HAMILTON TOWNSHIP SCHOOL DISTRICT

REGISTRATION CHECKLIST

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** _____/_____/_____

REVIEW THIS PACKET AND THE REQUIRED DOCUMENTATION TO REGISTER YOUR CHILD

ONLY THE PARENT/LEGAL GUARDIAN CAN REGISTER THE CHILD

PROOF OF RESIDENCY *PLEASE BRING IN THE APPROPRIATE PROOF OF RESIDENCY FOR YOUR FAMILY*

_____ (OWNER) Deed, Mortgage, or Tax Bill in parent's/guardian's name
_____ (RENTER) Lease or Tenant Agreement in parent's/guardian's name
_____ (LIVES W/OWNER) Deed/Tax Bill of owner with whom you reside & Resident's Affidavit**
_____ (LIVES W/RENTER) Renter's Lease with who you reside with & Resident's Affidavit**
_____ **RESIDENT'S AFFIDAVIT - FILLED OUT AND NOTARIZED

Resident's Affidavit is available at the Registration Office and at* ***hamiltonschools.org/registration

(2) FORMS OF ID WITH THE PARENT'S/LEGAL GUARDIAN'S NAME WITH CURRENT MAYS LANDING ADDRESS

_____ DRIVER'S LICENSE
_____ UTILITY BILL
_____ VOTER REGISTRATION CARD
_____ PAYCHECK STUB
_____ BANK STATEMENT
_____ ANY FORMAL/LEGAL DOCUMENTATION WITH NAME AND CURRENT ADDRESS

CHILD'S DOCUMENTATION

_____ ORIGINAL BIRTH CERTIFICATE
_____ COURT DOCUMENTATION OF GUARDIANSHIP (if applicable)
_____ CUSTODY DOCUMENTATION IF DIVORCED (if applicable)
_____ STATE AGENCY PLACEMENT DOCUMENT OF GUARDIANSHIP (if applicable)

GRADE PLACEMENT DOCUMENTATION

_____ TRANSFER CARD FROM PREVIOUS SCHOOL
_____ REPORT CARD FROM PREVIOUS SCHOOL
_____ IMMUNIZATION RECORDS (MANDATORY FOR ALL GRADES)
_____ PHYSICAL FORM FILLED OUT BY DOCTOR (MANDATORY FOR PRE-K, KINDERGARTEN, OR GRADES 1-8 TRANSFERRING FROM ANOTHER STATE OR COUNTRY)

TODAY'S DATE: _____

Dear Parent/Guardian:

This package includes all documents necessary to register your child/children in the Hamilton Township School District.

Please sign below to attest that all the information you provide on these documents is accurate and that you are aware that falsification on your part will be considered falsifying a government document.

_____ _____ ____/_____/_____
SIGNATURE PRINTED NAME DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT DATE: _____

REGISTRATION CARD

***Has this child been registered at Hamilton Township Before?** **YES** **NO**

If YES, please provide the approximate date the last attended (month/year) _____/_____

***Have you or your family been displaced?** **YES** **NO**

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

PHYSICAL ADDRESS: _____

STREET *MAYS LANDING, NJ 08330*

EXACT LOCATION: _____

nearest intersection and neighborhood/subdivision if applicable

HOME PHONE: _____ **CELL PHONE:** _____

EMERGENCY NAME: _____ **EMERGENCY PHONE:** _____

GRADE: _____ **GENDER:** _____ **DATE OF BIRTH:** _____/_____/_____

COUNTRY OF BIRTH: _____ **CITY OF BIRTH:** _____

LANGUAGE(S) SPOKEN @ HOME: _____ **STATE OF BITH:** _____

MIGRANT? YES NO

IF COUNTRY OF BIRTH IS NOT U.S., PLEASE PROVIDE DATE ENTERED THE U.S. _____/_____/_____

IF COUNTRY OF BIRTH IS NOT THE U.S. PLEASE PROVIDE NUMBER OF YEARS IN AMERICAN SCHOOLS _____

PREVIOUS SCHOOL INFORMATION

FROM CITY/STATE: _____ **LAST GRADE ATTENDED:** _____

NAME OF PREVIOUS SCHOOL: _____

ADDRESS OF PREVIOUS SCHOOL: _____ CITY, STATE: _____

PHONE NUMBER OF PREVIOUS SCHOOL: _____ FAX: _____

PARENT/ LEGAL GUARDIAN INFORMATION

ONLY Parents/Legal Guardians can register students

Documented Legal Custody/Court Related Issues? YES NO *If YES, date of documents:*_____

GUARDIAN 1

NAME: _____

RELATIONSHIP: _____

OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

GUARDIAN 2

NAME: _____

RELATIONSHIP: _____

OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

NAME OF CHILDREN IN FAMILY/OTHER CHILDREN IN HOME

Name	*Date of Birth*	*Name*	*Date of Birth*
1) _____		4) _____	
2) _____		5) _____	
3) _____		6) _____	

ADDITIONAL INFORMATION

Did your child participate in:		*If YES, how many years?*
SPEECH	YES	_____
BILIGUAL/ESL/ELL	YES	_____
504 Plan	YES	_____
Basic Skills	YES	_____
Special Education/ Resource/Self Contained	YES	_____

REGISTRATION DATE: _____

START DATE: _____

BUS NUMBER: _____

STATE ID: _____

GENESIS ID: _____

LUNCH PIN: _____

OFFICE USE ONLY

HAMILTON TOWNSHIP SCHOOL DISTRICT

DATE: _____

EMERGENCY CONTACT INFORMATION

_____ **PLEASE CHECK THIS BOX IF THERE HAS BEEN A CHANGE OF PARENT/GUARDIAN, ADDRESS, OR TELEPHONE**

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

PHYSICAL ADDRESS: _____

STREET *MAYS LANDING, NJ 08330*

GRADE: _____ **GENDER:** _____ **DATE OF BIRTH:** _____/_____/_____

SCHOOL: _____ **TEACHER/H.R.** _____

PARENT/ LEGAL GUARDIAN INFORMATION

To serve your child in case of an accident or sudden illness, it is necessary that you give the following information for emergencies

GUARDIAN 1

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

GUARDIAN 2

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

ADDITIONAL EMERGENCY INFORMATION

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

EMERGENCY 1

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMERGENCY 2

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

OTHER FAMILY INFORMATION

Please list other children living with you who attend New Jersey Public Schools (Name, School)

Name School

1) _____

2) _____

3) _____

HAMILTON TOWNSHIP SCHOOL DISTRICT

ETHNICITY

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** _____/_____/_____

FOR FEDERAL AND STATE REPORTING ONLY

PLEASE INDICATE YOUR CHILD'S ETHNIC GROUP BY CIRCLING THE APPROPRIATE LETTER

A	ASIAN	*A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea Malaysia, Pakistan, the Phillippine Islands, Thailand, or Vietnam*
B	BLACK/AFRICAN AMERICAN	*A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American"*
I	AMERICAN INDIAN OR ALASKA NATIVE	*A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affliation or community attachment*
P	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	*A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
H	HISPANIC OR LATINO	*A person of Cuban, Mexican, Puerto Rican, Sout or Central American or other Spanish culture or origian, regardless of race.*
W	WHITE	*A person having origins in any of the original peoples of Europe, Middle East, North Africa.*
M	MULTI-RACIAL	*Please check below all that apply.* **A ____ B ____ I ____ P ____ H ____ W ___**

_____ _____ ____/_____/_____

SIGNATURE PRINTED NAME

HAMILTON TOWNSHIP SCHOOL DISTRICT

LANGUAGE

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** _____/_____/_____

PARENT/GUARDIAN'S NAMES: _____

FOR STUDENT RECORD AT SCHOOL

Dear Parents

We need you to fill out this form and return it to your child's school where it will be filed. Thank you.

1) WHAT LANGUAGE DID YOUR CHILD LEARN TO SPEAK FIRST? PLEASE CHECK THE LANGUAGE.

_____ ENGLISH
_____ SPANISH
_____ FRENCH
_____ CANTONESE
_____ VIETNAMESE
_____ URDU
_____ PASHTO
_____ HINIDI
_____ GUAJARATI
_____ CREOLE
_____ OTHER: _____

2) NATIONALITY: _____

3) WHAT LANAGUAGE IS SPOKEN IN YOUR HOME OF THE TIME _____

4) IN WHAT LANGUAGE DO YOU READ AND WRITE? _____

5) IN WHAT LANGUAGE DOES YOUR CHILD READ AND WRITE? _____

6) IN WHAT COUNTRY WAS YOUR CHILD BORN? _____

7) IF OTHER THAN THE UNITED STATES, WHAT YEAR DID YOUR CHILD COME TO THE UNITED STATES? _____

_____ _____ _____/_____/_____

SIGNATURE PRINTED NAME DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT

STUDENT HEALTH INSURANCE/HISTORY

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

GRADE: _____ **GENDER:** _____ **DATE OF BIRTH:** _____/_____/_____

SCHOOL: _____ **TEACHER/H.R.** _____

DOES YOUR CHILD HAVE HEALTH INSURANCE?

circle one

YES *If YES, please provide the name of the insurance company on the line below:*

_____

NO *If NO, please review the following information and sign below:*

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 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 pursuant to 20 U.S.C.§ 1232g(b)(1) and 34 C.F.R. 99.30(b).

LIST ANY MEDICAL/SURGICAL CARE YOUR CHILD HAS RECEIVED DURING THE PAST YEAR:

_____

PLEASE PROVIDE THE FOLLOWING HEALTH INFORMATION IN REGARDS TO YOUR CHILD'S HEALTH

DATE OF LAST DENTAL EXAM: _____ **DOES YOUR CHILD HAVE BRACES?** YES NO

DATE OF LAST EYE EXAM: _____ **DOES YOUR CHILD WEAR EYE GLASSES** YES NO

EYE CONTACTS? YES NO

ALLERGIES: _____

If your child has had allergies, please describe the type of reaction and date of last reaction (if applicable)

_____

IMMUNIZATIONS/TETANUS SHOT DATES: _____

MEDICATIONS? _____

RESTRICTIONS? _____

DOCTOR: _____ **PHONE:** _____

DENTIST: _____ **PHONE:** _____

HOSPITAL: _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____ ____/_____/_____

SIGNATURE PRINTED NAME DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT

STUDENT HEALTH INSURANCE/HISTORY

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL

NAME OF PUPIL: _____

LAST NAME FIRST NAME M.I.

GRADE: _____ **GENDER:** _____ **DATE OF BIRTH:** _____/_____/_____

SCHOOL: _____ **TEACHER/H.R.** _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
CHICKEN POX	_____	_____	**STREP INFECTION**	_____	_____
SCARLET FEVER	_____	_____	**HEPATITIS**	_____	_____
RHEUMATIC FEVER	_____	_____	**MENINGITIS**	_____	_____
KIDNEY PROBLEMS	_____	_____	**SIEZURES**	_____	_____
EAR INFECTIONS	_____	_____	**NOSEBLEEDS**	_____	_____
DIABETES	_____	_____	**ASTHMA**	_____	_____
PNEUMONIA	_____	_____	**LYMES**	_____	_____
MONONUCLEOSIS	_____	_____	**HEART DISEASE**	_____	_____

ALLERGIES:

MEDICATION ALLERGIES: _____

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES (LATEX, BEES, SEASONAL, ETC.) _____

HAS YOUR CHILD…	YES	NO
1) HAD MORE THAN SIX COLDS OR THROAT INFECTIONS EACH YEAR?	_____	_____
2) HAD MORE THAN THREE EAR INFECTIONS?	_____	_____
3) HAD TROUBLE HEARING?	_____	_____
4) EVER HAD TUBES INSERTED IN EARS SURGICALLY? YEAR _____	_____	_____
5) EVER WORN HEARING AIDS?	_____	_____
6) EVER HAD TROUBLE SEEING?	_____	_____
7) EVER WORN CONTACT LENSES?	_____	_____
8) EVER WORN GLASSES?	_____	_____
9) HAD ANY TROUBLE WITH HIS/HER TEETH?	_____	_____
10) SEEN A DENTIST RECENTLY? LAST VISIT _____	_____	_____
11) INABILITY TO CONTROL BOWEL OR BLADDER?	_____	_____
12) EVER HAD A CONVULSION OR FAINTING SPELL?	_____	_____

13) HAD ANY OTHER DISEASE OR ILLNESS? *IF YES, PLEASE LIST:* _____

14) HAD TO STAY IN A HOSPITAL OVERNIGHT? IF YES, PLEASE DATE AND DESCRIBE: _____

_____

15) HAS YOUR CHILD EVER HAD ANY SERIOUS ACCIDENTS? (burns, poisoning, broken burns, serious cuts)

_____

_____

HAMILTON TOWNSHIP SCHOOL DISTRICT

STUDENT HEALTH INSURANCE/HISTORY

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL

	YES	NO
16) HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING A HEART PROBLEM OR HEART MURMUR?	_____	_____

17) HAD YOUR CHILD EVER HAD:

	YES	NO		YES	NO
WHEEZING	_____	_____	**SINUS PROBLEMS**	_____	_____
ECZEMA	_____	_____	**REACTION TO MEDICATION** ____		_____
HIVES	_____	_____	**REACTION TO INJECTIONS** _____		_____
ASTHMA	_____	_____	**REACTION TO INSECT BITES** ____		_____
HAY FEVER	_____	_____			

	YES	NO
18) HAS YOUR CHILD EVER BEEN TREATED FOR ALLERGIES?	_____	_____

DOES YOUR CHILD HAVE OTHER ILLNESSES OR PROBLEMS THAT WE SHOULD BE AWARE OF?
(Please describe if applicable)

_____

_____

DOES YOUR CHILD TAKE ANY MEDICATION?
(Please describe if applicable)

_____

_____

	YES	NO
DO YOU HAVE HEALTH INSURANCE?	_____	_____
DO YOU HAVE DENTAL INSURANCE?	_____	_____
DO YOU HAVE VISION INSURANCE?	_____	_____
WOULD YOU LIKE INFORMATION ON NJ FAMILY CARE INSURANCE?	_____	_____

The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency this information can be shared with emergency personnel.

_____ YES, please share information _____ NO, please call to discuss
INITIAL *INITIAL*

I give permission for my child to receive the annual health screenings as required by the New Jersey Department of Education.

_____ _____ ____/_____/_____
SIGNATURE PRINTED NAME DATE

NAME OF CHILD's PEDIATRCIAN: _____

HAMILTON TOWNSHIP SCHOOL DISTRICT

PERMISSION TO RELEASE RECORDS

NAME OF PUPIL: _____
LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** _____/_____/_____

PREVIOUS SCHOOL: _____

SCHOOL ADDRESS: _____

ATTENTION TO: _____

PHONE: _____ **FAX:** _____

PERMISSION TO RELEASE ALL RECORDS TO THE APPROPRIATE SCHOOL AND GRADE LEVEL SECRETARY

KINDERGARTEN AND 1ST GRADE	**CONTACT INFORMATION**	
JOSEPH C. SHANER SCHOOL	☐ *ATTN: Dianne Valiante*	
5801 Third St. Mays Landing, NJ 08330	Phone: 609-476-6141	Fax: 609-625-8346

PRE-K, 2ND - 5TH GRADE	**CONTACT INFORMATION**	
GEORGE L. HESS SCHOOL	☐ PRE-K, 2nd THRU 5th:	*Cathie Palmeri*
700 Babcock Rd., Mays Landing, NJ 08330	Phone: 609-476-6116	Fax: 609-476-6110
	☐ 2nd THRU 5th:	*Diane Manno*
	Phone: 609-476-6125	Fax: 609-476-6112

6TH, 7TH, 8TH GRADE	**CONTACT INFORMATION**	
WILLIAM DAVIES MIDDLE SCHOOL	☐ 6TH GRADE	*Kristina Morey*
1876 Dr. Dennis Foreman Dr.,	7th GRADE LAST NAMES (M-Z)	
	Phone: 609-476-6254	Fax: 609-625-2267
Mays Landing, NJ 08330		
	☐ 7TH GRADE LAST NAMES (A-L)	*Dawn Leek*
	8TH GRADE	
	Phone: 609-476-6263	Fax: 609-476-6251

I give permission for you to release the records for the student indicated above (note: Permission not required under (NJAC). I understand the Federal NO Child Left Behind Act requirements, I must now authorize the release of my child's discipline records to be included with the release of my child's permanent records, and my signature below indicates my authorization and permission to release the records to the above mentioned school as soon as possible.

According to New Jersey Adminstrative Code 6:3-2.1 to 2.8, "Mandated pupil records shall be forwarded to the receiving district…" Please send the cumulative folder, the health records, grade-to-date, child study team records and any mandated records on the pupil listed above as soon as possible.

_____ _____ _____/_____/_____
SIGNATURE PRINTED NAME DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT

CERTIFICATE OF TRANSPORTATION

NAME OF PUPIL: _____
LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** _____/_____/_____

PHYSICAL ADDRESS: _____
STREET *MAYS LANDING, NJ 08330*

GUARDIAN 1

NAME: _____
RELATIONSHIP: _____
WORK PHONE: _____
CELL PHONE: _____

GUARDIAN 2

NAME: _____
RELATIONSHIP: _____
WORK PHONE: _____
CELL PHONE: _____

TO & FROM HOME TRANSPORTATION

Please fill out this section of the form if your child will be transported both TO and FROM home ONLY.

My child _____, who will be in grade _____ at the _____ school, should be transported to and from our home during the _____ school year.

Our permanent home address is: _____.

TO & FROM A LOCATION OTHER THAN HOME (ex. BABYSITTER/DAY CARE CENTER)

Please complete this section of the form if your child will be transported to or from school OTHER THAN HOME.

IMPORTANT NOTE: Requests are granted on a 5-Day Basis

(The Bus stop location must be the same for all 5 days of the week. If there is not an established stop at the location of your child is to be transported, he or she will be transported to the stop nearest the babysitter/day care)

PERMISSION IS HEREBY GRANTED TO _____ **Grade** _____
STUDENT'S NAME GRADE LEVEL

WHO PERMANENTLY RESIDES AT _____
HOME ADDRESS

TO BE TRANSPORTED TO SCHOOL FROM _____
STARTING LOCATION

AND TRANSPORTED FROM SCHOOL TO _____
ENDING LOCATION

EFFECTIVE DATE: _____/_____/_____ REASON FOR REQUEST: _____

BABYSITTER/DAY CARE CENTER

NAME: _____ CONTACT PHONE: _____

As a matter of extreme importance to the school, the telephone information as listed at the top of this notice is to be made. known. If all information is not provided this form will be returned to you and that will delay the start of this change.

I, the undersigned, release and discharge the Board of Education, its agents, servants, and employees of and from any liability arising from the requested change in bus stop. I have read this Certificate of Transportation Change and understand all its terms. I hereby execute it voluntarily with full knowledge of its significance.

_____ _____ _____/_____/_____
SIGNATURE PRINTED NAME DATE