# WATERFORD TOWNSHIP SCHOOL DISTRICT ENROLLMENT REQUIREMENTS

**ONLY** the parent or legal guardian may enroll a student and the student **MUST** reside in Waterford Township

## DOCUMENTS REQUIRED

1. **Proof of Residence – (6 points needed)** [NJSA 18A:38(a)] [NJAC 6A:22-3.4]
   a. Current Property Tax Bill (4 points), **OR**
   b. Current Mortgage or Lease (4 points)
      - Leases **MUST** be **CURRENT** and signed by **BOTH** parties- (tenant & landlord)

   c. Agreement of Sale within 30 days (4 points), **AND**
   d. Current Utility Bill [Gas, Electric, Water, Sewer] (2 points each)
      - Bill **MUST** be current.
      - Bring **ENTIRE** bill along.

   e. Other Current document with address (1 point each)
   (Bank Statement, Car Insurance, Medical Bill or Cable) [2 point maximum]
   f. **Affidavit** – If the parent/guardian is **NOT** the homeowner or lessor, the homeowner or lessor **MUST** complete a notarized affidavit [we will provide] & prove their residency by providing the documents listed above.

2. **Proof of Parent / Guardian Identity** [NJSA 18A:36-25]
   a. Current Photo Drivers License **OR** Photo ID.
   b. DCP&P placement **OR** Court Documents – if applicable
   c. If parent & child have different names due to marriage **MUST** supply marriage certificate.

3. **Proof of Custody (if divorced or separated)**
   a. Custody Agreement showing Joint or Residential Custody **OR**
   b. Admission Form 3 [we will provide] parent agreement of School District.

4. **Proof of Student Identity** [NJSA 18A:36-25.1]
   a. Birth Certificate **(Original)**

5. **Health Information** [NJAC 8:57-4
   a. Immunization record
   b. Physical

6. **School Records (transfers only)**
   a. Transfer Card
   b. Report Cards
   b. IEP – if applicable

# 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 contained within the WTSD Parent Handbook). 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:__________________

Registration Form
Revised: Sept.2016

## 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: ______________________________________________________________________________

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 | FATHER / GUARDIAN |
|---|---|
| FIRST NAME: | FIRST NAME: |
| LAST NAME: | LAST NAME: |
| EMAIL: | EMAIL: |
| MAILING ADDRESS: | MAILING ADDRESS: |
| HOME PHONE: | HOME PHONE: |
| WORK PHONE: | WORK PHONE: |
| CELL PHONE: | CELL PHONE: |
| RELATIONSHIP TO STUDENT: | RELATIONSHIP TO STUDENT: |
| **PLEASE SELECT ALL THAT APPLY** | **PLEASE SELECT ALL THAT APPLY** |
| Emergency Contact: ☐ Send Mail: ☐ | Emergency Contact: ☐ Send Mail: ☐ |
| Student Resides: ☐ Send Call Out: ☐ | Student Resides: ☐ Send Call Out: ☐ |
| Primary Contact: ☐ Allow Pick Up: ☐ | Primary Contact: ☐ Allow Pick Up: ☐ |
| Allow Portal Access: ☐ **NOT ALLOWED CONTACT:** ☐ | Allow Portal Access: ☐ **NOT ALLOWED CONTACT:** ☐ |

**OTHER ALLOWED 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: |
| HOME PHONE: | HOME PHONE: | HOME PHONE: |
| WORK PHONE: | WORK PHONE: | WORK PHONE: |
| CELL PHONE: | CELL PHONE: | CELL PHONE: |
| **Please select all that apply** | **Please select all that apply** | **Please select all that apply** |
| Emergency Contact: ☐ Send Mail: ☐ | Emergency Contact: ☐ Send Mail: ☐ | Emergency Contact: ☐ Send Mail: ☐ |
| Student Resides: ☐ Send Call Out: ☐ | Student Resides: ☐ Send Call Out: ☐ | Student Resides: ☐ Send Call Out: ☐ |
| Primary Contact: ☐ Allow Pick Up: ☐ | Primary Contact: ☐ Allow Pick Up: ☐ | Primary Contact: ☐ Allow Pick Up: ☐ |
| Allow Portal Access: ☐ | Allow Portal Access: ☐ | Allow Portal Access: ☐ |

***SEE REVERSE***

## 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 ______________
German Measles ______________
Measles ______________
Mumps ______________
Rheumatic Fever ______________
Scarlet Fever ______________
Whooping Cough ______________

**OPERATIONS**

Tonsillectomy ______________
Appendectomy ______________
Hernia ______________
Other ______________

**MEDICAL HISTORY**

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

**PHYSICAL EXAMINATION** Height ________ Weight ________ Blood Pressure ________

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



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 #