



Kenilworth Public Schools
Office of the Superintendent

www.kenilworthschools.com
426 Boulevard
Kenilworth, New Jersey 07033
908-276-5936

Student Registration Checklist

- Student Registration Form
- NJSMART Information Form
- Custody Alert Form
- Record Release Form
- Health History Form
- Comprehensive Physical Examination Form
- Certification of Immunization Form
- Child's Birth Certificate
- Current tax bill, mortgage statement or lease
- Two current utility bills
- Transfer Card
- Report Card
- Test scores
- Military Status
- Custody papers (if applicable)



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Registration Information

Name of Student		Preferred Name	
Street			
City		State, Zip	
Home Phone		Grade	
Previous Address		Previous Phone	

Is this the student's Primary Residence? YES NO	Starting Date	Is the student's address temporary? YES NO	Is the student currently Homeless? YES NO
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Migrant <input type="checkbox"/> Immigrant	Ethnicity <input type="checkbox"/> Native American/Eskimo <input type="checkbox"/> Native Hawaiian/Pacific Islander Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Caucasian/European	<input type="checkbox"/> Asian/ Middle Eastern <input type="checkbox"/> American Indian/Alaska	<input type="checkbox"/> African/African American
Date of Birth		Birth Place	

Mother/Guardian Information

Mother/Guardian		Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow
Address			
Home Phone		Work Phone	
Cell Phone		Email Address	
Employer		Occupation	
Employer Address			

Father/Guardian Information			
Father/Guardian		Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow
Address			
Home Phone		Work Phone	
Cell Phone		Email Address	
Employer		Occupation	
Employer Address			

EMERGENCY CONTACT INFORMATION			
Name			
Relationship to Child		Work Phone	
Day Phone		Cell Phone	
Physician		Phone	
Physician's Address			

HEALTH INSURANCE
Do you currently have health insurance <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what is the name of the Health Care Provider? _____

CUSTODY
Does anyone other than the parent have legal custody of student? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain and provide a copy of legal custody order.

OTHER CHILDREN IN HOUSEHOLD			
Name	Date of Birth	Gender	School
		M F	
		M F	
		M F	
		M F	
		M F	

PREVIOUS SCHOOL INFORMATION			
Name of school child last attended			
Address, City, State, Zip			
School's Phone		School's Fax	
Last grade Attended		Last day attended	

PREVIOUS SCHOOL INFORMATION	
What language is most often spoken at home?	
Do you have concerns about your child's learning needs, such as reading, writing, math, emotional, or behavioral? YES NO If yes, please explain:	
Is your child or has your child ever been classified for special education? YES NO If yes, provide a copy of your child's IEP	
Is your child currently eligible for Section 504? YES NO If yes, provide your child's accommodation plan	
Is your child currently eligible for Intervention & Referral Services (I&RS) or Pupil Assistance Committee (PAC)? YES NO If yes, provide your child's accommodation plan	

REQUIRED NOTICE: Eligibility to attended school is subject to review and re-evaluation. There is a potential for assessment of tuition in the event that an initially admitted applicant is later found ineligible.

ASSISTANCE: Questions regarding residency requirements may be addressed to the Board Secretary of the Kenilworth Public Schools, (908) 276-5936.

Parent/Guardian Signature: _____ Date: _____



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Record Release Form

Student Name: _____ Date: _____

Name of School: _____ Date of Birth: _____
(Former)

School Address: _____
(Street) (City, State) (Zip)

School Telephone: : _____ School Fax: : _____

Last Grade Completed: _____ State ID Number: : _____

I hereby authorize you to forward *all* documents pertaining to the above student.

All documents must have the State ID Number on them.

- Cumulative Records
- Health Records (immunizations, etc.)
- Guidance Records (Standardized test scores, Scholastics evaluations, Attendance records)
- Discipline Records (All information related to disciplinary actions and any notice that the students committed juvenile offenses)
- Free/Reduced Lunch Forms
- I&RS, PAC or Section 504 Plans
- Other: _____

Please forward all official records to:

- Harding Elementary School, 426 Boulevard, Kenilworth, NJ 07033, (908) 276-5936
- David Brearley Middle School, 401 Monroe Avenue, Kenilworth, NJ 07033, (908) 931-9696
- David Brearley High School, 401 Monroe Avenue, Kenilworth, NJ 07033, (908) 931-9696

I hereby authorize you to forward *all* documents pertaining to the above special education student.

- Child Study Team Evaluations (IEP's, Social History, Psychological, Learning Evaluations, Annual Reports, etc.)

Please forward all official records to:

- Harding Elementary School, Office of Special Services, 426 Boulevard, Kenilworth, NJ 07033

Signature of Parent or Guardian

Signature of School Official



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Student Health Information Form

Student Name _____ DOB _____ Sex _____ Grade _____

General Health Questions	Yes	No	Comments if "Yes" & date of occurrence
Has the student been under a doctor's care in the past 12 months?			
Has the student been hospitalized in the last 12 months?			
Has the student ever had any surgeries?			
Does the student have any missing organs? (eye, kidney, testicle, etc.)			
Has the student ever had chest pain during or after exercise?			
Does the student have trouble with breathing or coughing during or after activity?			
Condition	Yes	No	Comments if "Yes" & date of occurrence
Anemia			
Allergies (food, insects, medications, latex)			
Allergies/Hay fever (seasonal)			
Asthma			
Use of Inhaler?			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Bladder problems			
Bowel problems			
Bronchitis			
Cancer			
Cerebral Palsy			
Chicken Pox			
Cystic Fibrosis			
Dental Problems			
Developmental problems			
Diabetes			
Ear Infections (frequent)			
Eczema			
Glasses or contact lenses			
Head or Spinal injury			
Headaches (frequent)			
Hearing Aide(s)			
Hearing problems or Deafness			
Heart problems			
Hemophilia			

Hepatitis			
High Blood Pressure			
Condition	Yes	No	Comments if "Yes" & date of occurrence
Hydrocephalus			
Immune disorder			
Kidney problems			
Lyme Disease			
Meningitis			
Migraines			
Mononucleosis			
Muscular Dystrophy			
Muscle problems			
Orthopedic problems			
Pneumonia			
Seizures			
Sickle Cell Disease			
Skin problems			
Skull Fracture			
Speech problems			
Stomach problems			
Strept throat (frequent)			
Tuberculosis			
Vision problems			
Other			

List all prescription and over-the-counter **medications** your child takes regularly:

Describe any other important health-related information about your child:

Student's Pediatrician or Primary Care Provider:	Medical Specialists or Specialty Clinics caring for this student:
Has the student ever seen a Dentist? Yes No (circle one)	Name of Dentist:

For Parents/Legal Guardians of Students

The information on this form is current and correct to the best of my knowledge. I understand that if the medical status of my child changes in any significant way, **I will notify his/her school nurse of the change immediately.** I also understand that my child's health/medical information may be shared with other school staff members in order to ensure my child's health and safety while at school.

By signing below, I am agreeing to the above statements.

Signature of Parent or Legal Guardian:	Date:
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For Nursing Use Only:

Action Plan Received IHP Emergency Response Plan 504 Plan Medication Forms



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Comprehensive Physical Examination Report

To be completed by a licensed physician/licensed nurse practitioner.			
Name: _____		Ht. _____	Wt. _____ BMI _____ Age _____
DOB: _____		BP _____	T _____ P _____ R _____
Current Meds: _____		Allergies: _____	
Past Medical History		Asthma: No Yes: Intermittent • Moderate • Persistent • Severe • Persistent • Exercise induced <i>If yes, please see school Nurse for Asthma Action Plan.</i> Anaphylaxis Allergies: No Yes: Food • Insects • Latex • Unknown source <i>If yes, please see school Nurse for Emergency Allergy Plan.</i> History of Anaphylaxis No Yes Epi Pen required No Yes	
Major illness _____			
Hospitalizations/Surgeries _____			

Nutritional Assessment		Dental Assessment	
Special Diet _____		Any Dental Disease No Yes	Reproductive
Vitamins/Supplements _____		Dental Caries No Yes	Menarche age _____ LMP _____
Comments: _____		Brush Teeth Regularly No Yes	
		Dental Visit in the last year No Yes	
Vision Screen (if indicated) Not indicated		Hearing Screen (if indicated) Not indicated	TB: High-risk Group? No Yes
Subjective: any eye disorder Yes No		Subjective: response to voices Yes No	Positive/Referred _____ mm
Wear eyeglasses/contacts Yes No		Delayed speech development Yes No	
Objective: visual acuity R 20/ __ L		Recurrent O.M. Yes No	
20/ __		Hearing 20db HL (pass or fail)	
with glasses/contacts Yes No		1000Hz 2000Hz	
Muscle balance pass fail		4000Hz	
Color perception pass fail		Right ear _____	

		Left ear _____	

Review of System	WNL	Abnormal	Comments
Constitutional			
Eyes			
ENT			
Cardiovascular			
Respiratory			
GU			
GI			
Musculoskeletal			
Neurological			
Psychiatric			
Endocrine			
Hemat./Lymphatic			
Allergic/Immunological			

Social History/Devel. Assessment (Use additional sheets for more information).		Anticipatory Guidance	
<i>Cognitive Devel.</i>		Nutritional/Diet _____	
Speech/Lang. Devel.		SkinCare/Hygiene _____	
Social/Emot. Devel.		Oral/Dental _____	
Health Beh./Habits (Drugs/ETOH/Tobacco)		Behavioral Devel. _____	
		Safety _____	
		School Status _____	
		Health/Reproduction _____	
		High Risk Activities _____	
Comments:			
Medical Provider's Name (print) _____		Physician Stamp required:	
Phone #: (_____) _____			
Signature of Medical Provider: _____			
Date: _____			



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**K ENILWORTH PUBLIC SCHOOLS
S CHOO L ENTRANCE HEALTH FORM
Ce rtification of Immunization**

To be completed by a physician, registered nurse, or health department official.

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day and year of the required vaccines shall be acceptable in lieu of recording of recording these dates on this form as long as the record is attached this form).
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: /_____/_____/_____
Last First Middle Mo. Day Year

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN					
	1	2	3	4	5	
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)						
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)						
*Tdap booster (6 th grade entry)						
*Polio myelitis (IPV, OPV)						
*Haemophilus influenza Type b (Hib conjugate) *only children <60 months of age						
*Pneumococcal (PCV conjugate) *only children <2 years of age						
Measles, Mumps, Rubella (MMR vaccine)						
*Measles (Rubeola)				Serological Confirmation of Measles Immunity:		
*Rubella				Serological Confirmation of Rubella Immunity:		
*Mumps						
*Hepatitis B Vaccine (HBV)						
*Varicella Vaccine				Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine						
Meningococcal Vaccine						
Human Papillomavirus Vaccine						
Other						
Other						

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the **MINIMUM** requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children*.

Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): ____/____/____



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**NJ SMART DATA SHEET
Required by the N J Department of Education**

First Name _____ Middle Name _____ Last Name _____

Address _____

City _____ State: _____ Zip Code _____

State ID Number (obtained from previous school district -10 digit number) _____

Date of Birth _____ Social Security Number _____

Birth City _____ Birth State _____ Birth Country _____

Birth Certificate Number _____ Country of Citizenship _____

First Entry in US School _____ US Entry Date (if born outside of US) _____

Primary Language _____ Home Language _____

Health Insurance Yes No Name of Health Insurance Carrier _____

Ethnicity White Black Hispanic American Indian/Alaskan Asian Hawaiian/Pacific Islander

High School Entry Date _____ Month _____ Date _____ Year _____ Year of Graduation _____

Gender Male Female Special Education Yes No I&RS Yes No 504 Yes No

Residency Kenilworth Winfield Park Choice

Choice Students Yes No City of Residency _____ School District _____

Name of School student should attend if they did not attend Brearley _____

TO BE COMPLETED BY KENILWORTH SCHOOL DISTRICT

For Winfield Park students:

Residency Coding (Tracking>Other>Residency District Tracking)

Resident County / District / School	Start Date	End Date
County: 39.Union		
District: 5810.WINFIELD TOWNSHIP		
School: 000.Unknown		

Tuition Coding (Tracking>Other>Tuition Tracking)

(Only fill Attending County / District / School if student is sent out of district)	Start Date	End Date
County:		
District:		
School:		
Tuition: 01.Paid by another school district		

For Choice students:

Residency Coding (Tracking>Other>Residency District Tracking)

Resident County / District / School		Start Date	End Date
County:	39.Union		
District:	2190.HILLSIDE TOWNSHIP		
School:	060.Calvin Coolidge E.S.		

Tuition Coding (Tracking>Other>Tuition Tracking)

(Only fill Attending County / District / School if student is sent out of district)		Start Date	End Date
County:			
District:			
School:			
Tuition:	06.Paid by the state: a non-resident student attending a choice school		

For Shared Time students:

Shared Time Tracking (Tracking>Other>Shared Time Tracking)

(filling in County / District / School is optional)		Start Date	End Date
County:	39.Union		
District:	5260.UNION COUNTY VOCATIONAL SD		
School:	050.Union Co. Voc.-Tech.		
Shared Time:	sent		

For Out of District Placed students:

Residency Coding (Tracking>Other>Residency District Tracking)

Student's Current School: **Out-of-District Students**

Resident County / District / School		Start Date	End Date
County:	39.Union		
District:	2420.KENILWORTH		
School:	010.David Brearley H.S.		

Tuition Coding (Tracking>Other>Tuition Tracking)

Student's Current School: **Out-of-District Students**

(Only fill Attending County / District / School if student is sent out of district)		Start Date	End Date
County:	40.Union (Private - Disability)		
District:	8282.New mark School - Plainfield		
School:	R47.New mark School - Plainfield		
Tuition:	09.Paid by our school district		



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Student Registration - Military Status

Effective August 6, 2015, the State of New Jersey requires all public schools to identify students' parent(s) or guardian(s) who are on Active Duty, in the National Guard, or in the Reserve components of the United States military services.

Please indicate the following military connection status for your child:

Not military connected - no active duty, National Guard or Reserve parent/guardian.

Active Duty - student is a dependent of a member of the Active Duty Forces – full time Army, Navy, Air Force, Marine Corps, or Coast Guard.

National Guard or Reserve - student is a dependent of a member of the National Guard or Reserve Forces – Army, Navy, Air Force, Marine Corps, or Coast Guard.

Unknown - It is unknown whether or not the student is military connected.



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Custody Alert Form

The legal parent, custodian or court-ordered guardian for

_____ is _____
(Student Name) (Parent/Guardian Name)

The following people may not have legal access to the child or the child's records without written permission from the custodial person (must be accompanied by a copy of the custody papers or restraining order):

Name _____

Relationship to student _____

Address _____

Phone number _____

Signature of Parent