KEANSBURG SCHOOL DISTRICT

Keansburg Preschool Programs

81 Frances Place
Keansburg, NJ 07734
Phone 732-787-2007 x. 5400
Caruso Site Fax: 732-495-3287
Port Monmouth Road Site Fax : 732-495-7291
www.keansburg.k12.nj.us

Ms. Anne M. Hazeldine
Principal of Early Childhood

Ms. Kathleen O'Hare
Superintendent of Schools

PRESCHOOL REGISTRATION PACKET

- ONLY A PARENT/GUARDIAN MAY ENROLL A STUDENT IN PERSON
- STUDENT MUST LIVE IN KEANSBURG BOROUGH WITH PARENT/LEGAL GUARDIAN
- REGISTRATION BY APPOINTMENT ONLY MONDAY - FRIDAY 9AM - 1PM

THE FOLLOWING DOCUMENTS MUST BE PRESENTED AT THE TIME OF ENROLLMENT:

ORIGINAL BIRTH CERTIFICATE - Proof of student's date of birth.

IMMUNIZATION RECORD - Failure to provide appropriate information regarding immunization may result in your child not being able to enroll in school.

MANTOUX TB TEST -Students relocating from another area may need a TB test mandated by law. If required, must be provided within 30 days.

PHYSICAL EXAM FORM - PROVIDED IN PACKET - Must be completed within the last year.

CUSTODY, PROOF OF LEGAL GUARDIANSHIP/FOSTER PARENT PAPERS - If applicable.

PROOF OF RESIDENCY - HOMEOWNER: Deed, Current Property Tax Bill, HUD -1 Settlement along with (2) current Utility Bills, Valid Driver's License or Voters Registration Card.

PROOF OF RESIDENCY - RENTER: Current lease along with (2) current Utility Bills, Valid Driver's License or Voter Registration Card.

LIVING WITH ANOTHER FAMILY IN KEANSBURG BOROUGH OR YOUR NAME IS NOT ON THE LEASE:
Owner of the property or the landlord must fill out a Certificate of Domicile (Landlord Letter) and provide proof of residency. You must provide proof of residency (2) documents with your name and the Keansburg address.

Please call the office for further information regarding the non-traditional residency if needed at 732-787-2007 ext. 5400.

KEANSBURG SCHOOL DISTRICT
REGISTRATION FORM

School: _____ Grade: PREK Date: _____

Student's Name: _____
LAST FIRST MIDDLE INITIAL

Street Address: _____

_____

Mailing Address (if different) _____

_____

Primary Phone: _____

Email address: _____

Date of Birth: _____ Age: _____

Birth Place: City _____ State: _____

Birth Country: _____ U.S. Citizen: ____ Yes / _____ No

IF CHILD WAS BORN OUTSIDE THE U.S.A., DID THE CHILD ATTEND A LEARNING INSTITUTE? ____Yes / ____No
If Yes, what date: _____

Are you enrolling this student under the McKinney Vento Act? ____ Yes / ____ No

Ethnicity: Non-Hispanic or Latino ____

Race must be selected if ethnicity is Non-Hispanic or Latino

Race: ____White ____ Black or African American ____ American Indian or Alaska native ____Asian

____ Native Hawaiian or Other Pacific Islander ____ Hispanic or Latino

Native Language: _____ Primary Language Spoken at Home: _____

Parents/guardians: ____Married ____Divorced ____ Separated ____ Single ____ Widowed

Student resides with: _____

Who has legal custody: _____

Who has Physical 'Residential' custody: _____

If Divorced or Separated, provide the following information of the Non-Custodial Parent:

Name: _____ Email: _____

Home Address: _____ Primary Phone: _____

_____ Alternate Phone: _____

PLEASE INDICATE IF THERE ARE ANY SPECIAL CUSTODY CIRCUMSTANCES THE SCHOOL SHOULD BE MADE AWARE OF CONCERNING YOUR CHILD: DOCUMENTATION IS REQUIRED:

_____

_____

PREVIOUS SCHOOL INFORMATION

Last School Attended (If applicable) _____

Address: _____ State ID: _____

_____ Phone: _____

Was the student enrolled in any program listed below? Please check all that apply:

____ ESL (English as a second language) ____ Speech ____ Basic Skills/Title 1

____ Special Education / IEP ____ Other _____ Alternate School Programs

HAS THE STUDENT EVER BEEN ENROLLED IN KEANSBURG SCHOOL DISTRICT BEFORE? ____ Yes / ____ No

If so, give school name and dates of attendance: _____

List Siblings who live in the household:

NAME	GENDER	DATE OF BIRTH	SCHOOL	GRADE

EMERGENCY INFORMATION SHEET

Mother/Guardian Name: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

Email: _____ Work Phone: _____

Father/Guardian Name: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

Email: _____ Work Phone: _____

Emergency Contact #1 - other than parent: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

Relationship to student: _____

Emergency Contact #2 - other than parent: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

Relationship to student: _____

Student / sibling 14 years of age permitted to pick up student:

Name: _____ Phone: _____

Parent signature: _____ Date: _____

MEDICAL INFORMATION:

Family Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital Preference: _____

List below any medical/surgical care your child has received in the last year:

Care: _____ Date:_____

Care: _____ Date: _____

Does your child have Health Insurance:

____ Yes - Insurance Carrier: _____

____ No - NJ Family Care provides free or low cost 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 N Family Care Program to contact me about health insurance.

____ Yes ____ No

Signature: _____

Printed Name: _____ Date: _____

Written consent pursuant to 20U.S.C & 1232g (b) 34 C.F.R (b).

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Home Language Survey Form

Introduction

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Information

Student Name: _____ Student Birth Date: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Phone number: _____

Survey Questions

Question 1

What was the first language used by the student?

A language other than English - Proceed to question 2a.
English - Proceed to question 2b.

Question 2a

At home, does the student hear or use a language Other than English more than half of the time?

YES - Proceed to question 7

NO - Proceed to question 4

Question 2b

At home, does the student hear or use a language Other than English more than half of the time?

YES - Proceed to question 4

NO - Proceed to question 3

Question 3

Does the student understand a language other than English?

YES - Proceed to question 4 NO - proceed to question 9

Question 4

When interacting with his/her parents/guardians, does the student use a language other than English more than half the time?

YES - Proceed to question 7 NO - proceed to question 5

Question 5
When interacting with caregivers other than their parent/guardian, does the student use a language other than English more than half of the time?

____ YES

____ NO

Question 6
Has the student recently moved from another school district/charter school where he/she was identified as an English language learner (ELL)?

____ YES

____ NO

Question 7
What are the home languages spoken? Proceed to step 8.

8. Proceed to Step 2: Records Review Process.

Home Language Survey is complete

9. Do not proceed to Step 2: Records Review Process.

Home Language Survey is complete. Student is not an English Language Learner (ELL)

PLEASE FILL OUT ONLY IF YOUR CHILD IS A SPECIAL EDUCATION STUDENT

Special Education Medicaid Initiative (SEMI) Parental Consent form

_____ School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before assessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about the services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As the parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____ Date of Birth: ____ / ____ / _____

Parent/Guardian: _____

I give consent to bill for SEMI: YES ____

NO ____

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school in writing.

COPY TO PPS DEPARTMENT AND BUILDING CHILD STUDY TEAM

PRESCHOOL REGISTRATION INFORMATION

Today's Date: _____

Child's Name: _____

Date of Birth: _____

SECTION I:

When you were pregnant with your child, were there any complications? Yes_____ No_____
If 'yes' please explain: _____
_____
After delivery, was the baby in the hospital longer than two (2) days? _____
If yes, please explain: _____
_____

At what age did your child begin to: walk? _____ talk? _____
Does your child have any of the following habits:
Toilet accidents? _____ Temper tantrums? _____ High activity level? _____
Difficulty separating from you? _____ Excessive crying? _____
Has your child experienced any of the following difficulties Past or Present?
Speech _____ Hearing _____ Eating _____ Sleeping _____

Does your child have any Physical Restrictions? _____ Allergies: _____
If 'Yes' to either, please explain: _____
_____

What are your child's strengths? _____
What are your child's challenges? _____
Is there anything you find difficult about parenting? _____
Is there anything else you would like us to know about your child? _____
_____
_____

Does your child have any relatives enrolled in the Preschool Program? _____
Please list names and relationship:
_____ _____
_____ _____
_____ _____

Has your child attended another Preschool? _____ If 'Yes' please provide the following:
Name: _____
Address: _____ Phone: _____
City: _____ State: _____

Has your child ever received services from Early Intervention? Yes ____ No ____
If 'Yes' When _____ Where _____

Where did you hear about our preschool program? _____
Does your child need transportation to attend school? Yes _____ No _____

SECTION II

Written Consent pursuant to 20 U.S.C 1232g (b) (1) 34 C.F.R 99.30 (b).

HEALTH HISTORY INFORMATION

Please answer all questions to the best of your knowledge. ALL information will be kept confidential.

Child's Name: _____ Gender: _____
D.O.B: _____ Age now: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Father: _____Age:_____ Mother: _____ Age: _____
Child's Place of Birth: _____ Hospital: _____

Family History:

A. List any persons (other than siblings) residing in the home and their relationship to the child:

1. _____ _____
2. _____ _____
3. _____ _____

B. Any instances of serious illnesses among *immediate family members*: Yes: _____ No: _____
Such as: Epilepsy ____ Alcoholism ____ T.B. ____ Diabetes ____ Asthma ____Hay Fever ____
Other _____

SECTION III

PREGNANCY

A. Any problems during pregnancy?	YES	NO
a. Illness	____	____
b. Infection	____	____
c. Convulsions	____	____
d. Bleeding	____	____
e. Emotional Problems/stress	____	____
f. Medications	_____	
	_____	
g. Other	_____	

If you answered "yes" to any of the above, please explain : _____
_____

B. Did mother smoke during pregnancy? _____
C. Does anyone in the home smoke? _____
D. Was pregnancy full term _____ or premature _____(how many weeks early) _____
E. Was the delivery a normal spontaneous one? _____
If not a normal, spontaneous delivery, please explain below what type of delivery and reason:
(Ex. forceps, cesarean, etc:)
_____ _____
_____ _____

SECTION IV

CHILDBIRTH HISTORY

A. Birth weight _____
B. Any problems after birth (ex difficulty breathing, convulsions, weight loss, incubator, etc)? _____
    a. If 'Yes', please explain: _____
    _____

Developmental History/Milestones

A. Please indicate as closely as possible in months and years:
    a. Held head erect while lying on stomach _____
    b. Follow objects _____
    c. Sat independently _____
    d. Stood alone _____
    e. Walked alone _____
    f. Talked (babbled), imitate sounds _____
    g. Talked (in words/sentences) _____
    h. Bladder trained _____
    i. Bowel trained _____
    j. Fed self _____
    k. Right or Left handed _____

B. Any head injuries, illnesses, asthma, hay fever, allergies, frequent ear infections, fractures, convulsions, etc.
Yes_____ No___ If 'yes' please explain:
_____
C. Any hearing, vision, speech, or orthopedic issues: Yes _____ No _____ If 'yes' please explain:
_____
D. Is your child taking medication? Yes _____ No _____ If 'yes' please explain:
Medication:_____Condition:_____Medication:___
_____Condition:_____
E. Is your child allergic to any food or drug? Yes _____ No _____ If 'yes' explain:
_____
F. Describe your child's eating habits:
_____
_____
_____

G. Describe your child's Social Skills: YES NO

1. Shy ____ ____
2. Outgoing (friendly) ____ ____
3. Happy ____ ____
4. Talkative ____ ____
5. Confident ____ ____
6. Fearful ____ ____
7. Temper Tantrums ____ ____
8. Easily Angered ____ ____
9. Moody ____ ____
10. Quiet ____ ____
11. Aggressive ____ ____
12. Withdrawn ____ ____

If you wish to explain your child's social skills further:

_____
_____
_____
_____

_____ _____
Parent Signature Date

IMMUNIZATION

Chapter 14 of the State Sanitary Code requires that any child found deficient in his/her immunizations against the following childhood diseases WILL NOT be permitted to attend school:

- **DTaP - 4 doses**
- **Polio - 3 doses**
- **MMR - 1 dose**
- **HIB - 1 dose after FIRST birthday**
- **HEPATITIS-B - 3 doses**
- **Varicella - 1 dose, on or after the FIRST birthday/ or a physician's or parental statement of previous varicella (chickenpox) infections.**
- **PCV7 - 1 dose after FIRST birthday**
- **Influenza - 1 dose *yearly* between September 1 and December 31**

In addition to the above immunizations you ***MUST*** have proof of a:

- **Current physical**

Immunization records must show the month, day and year of administration.

Registration will NOT be completed unless all of the above documentation is presented.

If you have any questions, please contact the Preschool Health Office at:

(732) 787-2007 -

Caruso Pre-K - ext. 5870	PMR Pre-K - ext. 5770
Fax: (732) 495-3287	Fax: (732) 495-7291

This is a required form for school entry. Please complete the form.

Name of Student: _____

Date of Birth: _____

Parent/Guardian:_____

Date of Exam: _____Height: _____ Weight: _____

General Appearance	
Eyes	
Ears	
Mouth	
Nose	
Throat	
Glands	
Lungs	
Hair	
Skin	
Posture	
Heart	
Blood Pressure	

Doctor's Name - Please Print:_____

Doctor's Signature:_____

Doctor's Address:_____

Date:_____

Note: This physical exam form must be returned to the child's school nurse by the Parent/Guardian.

Form 312010