REGISTRATION REQUIREMENTS
ONLY THE NATURAL PARENT OR GUARDIAN MAY REGISTER A STUDENT!

1. Proof of Residency (necessary before beginning any registration);
   - Two (2) Proofs of Residency must be presented indicating the student lives in the sending district.
     Acceptable examples of such proof are:
     a. Tax bill or Deed
     b. Contract of Sale or Closing Statement
     c. Copy of Lease or rental receipt with address of property
     d. Utility bill or Digital Driver’s License (acceptable as second proof only)
   - In the event the student and parent are residing with a third party, the third party must provide two (2) Proofs of Residency, as listed above. In addition, the third party must provide notarized letter stating the parent and student are residing at their address. One proof of residency for the registering party is also required.
   - In the event the student is not residing with the parent/guardian, or does not have a court order indicating placement, then the registering party must apply for an Affidavit of Guardianship/Residency agreement.

2. Health Records (Immunizations)

3. Original Birth Certificate with raised seal (Bureau of Vital Statistics)

4. Transfer Card from Previous School

5. Latest Report Card

Provisional registration approvals will grant a party 30 days to provide any listed missing information. Failure to comply may result in exclusion from school until proper documentation is provided.
To Whom It May Concern,

The following pupil has been enrolled in the Island Heights Grade School for the current school year.

____________________
Date of Registration: ____________

Please forward the following information and records to the Island Heights Grade School as soon as possible so that proper placement can be made for this pupil.

_______ Cumulative Records
_______ Basic Skills/Chapter I Records
_______ Medical Records/Health Card
_______ Confidential Records/Child Study Team Reports
_______ Other Records of Importance

Thank you for your prompt attention to our request.

Sincerely,

Timothy J. Rehm
Superintendent/Principal

I give my permission for the ____________________________ to release records as indicated above for my child.

____________________  ____________________________
(Name of School)  (Parent’s/Guardian’s Signature)  (Date)
ISLAND HEIGHTS SCHOOL DISTRICT

EMERGENCY DATA FORM FOR PUPILS

Emergencies such as sudden illness and injury tend to arise during the course of the school day and school year. It is for the welfare of the children attending the Island Heights Grade School to be able, at all times, to contact an adult member of the family, or a responsible neighbor, who will assist when these emergencies arise. Therefore, we ask your cooperation by completing the "Emergency Data" information below.

Thank you,

Timothy J. Rehm
Superintendent/Principal

Pupil's Name: ____________________________  (Last Name)  (First Name)  (Middle Initial or Name)

Address: ____________________________________________

P. O. Box #: ____________________  Present Grade Level: ______  Mom’s Cell Phone #: ____________________________

Home Telephone #: ______________________  Dad’s Cell Phone #: ____________________________

Pupil’s Date of Birth: ____________________________  Is your child _____ Left Handed? _____ Right Handed?

Please List Your Child’s Allergies or Handicaps: ____________________________________________

Please List Languages Spoken At Home If Other Than English: ____________________________________________

Mother’s Name: ____________________________  Address: (if different) ____________________________

Father’s Name: ____________________________  Address: (if different) ____________________________

Mother’s Place of Employment and Phone Number: ____________________________________________

Father’s Place of Employment and Phone Number: ____________________________________________

IN CASE OF THE SUDDEN ILLNESS OF YOUR CHILD WHEN NEITHER SPOUSE CAN BE CONTACTED, PLEASE LIST THE NAMES AND PHONE NUMBERS OF TWO INDIVIDUALS WHO WILL ASSUME RESPONSIBILITY FOR YOUR CHILD UNTIL YOU BECOME AVAILABLE:

Name & Relationship ____________________________  Phone Number: ____________________________

Name & Relationship ____________________________  Phone Number: ____________________________

IF YOU WOULD PREFER THAT YOUR PERSONAL PHYSICIAN BE CONTACTED IN CASES OF EXTREME EMERGENCY, PLEASE STATE YOUR PERSONAL PHYSICIAN’S NAME AND PHONE NUMBER BELOW:

Name: ____________________________  Phone Number: ____________________________

__________________________________________  ____________________________

Parent’s/Guardian’s Signature)  (Date)
NEW PUPIL INFORMATION

Name: ____________________________

Date of Birth: ______________________

Residence: __________________________

Birthplace: _________________________

Box: ________________________________

Proof of Birth Date: BC _____________

Cell Phone #: ________________________

Former School: ______________________

Phone: _______________________________

Address: ____________________________

Age: ________________________________

PARENT/GUARDIAN INFORMATION

Father: _______________________________

Mother: ______________________________

Birthplace: __________________________

Birthplace: __________________________

Occupation: __________________________

Occupation: __________________________

Where Employed: _____________________

Where Employed: _____________________

Phone: ______________________________

Phone: ______________________________

Former Residence: ____________________

Cell Phone #: _________________________

Date moved into Island Heights: _________

EMERGENCY INFORMATION

Illness Alternate: Name: ____________________________

Phone: ____________________________

Name: ____________________________

Phone: ____________________________

All other children of school age: Name: ______________

Birthday: _________________________

All children under school age: Name: ______________

Birthday: _________________________

IMMUNIZATION RECORD: (DATES)

D. P. T. : ____________________________

Polio: ____________________________

Measles: __________________________

TB Tine: __________________________

Mumps: ____________________________

Rubella: __________________________

ASSIGNMENT TO:

Teacher: ____________________________

Grade: ___________ Date: _____________

Parent's/Guardian's Signature: ____________________________

Date: _____________________________
Dear Parents and Guardians,

Throughout the school year, pupils will walk to the Island Heights Library to participate in the school’s library program. The pupils will go as a class with their classroom teacher at least once a week. This program is part of their curriculum and we ask that you be aware of this important learning experience.

It is important that the children learn to be responsible for the return of books and materials they borrow from the library. These books must be returned in good condition and on time. We ask your support as parents in this part of our library skills program.

Also, throughout the school year, there will be walking trips to points of interest within the town of Island Heights. The classes will always be accompanied by your child’s teacher and by other responsible adults who have volunteered to be chaperones.

Please sign the form below and return it to school, as soon as possible, so that we know you are informed of these particular activities which will take place during the school day of the current school year.

Sincerely,

Timothy J. Rehm
Superintendent/Principal

Dear Mr. Rehm,

Please be advised that I am aware that my child __________________ will be visiting the Island Heights Library with his/her class on walking trips and may also be taking walking trips to other points of interest within Island Heights on various occasions throughout the school year.

________________________  ______________________
Parent’s/Guardian’s Signature       Date
TO: Parents & Guardians of Island Heights Grade School Pupils
FROM: Mr. Timothy Legendre, Physical Education Instructor
RE: Physical Education Program

Please complete the information below and return this memo, with your signature, to the Island Heights Grade School.

Mr. Legendre

Dear Mr. Legendre,

Please be advised that I am aware that my child ________________________

will participate in the physical education program at the Island Heights Grade School.

--- To the best of my knowledge, my child is in good physical health. _________________

--- To the best of my knowledge, my child is not in good physical health. _______________

--- To the best of my knowledge, my child has the following abnormalities and/or health

problems about which you should be aware for the benefit of both you and my child.

_________________________________________________________________________________

(Parent’s/Guardian’s Signature) ___________ (Date) ___________
ISLAND HEIGHTS GRADE SCHOOL DISTRICT

PART A
HOME SURVEY

1. Student’s Name __________________________
2. Date of Birth __________________________
3. Address _________________________________
4. Parent’s/Guardian’s Name __________________

PART B
LANGUAGE INFORMATION

1. What language did your child speak first? English ___ Spanish ___ Other ___ (language)
2. What language do you speak most often to your child at home? English ___ Spanish ___ Other ___ (language)
3. What language does your child most often use when speaking to you at home? English ___ Spanish ___ Other ___ (language)
4. What language does your child most often use when speaking to: brothers and sisters? English ___ Spanish ___ Other ___ (language)
5. What language does your child speak most often with other family members? English ___ Spanish ___ Other ___ (language)

PART C
STUDENT RACE/ETHNICITY INFORMATION

Circle Yes or No to each of the following about your child:

Hispanic or Latino Yes No
American Indian Yes No
Asian Yes No
Black/African American Yes No
Pacific Islander/Hawaiian Yes No
White Yes No

___________________________  __________________________
Parent’s/Guardian’s Signature                                      Date
REGULATIONS REGARDING ADMINISTRATION OF MEDICATION TO PUPILS IN SCHOOL

If your child is to receive medication during school hours, please be aware of the following requirements:

1. All medications, whether prescription or over-the-counter, must be ordered in writing, by a physician or certified nurse practitioner.
2. The parent/guardian must provide a written request for the administration of medication.
3. Written orders must be provided by the private physician or certified nurse practitioner detailing the type of illness, name of the prescribed medication, dosage, time of administration and duration of the order. All orders must be renewed annually. Orders may be faxed, but must be followed up by a hard copy.
4. Medication must be provided by the parent in the original container and labeled by the pharmacy or physician. Medication will be kept in the Health Office. Children are NOT allowed to carry medications on their person in school. (See below regarding exceptions of epi-pen and inhalers)
5. Records and documentation of administration will be maintained by the school nurse.
6. The school nurse or the parent will be the only persons permitted to administer medication to pupils during school and on school trips. Teachers are not permitted to administer medications.

Please be aware that the school nurse is not always available to administer medications during a school trip. Parents of children receiving medication are advised to make an effort to accompany their child on field trips so they may administer medication to their child.

In cases of life-threatening illnesses, a condition wherein if the medication is not received, the individual’s life is threatened (i.e. documented severe allergic reaction, asthma), children may be allowed to carry and self-medicate if the following criteria are met:

1. Written authorization by the parent that the child may self-medicate
2. Written certification from a doctor/certified nurse practitioner that:
   A. The child has been diagnosed with a life threatening condition
   B. The child has received instruction and is capable of performing the appropriate self-medication.
   C. The child demonstrates to the school nurse his/her ability to self-medicate correctly and understands the conditions for such.
3. The Board of education will inform the parent that the District, its employees and/or agents shall not be liable for any injury resulting from self-medication and the parent will sign a statement acknowledging such.
4. The child will report to the school nurse whenever he/she has self-medication so the nurse may be aware of such and take appropriate action as needed.
5. The criteria will be met annually.

The NJ State laws and local school policies are designed to protect the health of children by insuring uniform practice and procedure. This helps to promote pupil health and safety which is always our primary concern. Please contact the School Health Office with any questions.

Judith Mekles, RN
Child’s Name: ___________________________ Date: ________________

Please complete the following health history. Does your child have a history of:

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>If yes: Date:</th>
<th>Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lyme Disease</td>
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<tr>
<td>Neuro/Muscular Disorders</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>Convulsions/Seizures:</td>
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<tr>
<td>Diabetes</td>
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<td>Heart Disease</td>
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<tr>
<td>Heart Murmur</td>
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<tr>
<td>Middle Ear Infections</td>
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<tr>
<td>Strep Infections</td>
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<tr>
<td>Rheumatic Fever</td>
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<tr>
<td>Mononucleosis:</td>
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<tr>
<td>Surgery</td>
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<tr>
<td>Injury</td>
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<tr>
<td>Congenital Defects</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Age of onset: ____________________________

Type: ____________________________

Treatment: ____________________________

Onset: ____________________________

Treatment: ____________________________

Explain: ____________________________

Date: ____________________________

Explanation with Dates: ____________________________

Explain: ____________________________

Signature of Parent/Guardian
September 2020

Dear Parent/Guardian:

In order to provide the best possible health services for your child, I need to know your child’s health history and current status. Your response to this letter will allow me to update your child’s school health file. Please indicate below any changes in your child’s health status or general health history. If there have been no changes please check “none of the above” and return to school.

Asthma Treatment:

Allergies Type:

Treatment:

Any Hospitalizations: Reasons and Dates:

Injuries: Describe:

Surgery Type and Date:

Ear Infections

Current Medications: Name and Dosage:

Other health conditions(s) or concerns
Describe:

NONE OF THE ABOVE

Please circle yes or no:

Has your child been diagnosed with COVID-19? YES NO If yes, Date:

If diagnosed, was your child symptomatic? YES NO

If diagnosed, was your child hospitalized? YES NO

Has any member of your household been diagnosed with COVID-19? YES NO

My child (will) (will not) participate in the school health screenings program.

CIRCLE ONE

If your child will not be participating in any portion of the health screenings program, please state which screening you do not wish your child to receive. If you wish, you may cite your reasoning. A form will be sent home for completion by your private healthcare provider for any screenings you do not wish your child to receive.

Please check the appropriate response below (GRADE 5 ONLY):

I wish to be present during my child’s scoliosis screening.

I DO NOT wish to be present during my child’s scoliosis screening.

Please return these forms as soon as possible.

Child’s Name: ________________________ Grade: ________________

Parent/Guardian Signature: __________________________ Date: ___________
To: The School Health Office  
Island Heights Grade School  
Island Heights, New Jersey  
School Year:  

I hereby give my permission for the school nurse to forward information concerning my child’s health (i.e. allergies, asthma, other chronic conditions) to those school staff members who may need to know. I recognize that sharing this information is important to my child’s safety and well being while attending school.

________________________  ________________________
Child’s Name                    Signature of Parent/Guardian

________________________  ________________________
Grade Attending               Date

Cc: Individual Health File  
In/08
Dear Parent/Guardian,

Your child requires a report of a physical examination performed within the last year. Please have your physician or certified nurse practitioner complete and sign the attached school physical form prior to your child’s admission. If you have any questions, please contact the school nurse at the school health office.

Thank you

Sincerely,

[Signature]

Judith Mekles, RN
School Nurse
TO BE COMPLETED BY PHYSICIAN OR CERTIFIED NURSE PRACTITIONER

SCHOOL PHYSICAL

Child's Name: ________________________________  Child's Birth Date: ________________

Weight: ___________________________  Height: ___________________________

Vital Signs:  T: ______  P: ______  R: ______  B/P: ______

Allergies:  Insect Bites: ___________________________  Food: ___________________________

Medications: __________________________________  Other: ___________________________

(If allergies require restrictions, alterations in diet or treatment, a signed physician's order is required.)

Eyes/Vision: ___________________________  Ears/Hearing: ___________________________

Hair/Scalp: ___________________________  Nose/Throat: ___________________________

Teeth/Gums: ___________________________  Skin: ___________________________

Lungs: ________________________________  Heart: ___________________________

Abdomen: ___________________________  Speech: ___________________________

Musculo/Skeletal: ___________________________  Nutrition: ___________________________

Current prescribed Medications: __________________________________

Any Significant Diagnosis or Chronic Condition: ___________________________

________________________________________________________

Do you have any recommendations for the school to follow concerning the health status of this child?

***Please include a copy of current immunizations. If the child is exempt for medical or religious reasons, proper documentation must accompany this form.***

________________________________________________________  ___________________________

Physician's Signature  Date of Examination

Printed name and address of Physician: ______________________________________

________________________________________________________

jm 3/02  2