Orange Township Public Schools

Dr. Gerald Fitzhugh, II
Superintendent of Schools

Lisa Spottswood Brown
Manager of Data and Student Pupil Services

To All Persons Registering a Child:

Only **PARENTS OR LEGAL GUARDIANS** may register a student in the Orange Township Public School District. The following items must be provided to process a student's registration packet. At the time of registration, please present **ALL** of the following items:

STUDENT'S INFORMATION

- Birth Certificate (must be copied and kept in DR file)
- New Jersey State ID (in-state transfers)
- Immunization Records
- Physical Examination dated with a year (not mandatory for enrollment)
- A Transfer Card
- Recent Report card and Test Scores
- Complete Transcript (high school students)
- Individual Educational Program (IEP) (if applicable)

PARENT/GUARDIAN PROOF OF IDENTITY

- Current Government Issued Photo ID, State ID, or Passport

PROOF OF RESIDENCY

At the time of registration, you must present **ONE** of the following **primary** documents **PLUS TWO** of the following **secondary** documents. All documents must be **originals** dated within the last thirty (30) days:

Acceptable Primary Documents

- Contract of Purchase or Sale
- Tax bill
- Mortgage statement
- Current Lease
- Property Deed
- Water bill

Acceptable Secondary Documents

- Utility bill (must be in your legal name)
- Credit Card statement (must be current)
- Current Driver's license **or** Current Vehicle Insurance **or** Registration Card
- Current Paycheck stub
- State Benefit Statements or Public Assistance Documents
- Medical insurance bill
- Bank Statement
- Cable/Satellite bill

ALL PARENTS NEEDING AN OWNER/LANDLORD AFFIDAVIT MUST REPORT TO THE DISTRICT REGISTRAR'S OFFICE.

*********Please see special conditions that apply below*********

PROOF OF RESIDENCY SPECIAL CONDITIONS:

- If you **do not** have a lease and you and your child (ren) are residing with a friend or relative in a **private** home, the homeowner must provide proof of ownership. Additionally, the Owner/Landlord Affidavit Form must be completed by the homeowner. **Two** (2) additional proofs of residency from our secondary list of accepted documents must be provided by the parent/guardian of the child (ren) being registered.

- If you **do not** have a lease and you and your child (ren) are residing with a friend or relative in an apartment building, the Landlord or Managing Agency must complete the Owner/Landlord Affidavit Form **not the tenant renting the apartment.** **Two** (2) additional proofs of residency from our secondary list of accepted documents must be provided by the parent/guardian of the child(ren) being registered.

********** **NOTE** **********

For admission to kindergarten, a child must be five years of age **on or before** October 1st.

Registration for Guardian Affidavit, DYFS and Court Placements:

- DYFS Placement must submit court order or DYFS ID letter.
- For Guardianship and/or Legal Custody you must report to:

Wilentz Justice Complex
212 Washington Street Room 113
Newark NJ 07102
(973) 776-9300
Hours of Operation 8AM – 4:30PM

Incomplete Registration Packets Will Not Be Accepted and May Delay Student's Enrollment

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STUDENT RESIDENCY

THE DISTRICT RESERVES THE RIGHT TO CONDUCT RESIDENCY CHECKS

Students not legally domiciled in Orange Township are not entitled to a free education in the Orange Public School District.

Please be advised that enrollment in Orange Public Schools is permissible only for those children whose parent(s)/guardian(s) are residents of Orange. Pursuant to **N.J.AC. 6A:22-4.1**, eligibility for admission to the Orange Public School District is subject to thorough review and evaluation and there is a potential for assessment of tuition in the event that an initially admitted student is later found ineligible for enrollment.

Furthermore, any resident who knowingly permits their name and/or address to be used in the registration of a non-resident student for the purpose of attending Orange Public Schools will be prosecuted to the fullest extent of the law and sued for the tuition for the period of ineligible attendance in the school district.

Residency checks are completed on students on a regular basis and may be conducted as early as 6:00am.

I attest to the best of my knowledge the residency information submitted is true and correct. I fully understand fraudulent statements, claims or documents will be prosecuted to the full extent of the law.

Please sign below:

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

STUDENT INFORMATION FORM

PLEASE COMPLETE ALL SECTIONS
(As it appears on the birth certificate)

Last Name	First Name	Middle Name
Home Address	City, State, & Zip Code	Date Moved In
Previous Address	City, State, & Zip Code	Current Home Telephone Number
Date of Birth	City and State of Birth	Country of Birth
State Identification# (SID)	Gender: Female ☐ Male ☐	

Ethnicity: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Alaskan/Native ☐ Amer. Indian ☐ Pacific Islander

Entering Grade: ☐ KF ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Language Spoken at home? _____

Student Is Living With: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other

School:

☐ Rosa Parks Community School	☐ Heywood Avenue School	☐ Orange Preparatory Academy
☐ Cleveland Street School	☐ Lincoln Avenue School	☐ Park Avenue School
☐ Forest Street School	☐ Oakwood Avenue School	☐ Orange High School

Previous School Information:

_____ _____ _____ From: _____ To: _____
School Name Location Grade Dates of Attendance

HAS THE STUDENT BEEN CLASSIFIED OR ENROLLED IN SPECIAL EDUCATION CLASSES?
☐ YES ☐ NO

HAS THE STUDENT BEEN RECEIVING ACCOMODATIONS THROUGH A 504 PLAN?
☐ YES ☐ NO

IS THE STUDENT COVERED BY HEALTH INSURANCE? ☐ YES ☐ NO

PLEASE LIST THE INSURANCE PROVIDER _____

I attest to the best of my knowledge the information listed above is true and correct. Fraudulent statements or claims may lead to prosecution to the fullest extent of the law.

_____ _____ ___/___/___
Signature of Person Completing this Application Relationship to the Student Date

(FOR OFFICE USE ONLY) Entry Date___/___/___ Student ID#_____

Staff Member Completing the Registration Packet _____ ___/___/___
Signature Date

MOTHER/LEGAL GUARDIAN

PLEASE PRINT CLEARLY

Last Name	First Name	Relationship to Student
Home Address	City, State, & Zip Code	Date Moved In
Home Telephone Number	Cell Telephone Number	Email Address
Date of Birth	City and State of Birth	Country of Birth

Ethnicity: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Alaskan/Native ☐ Amer. Indian ☐ Pacific Islander

Residency Information:		
☐ Homeowner	☐ Single Family House	☐ Multi-Dwelling House
☐ Renter	☐ Two Family House	☐ Apartment in a Private Home
	☐ Apartment Building	

Previous Address Information

Number and Street Name _____ City _____ State _____ Zip Code _____

Employer	Occupation	Work Telephone Number

Work Address

Number and Street Name _____ City _____ State _____ Zip Code _____

FATHER/LEGAL GUARDIAN

Last Name	First Name	Relationship to Student
Home Address	City, State, & Zip Code	Date Moved In
Home Telephone Number	Cell Telephone Number	Email Address
Date of Birth	City and State of Birth	Country of Birth

Ethnicity: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Alaskan/Native ☐ Amer. Indian ☐ Pacific Islander

Residency Information:		
☐ Homeowner	☐ Single Family House	☐ Multi-Dwelling House
☐ Renter	☐ Two Family House	☐ Apartment in a Private Home
	☐ Apartment Building	

Previous Address Information

Number and Street Name _____ City _____ State _____ Zip Code _____

Employer	Occupation	Work Telephone Number

Work Address

Number and Street Name _____ City _____ State _____ Zip Code _____

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REQUEST FOR PUPIL RECORDS

Date Requested _____ **Name of Previous School** _____

Student's Name _____ **Date of Birth** _____ **Grade** _____

Pursuant to the authority of **P.L. 2002, c63 (N.J.S.A. 18A:36-25.1)** and **section 1 of P.L. 1982, c. 79 (N.J.S.A. 2A:4A-60)**, the Orange Township Public School District request your assistance in providing any and all information and records you may have on the above named child. This request is being made pursuant to this student entering our school system.

Please include the following:

- ☐ Official transcripts
- ☐ Test results
- ☐ Key to the district grading system
- ☐ Health/Immunization records or medical reports
- ☐ Attendance records/data
- ☐ Disciplinary records including infractions imposed by your school district
- ☐ Notification that the district has obtained information pursuant to N.J.S.A. 2A:4A-60 (i.e., charges of juvenile delinquency)
- ☐ Special Education testing results and/or reports (IEP's, psychological reports, etc.)
- ☐ Guardianship Papers if applicable

_____
Staff Member Requesting Records

_____
Signature of Parent/Guardian

Orange Township Public Schools
Gerald Fitzhugh, II, Ed. D
Superintendent of Schools

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Superintendent of Schools

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HOME LANGUAGE SURVEY FORM

Introduction

This survey is the first three steps to identify whether a student is eligible to be a Multilingual Learner (ML). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Information

Student's Name _____ Student's Date of Birth _____/_____/_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Date of Entry into the U.S.: _____/_____/_____ Place of Birth: _____

1. What was the first language used by the student? _____

2. 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**

3. Does the student understand a language other than English?

☐ **Yes** ☐ **No** *(Student is not a Multilingual Learner)*

4. When interacting with others at home (parents, guardians, siblings), does the student use a language other than English more than half of the time? ☐ **Yes** *(Proceed to question 7.)* ☐ **No**

5. When interacting with others outside of the home, does the student use a language other than English more than half of the time? ☐ **Yes** ☐ **No**

6. Has the student recently moved from another school district/charter school where he/she was identified as a Multilingual learner? ☐ **Yes** ☐ **No**

7. List home languages spoken below, then proceed to the records review process.

_____ _____ _____

_____ _____ _____

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Student Health History

☐ Female ☐ Male

Student's Name

Student's Home Address

____/____/____
Date of Birth

Home Telephone #

Student Lives with:

Parent/Guardian (circle one)
Address (omit if same as above)
Phone Number

Parent/Guardian (circle one)
Address (omit if same as above)
Phone Number

Student's Physician | Physician's Phone Number | Physician's City & State

Normal Pregnancy ☐ Yes ☐ No

Normal Infancy and Childhood ☐ Yes ☐ No

Place of Birth:
Birth Weight:
Length of Pregnancy:

☐ Allergies	☐ Lead Poisoning	☐ UrinarTract Infections
☐ Food Allergies	☐ Anemia	☐ Kidney Problems
☐ Asthma	☐ Speech Impairment	☐ Bladder Problems
☐ Diabetes	☐ Tuberculosis	☐ Speech Problems
☐ Heart Murmurs	☐ Measles	☐ Hearing Problems
☐ Seizures	☐ Mumps	☐ Rheumatic Fever
☐ Sickle Cell Disease	☐ Whooping Cough	☐ Chicken Pox
☐ Sickle Cell Trait	☐ Developmental Delays	☐ Heart Problems

Please give more information about anything that was checked off:

Please answer all of the following questions:

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, when and why? _____

Does your child have any eye problems? ☐ Yes ☐ No

Does your child need/wear glasses? ☐ Yes ☐ No

Does your child see a dentist at least every six months? ☐ Yes ☐ No

Does your child have any dental problems? ☐ Yes ☐ No

Has your child ever had seizures? ☐ Yes ☐ No

Is your child taking medication regularly? ☐ Yes ☐ No

If so, what medication? _____ ☐ Yes ☐ No

Does your child have frequent ear infections? ☐ Yes ☐ No

Is your child in good physical shape to participate in all school activities? ☐ Yes ☐ No

Any medical or dental concerns that may affect your child's educational experience? ☐ Yes ☐ No

History of concussion or serious head injury? ☐ Yes ☐ No

History of broken bones? ☐ Yes ☐ No

Has your child ever had any surgery? ☐ Yes ☐ No

If so, what was done? _____

Has your child ever had a hernia? ☐ Yes ☐ No

If so, what type? _____

Does your child have any physical impairment? ☐ Yes ☐ No

Please inform us of any medical, emotional, or dental concerns you would like to discuss: _____

Family History

Does either parent have any health problems? ☐ Yes ☐ No

If so, explain: _____

Students are expected to have a physical exam completed (within the last 12 months) and given to the school nurse upon entrance to Orange Township Public Schools. Failure to comply within 30 days may result in your child being excluded by the building principal.

_____ _____

Parent/Guardian Signature **Date**

MUST BE COMPLETED BY THE SCHOOL NURSE ONLY:

Grade:____ **Previous School:**_____ **State or Country:** _____ **Language:**_____

PE Done: _____ **Immunization UTD:** _____ **Provisional Status:** _____ **A45 Done:** _____

PE Due: _____ **Immunization Needed:**_____ **Medical Authorization Given:** _____ **VSP Given:** _____ **Date:** _____

School Nurse Signature: _____ **Date:**_____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*
   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

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 accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about 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 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: _____

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

Parent/Guardian: _____

Date: _____/_____/_____

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.

OCTOBER 2017