's note stating whether or not there are any restrictions?

17. Has your child ever had:

	Yes	No		Yes	No
Wheezing	_____	_____	Sinus Problems	_____	_____
Eczema	_____	_____	Reaction to Medication	_____	_____
Hives	_____	_____	Reaction to Injections	_____	_____
Asthma	_____	_____	Reaction to Insect Bites	_____	_____
Hay Fever	_____	_____			

18. Has your child ever been treated for allergies: Yes _____ No _____

DOES YOUR CHILD HAVE OTHER ILLNESSES OR PROBLEMS THAT WE SHOULD BE AWARE OF? Please state:

DOES YOUR CHILD TAKE ANY MEDICATION? If so please list

Do you have Health Insurance? YES or NO

Do you have Dental Insurance? YES or NO

Do you have Vision Insurance? YES or NO

Would you like information on NJ Family Care Insurance? YES or NO

The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency, this information can be shared with emergency personnel.

YES please share information

_____ Initial

No please call me to discuss

_____ Initial

I give permission for my child to receive the annual health screenings as required by the New Jersey Department of Education.

Parent /Guardian Name Printed _____

Date _____

Parent/Guardian Signature _____

Name of Childs Pediatrician: _____ Phone # _____

TOWNSHIP OF HAMILTON SCHOOL DISTRICT

PERMISSION TO RELEASE ALL RECORDS

Kindergarten and First Grade (Attn: Donna Martin)

Joseph C. Shaner School
5801 Third Street Mays Landing, New Jersey 08330
(609)476-6141 (609)625-8346 fax

Pre-K, Second and Third Grade (Attn: Cathie Palmeri)

George L. Hess Complex
700 Babcock Road Mays Landing, New Jersey 08330
(609) 476-6116 (609)625-1505 fax

Fourth and Fifth Grade (Attn: Diane Manno)

George L. Hess Complex
700 Babcock Road Mays Landing, New Jersey 08330
(609)476-6125 (609)625-1505 fax

Sixth Grade (Attn: 6th Grade Office)

William Davies Middle School
1876 Dr. Dennis Foreman Drive Mays Landing, New Jersey 08330
(609)476-6263 (609)625-2267 fax Attn: D. Leek

Seventh Grade (Attn: 7th Grade Office)

William Davies Middle School
1876 Dr. Dennis Foreman Drive Mays Landing, New Jersey 08330
(609)476-6253 (609)625-2267 fax Attn: L. Stephenson-Grasso Johnson

Eight Grade (Attn: 8th Grade Office)

William Davies Middle School
1876 Dr. Dennis Foreman Drive Mays Landing, New Jersey 08330
(609)476-6254 (609)476-6251 fax Attn: M. Santilli

Student Name: _____ **Current Grade:** _____ **D.O.B.:** _____

Last School Attended: _____

Address: _____

I give my permission for you to release the records for the student indicated above (note: Permission not required under (NJAC). I understand under the Federal NO Child Left Behind Act requirements, I must now also authorize the release of my child's discipline records to be included with the release of my child's permanent records, and my signature below indicates my authorization and permission to release the records to the above mentioned school as soon as possible.

Parent/Guardian Signature

Date

According to New Jersey Administrative Code 6:3-2.1 to 2.8, "*Mandated pupil records shall be forwarded to the receiving district...*" Please send the cumulative folder, the health records, grade-to-date, child study team records and any mandated records on the pupil listed above as soon as possible.

Hamilton Township School District

For Federal and State Report Use Only:

Please indicate your child's ethnic group by circling the appropriate letter:

A - Asian

B – Black / African American

I – American Indian or Alaska Native

P – Native Hawaiian or other Pacific Islander

H – Hispanic or Latino

M – Multi-Racial

W - White

Signature of Parent or Guardian

Student Name

Hamilton Township School District
Registration Office
5801 Third Street
Mays Landing, NJ 08330
Office No. 609-476-6147 – Fax No. 609-909-9466

Student's Name: _____
(Nombre Del Estudiante)

Grade: _____
(Grado)

Parent's Name: _____
(Nombre De Los Padres o Representante)

Telephone: _____
(Teléfono)

Dear Parents:
(Estimados Padres o Representante:)

We need you to fill out this form and return it to your child's school. It will be filed there. Thank you.
(Necesitamos que complete este formulario (forma) y que sea devuelto a la escuela de su hijo(a). Este formulario (forma) sera archivado alli. Gracias.

(TO BE FILLED IN BY PARENT OR GUARDIAN)
(PARA SER LLENADO POR EL PADRE/MADRE o REPRESENTANTE)

1. What Language did your child learn to speak first? Please check the language.
¿El idioma que primero aprendió a hablar su niño es? Por favor marque el idioma.

English (Ingles) <input type="checkbox"/>	Spanish (Español) <input type="checkbox"/>	French (Frances) <input type="checkbox"/>	Cantonese (Cantones) <input type="checkbox"/>	Vietnamese (Vietnamita) <input type="checkbox"/>
Urdu (Urdu) <input type="checkbox"/>	Pashto (Pashto) <input type="checkbox"/>	Hindi (Hindi) <input type="checkbox"/>	Guajarati (Guajarati) <input type="checkbox"/>	Creole (Creole) <input type="checkbox"/>

Other (please name) _____
Otra (Por favor, nómbrale)

2. Nationality: _____
Nacionalidad

3. What language is spoken in your home most of the time? _____
¿El idioma que se habla con mas frecuencia en su hogar es?

4. In what language do you read and write? _____
¿En cuales idiomas puede usted leer y escribir?

5. In what languages does your child read and write? _____
¿En qué idioma puede el estudiante leer y escribir?

6. In what Country was your child born? _____
¿En que país nació su hijo(a)?

7. If other then the United States, what year did your child come to the United States? _____
¿Si fuera de los Estados Unidos, en qué año regreso su hijo(a) a los Estados Unidos?

Parent/Guardian Signature
(Firma del Padre o Representante)

Date
(Fecha)

**Hamilton Township School District
Certificate of Transportation
Transportation Office**

To & From Home

Please complete this section of the form if your child will be transported TO and FROM HOME and return it to the school.

My child _____, who will be in the _____ grade at the
(Print Student's Name)
_____ school, should be transported to and from our home during the
_____ school year.
Our permanent home address is _____.

To & From a Location Other Than Home (Ex: Babysitter/Day Care Center)

Please complete this section if your child will be transported to or from a location **OTHER THAN HOME** and return it to the school.

Important Note: Requests are granted on a **5-DAY BASIS ONLY**
(The bus stop location must be the same for all 5 days of the week. If there is not an established stop at the location your child is to be transported, he or she will be transported to the stop nearest the babysitter/day care.)

Permission is hereby granted to _____ Grade _____,
(Print Student's Name)
who permanently resides at _____ to be transported
(Print Home Address)
to school from _____, and to be
transported, **from school** to _____
effective _____.

Please state the reason for this request: _____.

As a matter of **extreme importance** to the school, the **telephone information** as listed at the bottom of this notice is to be made known. If all information is not provided, this form will be returned to you and that will delay the start of this change.

I, the undersigned, release and discharge the Board of Education, its agents, servants and employees of and from any liability arising from the requested change in bus stop. I have read this Certificate of Transportation Change and understand all its terms. I hereby execute it voluntarily with full knowledge of its significance.

Please provide the following information for our files.

Mother's Cell Phone # _____
Father's Cell Phone # _____
Home Telephone # _____
Mother's Work Telephone Number _____
Father's Work Telephone Number _____
Babysitter/Day Care Center Name _____
Babysitter/Day Care Center Telephone Number _____
Babysitter/Day Care Center Cell Phone # _____

Signature of Parent or Guardian _____ **Date** _____