



# KEANSBURG SCHOOL DISTRICT

## Keansburg Early Learning Center

142 Port Monmouth Road  
Keansburg, NJ 07734  
Phone 732-787-2007 x. 5002  
[www.keansburg.k12.nj.us](http://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.

Who has Physical 'Residential' custody: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

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Last School Attended (If applicable) \_\_\_\_\_

Address: \_\_\_\_\_ State ID: \_\_\_\_\_

Phone: \_\_\_\_\_

| 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:

[illegible]

## EMERGENCY INFORMATION SHEET

CHILD'S NAME: \_\_\_\_\_

**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](http://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).



# KEANSBURG SCHOOL DISTRICT

## Keansburg Preschool Programs

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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 (babbed), 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

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

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\_\_\_\_\_  
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

Fax: (732) 495-3287

PMR Pre-K - ext. 5770

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.