Jeffery S. Zito, Ed. D.
Superintendent
609-476-6300

Roxann Bryant
Director of Curriculum & Instruction
609-476-6108

1876 Dr. Dennis Foreman Drive
Mays Landing, NJ 08330
hamiltonschools.org

Christopher Veneziani
Assistant Superintendent
Business Administrator/Board Secretary
609-476-6302

Records Release Form

Please complete this form that will allow us to request records from your child's previous school in order to complete the registration process. Schools require that the new school requests records within two weeks of transfer.

Permission is granted for the release of records for_____
(Name of Student) PLEASE PRINT

PLEASE MAIL THE STUDENT'S ENTIRE CUMULATIVE FOLDER TO:

Preschool & Kindergarten: Joseph C. Shaner School, 5801 Third Street, Mays Landing NJ 08330

Grades 1-5: George L. Hess Educational Complex, 700 Babcock Road, Mays Landing NJ 08330

Grades 6-8: William Davies Middle School, 1876 Dr. Dennis Foreman Drive, Mays Landing NJ 08330

IEP Information:

☐ Grade 1-5: Mail to: George L. Hess Complex, 700 Babcock Road, Mays Landing, NJ 08330
ATTN: Mrs. Debbie Fiamingo (phone 609-476-6111) fiamingod@hamiltonschools.org

☐ Preschool/ Kindergarten & Grades 6-8: Mail to: 1876 Dr. Dennis Foreman Drive, Mays Landing, NJ 08330
ATTN: Mrs. Kristina Morey (phone 609-476-6246) moreyk@hamiltonschools.org

Students Date of Birth:

Previous School Name:

Previous School Address:

Does your Student have a IEP? Yes ☐ No ☐

Does your student have a 504 plan? Yes ☐ No ☐

PARENT INFORMATION AUTHORIZING RELEASE OF RECORDS:

Parent/Guardian Name:_____ Date:
(PLEASE PRINT)

Parent/Guardian Signature: _____ Date:

By completing this form, your electronic signature will act as an authorization for Hamilton Township School District to obtain the student file from your child's previous school in it's entirety. When you have completed the form, please return to

REGISTRATION@HAMILTONSCHOOLS.ORG

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McKinney-Vento/ Residency Questionnaire

To Be Completed by Parent/ Guardian

In accordance with New Jersey State Law (N.J.S.A. l8A:38-1 and 18A:7B-12), it is necessary to determine the residence of students entering the district by answering the following questions:
Student Name: _____ ID#:_____

1. Does the student reside in any of the following facilities or situations?

☐ A home the parent/ guardian owns or is renting (**skip remaining homeless registration procedures**)

☐ Family or Friends home by choice (Permanent residence)

☐ Family or Friends home out of necessity (temporary residence)

☐ Shelter-(youth home for adolescents, school age mothers, runaway youth, etc) Hotel/Motel/ Apartment/ Rooming House

☐ Transitional Housing

☐ Other (identify)

Parent Consultation:

I _____ understand that the district of residence will make the decision for placement of my child based upon the best interests of the child after consulting with me. If I disagree with the decision, I know that I may appeal to the County Superintendent of Schools.

☐ Return to his/her former school: _____

☐ Attend Hamilton Township School District

☐ Other: _____

Parent/ Guardian agrees with placement YES☐ NO☐

Parent/ Guardian signature: _____ Date:_____

Intake staff member signature: _____ Date:_____

District Homeless Liaison: _____ Date:_____

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Student Health History

Name of Student: _____ Date of Birth: _____
(LAST NAME, FIRST NAME, M.I)

Has Your Child Ever Had:	Yes	No	Has Your Child Ever Had:	Yes	No
Chicken Pox			Reaction to Medication		
Scarlet Fever			Reaction to infection		
Rheumatic Fever			Reaction to insect bites		
Pneumonia					
Mononucleosis			More than six colds or throat infections each year?		
Lyme Disease			More than three ear infections?		
Meningitis			Seen an **Eye** Doctor recently? Date:		
Hepatitis			Had trouble seeing?		
Diabetes			Ever worn contact lenses?		
Asthma			Worn glasses?		
Wheezing			Seen a dentist recently? Date:		
Nosebleeds			Had trouble with their teeth?		
Ear Infections			Wear Braces?		
Trouble hearing			Inability to control bowel or bladder?		
Worn Hearing Aids			Had a convulsion or fainting spell?		
Surgically inserted Tubes in ears? Year			Heart Disease?		
Seizures			Diagnosed with a heart problem or heart murmur		
Eczema					
Hives			Do you have Health Insurance?		
Seasonal Allergies			Do you have Dental Insurance?		
Sinus Problems			Do you have Vision Insurance?		
Kidney Problems					
Strep Infection					
CoVid-19 (positive test)					

LIST ANY MEDICAL/SURGICAL CARE YOUR CHILD HAS RECEIVED DURING THE PAST YEAR:

_____

DOES YOUR CHILD HAVE ANY OTHER ILLNESSES OR PROBLEMS THAT WE SHOULD BE AWARE OF?

_____

HAS YOUR CHILD HAD AN OVERNIGHT HOSPITAL STAY? IF YES, DATE AND DESCRIBE:

_____

_____

HAS YOUR CHILD EVER HAD ANY SERIOUS ACCIDENTS? {Burns, poisoning, broken bones, serious cuts?)

_____

ALLERGIES? (Medication/Food/Environmental):

If your child has allergies, please list type of allergy and type of reaction and last date of reaction (if applicable)

_____

_____

DOES YOUR CHILD TAKE ANY MEDICATIONS? _____ DOES YOUR CHILD HAVE ANY RESTRICTIONS?

Parent/ Guardian Signature: _____ Date: ____/____/____

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Student Health Insurance

Name of Student: _____Date of Birth:_____
(LAST NAME, FIRST NAME, M.I)

Does your Child have health insurance? (circle one)

Circle One

YES ☐ *If Yes, please provide the name of the insurance company on the line below:*

_____

NO ☐ *If NO, please review the following information and sign below:*
NJ Family Care provides free or low- c o s t health insurance for uninsured children and certain low income parents. For more information, call 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.

Parent/ Guardian Signature: _____ **Date: ____/____/____**

Name of PEDIATRICIAN: _____Phone: _____

Name of DENTIST: _____Phone: _____

Name of ORTHODONTIST: _____Phone: _____

Name of HOSPITAL: _____Phone: _____

The information on these forms 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 **_____ No, please call to discuss**

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

Parent/ Guardian Signature: _____ **Date: ____/____/____**

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 aforesaid child.

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

Parent/ Guardian Signature: _____ **Date: ____/____/____**