WATERFORD TOWNSHIP SCHOOL DISTRICT
REGISTRATION FORM

STUDENT INFORMATION

_____ _____ _____ _____

Last Name Generation First Name Middle Name

Date of Birth _____ Nickname _____ M / F

Race/Ethnicity (please check all that apply)

_____ Hispanic or Latino _____ Black

_____ American Indian/Alaskan _____ Pacific Islander/Hawaiian

_____ Asian _____ White

NJ SMART – FEDERAL LEP INFORMATION

Birth City _____ Birth State _____

Birth Country _____ Entry Date into US School System _____

Language used at home _____

Language most often spoken by student _____

First Language Spoken (Native) _____

Has the student attended US schools for more than 3 full years (Immigrant Status) ? Y / N

PRIOR SCHOOL INFORMATION

Prior School Name _____

Prior School City _____ Prior School State _____

PLEASE SELECT FROM THE FOLLOWING OPTIONS REGARDING THE STUDENT'S PARENT/GUARDIAN:

_____ No military affiliation _____ Active Duty

_____ National Guard or Military Reserves _____ Unknown

RESIDENCY INFORMATION (please circle)

•Own my Home •Rent/Lease •Live with district resident •Temporary Situation

MEDIA RELEASE

Periodically throughout the school year, photographs may be taken of our students and staff in various academic and non-academic activities. Since these images may be used in printed and online materials such as the school district newsletter and/or brochures, local/regional publications, district website, social media, video presentations, or be displayed at various seminars and/or workshops in which the district participates, we need to obtain permission to take them.

_____ I GIVE permission for my child to be photographed for school-related publications, website and presentations.

_____ I DO NOT give permission for my child to be photographed for school-related publications, website and presentations.

TECHNOLOGY ACCEPTABLE USE POLICY

I understand the conditions set forth in the district Technology Acceptable Use Policy (a copy of which is provided during registration). I further understand that any violation is unethical and may constitute a criminal offense. Should my child commit any violation, their access privileges may be revoked, disciplinary and/or appropriate legal action may be taken.

_____ I have reviewed and understand the AUP and WILL ALLOW my child to use the internet.

_____ I DO NOT give permission for my child to use the internet.

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE:

Signature:_____ Relationship._____

OFFICE USE ONLY

STUDENT ID #_____ STATE ID # _____

Date of Registration_____ Preschool_____ Kindergarten_____ Transfer_____

Teacher_____ Grade _____ School _____

Permanent Records: Req._____ Rec'd_____ CST Records: Req._____ Rec'd _____

WATERFORD TOWNSHIP PUBLIC SCHOOLS EMERGENCY FORM

Student Name:_____ **Date of Birth:**_____

Address:_____ **Main Phone Number:** _____

Grade:_____ **Teacher:**_____ **School Year:**_____

CUSTODY ISSUES: YES / NO **STUDENT LIVES WITH**: ___Mother ___Father ___Both Parents Other_____

PLEASE SELECT ONE OF THE FOLLOWING:

- ☐ **There are no custody issues regarding my child. If at any time this status changes, I am responsible for providing a copy of the custody papers to the Waterford Twp. Public School Office. If I do not, I understand that my child may be released to either parent or any persons listed on the emergency form.**
- ☐ **I have given the Waterford Twp. Public School Office a copy of the latest custody papers for my child. I am also aware that it is my responsibility to furnish any updated custody papers. If I fail to do so, the latest papers on file will be enforced.**

My child is not permitted to be released to:_____**(as noted by legal documentation)**

MOTHER / GUARDIAN: Primary Contact 1st or 2nd (circle)	**FATHER / GUARDIAN: Primary Contact 1st or 2nd (circle)**
First Name:	First Name:
Last Name:	Last Name:
Relationship to Student:	Relationship to Student:
Mailing Address:	Mailing Address:
Main Phone:	Main Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email Address:	Email Address:
PLEASE SELECT ALL THAT APPLY	**PLEASE SELECT ALL THAT APPLY**
Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐	Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐

OTHER CONTACTS within 30 minutes of the school

First Name:	First Name:	First Name:
Last Name:	Last Name:	Last Name:
Relationship to Student:	Relationship to Student:	Relationship to Student:
Mailing Address:	Mailing Address:	Mailing Address:
Main Phone:	Main Phone:	Main Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Please select all that apply	**Please select all that apply**	**Please select all that apply**
Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐	Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐	Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐

CONTINUE ON REVERSE

STAFF USE ONLY: Is any contact a current Staff or BOE Member?_____

MEDICAL / DENTAL / INSURANCE INFORMATION

Family Physician _____ Telephone #_____

Family Dentist _____ Telephone #_____

Does your child have health insurance? Yes/No If yes, name of insurance company _____

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. Signature:_____ Printed Name:_____

Date:_____ Written consent required to 20 U.S.C. & 1232 (b)(1) and 34 C.F.R. 99.30(b)

Please check if the student has any of the following conditions:

_____diabetes _____asthma _____vision or hearing problems _____heart conditions with restrictions

_____seizure disorder _____wears glasses _____on medication(s) _____heart conditions without restrictions

_____severe allergies _____wears contacts _____G.I. issues _____other

Please explain items above that are checked_____

_____

_____

My child is on the following medication(s):

_____ _____

_____ _____

_____ _____

Please list any and all allergies:

_____ _____

_____ _____

_____ _____

List brothers/sisters attending school in this district: Name:_____ Grade:_____ School: Atco / TR / WES

Name:_____ Grade:_____ School: Atco / TR / WES Name:_____ Grade: _____ School: Atco / TR / WES

INFORMATION ON THIS CARD MAY BE SHARED WITH OTHER STAFF MEMBERS. IN CASE OF EMERGENCY, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL ONLY WHEN YOU CANNOT BE REACHED. I GIVE MY SON/DAUGHTER PERMISSION TO RECEIVE EMERGENCY HOSPITAL TREATMENT IF NECESSARY.

Date_____ Mother/Guardian Signature:_____ Father /Guardian Signature_____

WATERFORD TOWNSHIP PUBLIC SCHOOLS
MEDICAL HISTORY FORM

Name:_____ Date:_____
(Last) (First) (Middle)

Address:_____

Birth Date:_____ Sex: ☐ Male ☐ Female

School: ☐ Waterford ☐ Atco ☐ Thomas Richards Grade: _____

Mother & Father's Complete Name:_____

Family Physician:_____ Phone: _____

IS YOUR CHILD SUBJECT TO: (Please circle YES or NO)

Frequent colds	YES	NO	Chronic cough	YES	NO
Bronchitis	YES	NO	Vision loss	YES	NO
Frequent sore throats	YES	NO	Poor posture	YES	NO
Allergies	YES	NO	Emotional problems	YES	NO
Speech difficulties	YES	NO	Earaches	YES	NO

HAS YOUR CHILD HAD:

Poor eating habits	YES	NO	Difficulty sleeping	YES	NO
Tonsils removed	YES	NO	Eye injury	YES	NO
Eye disease	YES	NO	Convulsions	YES	NO
Head injury	YES	NO	Epileptic seizures	YES	NO
			Severe fall	YES	NO

MISCELLANEOUS:

Does child stumble, fall of bump into things frequently?	YES	NO
Did mother have serious illness or measles during pregnancy?	YES	NO

FAMILY HISTORY: (Please circle)
TB, Diabetes, Heart Disease, Allergies, Asthma, Epilepsy, Cancer, Kidney Ailments, Blindness, Deafness, Poor vision

HAS CHILD HAD: (IF YES, INCLUDE DATES IF POSSIBLE)

Diabetes	YES	NO	Asthma	YES	NO
Kidney Disease	YES	NO	High fever	YES	NO
RH Factor	YES	NO	Mumps	YES	NO
Bone defects	YES	NO	Chicken Pox	YES	NO
Pneumonia	YES	NO	Measles	YES	NO
Rheumatic Fever	YES	NO	German Measles	YES	NO
Cardiac history	YES	NO	Scarlet Fever	YES	NO

MEDICAL HISTORY

Describe any major illnesses or medical conditions (including hospitalizations, convulsions, high fevers, vision concerns, hearing concerns, allergies, persistent colds, ear infections, or other medical problems) your child may have experienced:_____

_____

_____

_____

List any specialists that have seen your child:_____

Describe any medications your child is taking (including type of medication, dosage, time):_____

_____

El:ajl
C:\My Documents\Form.MedicalHistory.Feb04.doc

PLEASE RETURN THIS FORM TO:

Name of Child: _____ Birth date: _____
School: _____ Grade: _____

FORM TO BE COMPLETED BY PHYSICIAN DATE OF EXAMINATION: _____

VACCINE TYPE	Disease Date	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	6th Dose Mo/Day/Yr
Diphtheria, Tetanus, Pertussis-DTP *(If DT or Td, indicate in corner box)							
Tdap							
Oral Polio Vaccine (OPV) *(If Salk Vaccine, indicate IPV in corner box)							
MMR (Measles, Mumps & Rubella)							
Measles					or Measles Serology	Date	Titer
Rubella					or Rubella Serology	Date	Titer
Mumps					or Mumps Serology	Date	Titer
Haemophilus B (HIB) Required for Day/Child Care Enrollees (2 mos – 5th birthday only)							
Hepatitis B					Hepatitis A		
Varicella					HPV		
Pneumococcal (PCV)							
Influenza							
Meningitis							
Other							

☐ Provisional admission attached-Date Granted _____ ☐ Medical exemption attached _____ ☐ Religious exemption attached

CHILDHOOD DISEASES (GIVE DATES)

Chickenpox _____ Rheumatic Fever _____
German Measles _____ Scarlet Fever _____
Measles _____ Whooping Cough _____
Mumps _____

OPERATIONS

Tonsillectomy _____ Hernia _____
Appendectomy _____ Other _____

MEDICAL HISTORY

Convulsive Disorders _____ Fracture _____
Diabetes _____ Other Injuries _____
Kidney Disorders _____ Speech Defect _____
Cardiac Disorders _____ Asthma _____
Other Serious Illnesses _____ Allergies _____

PHYSICAL EXAMINATION Height _____ Weight _____ Blood Pressure _____

Ears _____ Abdomen _____
Nose _____ Hernia _____
Throat _____ Genitalia _____
Teeth _____ Feet _____
Gums _____ Skin _____
Thyroid _____ Nutrition _____
Heart _____ Posture _____
Lungs _____ Nervous Symptoms _____
Vision R _____ L _____ Hearing R _____ L _____

General Condition _____

Current Health Problems _____

Medications Being Taken _____

_____ _____
PRINT NAME OF PHYSICIAN SIGNATURE OF PHYSICIAN

THIS INFORMATION IS VITAL TO THE WELFARE OF THE CHILD. CONFIDENTIAL INFORMATION MAY BE DISCUSSED WITH THE SCHOOL NURSE.

KIH md 2-11-13 Waterford Physical Form

SEE REVERSE SIDE FOR DENTAL SCREENING → → → →

DENTAL SCREENING

Name of Student: _____

The above-named student has been seen by the dentist.

Results: _____

_____

Recommendations: _____

_____

_____ _____

Dentist Phone #

_____

Date