IRVINGTON PUBLIC SCHOOLS

REGISTRATION REQUIREMENTS

INFORMATION ACCEPTED (2 Forms Required):
Current:

1. PSE&G Bill
2. Homeowner's Tax Bill
3. Mortgage Statement
4. Department of Labor (Unemployment)
5. Current Typed Lease or Notarized Letter from a Family Member
6. Driver's License (can be used as second form of identification with number 5)

*Please note: Residency checks will be initiated for any notarized letter from a family member. A family member who signs a notarized letter an be held liable for tuition if it is found that the child does not reside at the address listed on the notarized form

INFORMATION NOT ACCEPTED

1. Cable Bill
2. Credit Cards Bills
3. Income Tax Statement
4. Pay Stubs
5. Home Phone, Cell Phone, etc. Bills

STUDENT REQUIREMENTS:

Must have these items along with the current information accepted above (1-6):

1. Original Birth Certificate or Passport
2. Immunization/Medical Records
3. Report Cards or Test Scores from previous school
4. Transfer from previous school
5. Proof of Guardianship (if application)
6. Proof of Legal Guardianship (were application)

Irvington Public Schools

SPECIAL SERVICES DEPARTMENT REGISTRATION FORM –PLEASE PRINT

OFFICE USE ONLY	COMMENTS
STATE ID # _____	☐Proof of Residency _____
REGISTRATION DATE /ENTRY DATE _____	☐Birth Certificate/Passport _____
GRADE-SECTION _____	☐Proof of Guardianship _____
HOMEROOM TEACHER _____	☐Transfer Card _____
HOME SCHOOL _____	☐Report Card/Transcript _____
SECRETARY'S SIGNATURE _____	☐Immunizations _____
NURSE'S SIGNATURE _____	☐Test Scores _____
GUIDANCE COUNSELOR'S SIGNATURE _____	☐IEP _____

I. STUDENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

HOME ADDRESS: _____ Apt._____

RENT: _____ OWN: _____ SHARE: _____ SHELTER: _____

PHONE#: _____ CELL#: _____ D.O.B: _____

BIRTHPLACE CITY: _____ AGE: _____ M/F: _____

DATE OF ENTRY TO US (if applicable) _____

HOME LANGUAGE

ETHNICITY: _____ OTHER LANGUAGE(S) SPOKEN AT HOME: _____
(by any member of the family)

PREVIOUS SCHOOL ADDRESS: _____

PREVIOUS GRADE: _____ GRADE (S) RETAINED: _____

II. PARENT/GUARDIAN INFORMATION

Father _____ Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student Yes / No

Mother _____ Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student Yes / No

Guardian _____ Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student Yes / No

PROOF OF GUARDIANSHIP: _____

___DYFS PLACEMENT ____FOSTER PLACEMENT _____ COURT PLACEMENT ____ GROUP HOME ____ OTHER

If your family is living in any of the following situations (check all that apply):

Shelter ___ Transitional Housing ___ Awaiting foster Care Placement___ Doubled-Up__ (ex. Living with friends/relatives)

Unsheltered__ (ex. Cars, parks, Campgrounds Temporary trailers, abandoned buildings) Hotel/Motel____

Contact Ms. Eileen Walton (973) 399-6897 ext. 1823 for information on district services

III. EMERGENCY CONTACTS

Name _____ Relationship_____ Address _____

Home # _____ Cell # _____ Work # _____

Name _____ Relationship_____ Address _____

Home # _____ Cell # _____ Work # _____

Name _____ Relationship_____ Address _____

Home # _____ Cell # _____ Work # _____

IV. OTHER MEMBERS OF HOUSEHOLD (Siblings)

NAME	DATE OF BIRTH	GENDER	GRADE
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	

EDUCATIONAL HISTORY

GRADE	SCHOOL	DATE OF ATTENDANCE	ADDRESS	TELEPHONE
Elementary School Pre-K – 5				
Middle School 6 – 8				
High School 9 – 12				

Previous Retention: ☐**Yes** ☐**No** **If yes, indicate grade/school.** _____

Previous Services: ☐**IEP** ☐**Speech** ☐**Bilingual/ESL** ☐**Intellectually Gifted** ☐**Basic Skills**

V. MEDICAL INFORMATION

Indicate below: Physical handicaps, surgery, seizure, elevated lead level, food allergies, hearing/vision/speech problems

_____

_____

_____

Health Care Insurance Provider _____

Family Physician _____ **Address** _____ **Phone** _____

School Nurse's Signature _____ **Date** _____

I hereby attest that all of the information on this registration form is correct, and I agree to pay all of the necessary reimbursements to the Board of Education for false documentation in any of the categories.

Father's Signature _____ **Date** _____

Mother's Signature _____ **Date** _____

Guardian's Signature _____ **Date** _____

REQUEST FOR STUDENT RECORDS
IRVINGTON PUBLIC SCHOOLS

School _____

Principal:_____

Phone#: _____ Fax #:_____

School: _____

Principal: _____

Phone#: _____ Fax#:_____

Due to the registration of the following student, please forward his/her records as soon as possible:

Name _____ Homeroom/Grade_____ DOB_____

√ CUMULATIVE ACADEMIC AND BEHAVIOR RECORDS

√ ATTENDANCE RECORDS

√ STANDARDIZED TEST SCORES

√ CHILD STUDY TEAM EVALUATIONS

√ INDIVIDUALIZED EDUCATION PROGRAM

√ MEDICAL RECORDS

√ OTHER _____

I give permission to release my child's records to _____.

Parent/Guardian's Signature _____ Date _____

Federal Law 99.21
No parent signature is required for educational records sent to another educational agency.

First Request	Date _____	☐Fax	☐Mail	☐Phone
Second Request	Date _____	☐Fax	☐Mail	☐Phone
Third Request	Date _____	☐Fax	☐Mail	☐Phone

Date Received _____

IRVINGTON PUBLIC SCHOOLS – MEDICAL OFFICE
EMERGENCY MEDICAL INFORMATION

School _____
School Year _____

Last Name_____ First Name _____ HR _____ Grade _____

Address of Student _____ Tel. # _____

Guardian's Name _____ Place of Business _____

Business Address _____ Business Tel. # _____

Cell # _____

Father's Name_____ Place of Business _____

Business Address_____ Business Tel. # _____

Cell # _____

Address (if different from student) _____

Mother's Name _____ Place of Business _____

Business Address _____ Business Tel. #_____

Cell # _____

Address (if different from student) _____

In my / or our absence, the following (relative, neighbor, or friend) is authorized to act for me / us on behalf of my / our child. Please be sure the following people have consented to act in your behalf.

1. Name _____ Phone # _____

   Street _____ Town _____

   Relationship _____

2. Name _____ Phone # _____

   Street _____ Town _____

   Relationship _____

3. Name _____ Phone # _____

   Street_____ Town _____

   Relationship _____

_____
Signature of Parent or Guardian

IRVINGTON PUBLIC SCHOOLS

1 UNIVERSITY PLACE

IRVINGTON, NEW JERSEY 07111

PARENT NOTIFICATION OF STATE MANDATED HEALTH SCREENINGS

The following screenings will be scheduled during the school year

Physical Examination – New Jersey law requires that routine physical examinations are given to students in grades K, 3, 6 and 9, students new to the district without a record of an examination, students in Special Education every three years, and candidates for a participating in athletics on a school athletic squad. There is no charge for this examination. If you wish to be present, please contact the school nurse. Parents are notified if a child needs further evaluation.

The school medical director may accept the report of a private doctor instead of the physical examination. If a parent wishes to have his or her child examined privately at the parent's own expense, the school will make available the Board approved form to be completed by the private examining physician. These forms are available in each school health office and in the office of the Superintendent of Schools during the summer when schools are closed.

IMPORTANT: Private medical examinations for this school year must be done after August 1st. The medical form should be returned to the school nurse by the end of September in that same year.

Tuberculosis Skin Testing – State law requires testing for tuberculosis infection. A Mantoux Intradermal Tuberculin test shall be given to all Kindergarten and 8th grade students, all transfer students in any grade from another state or country who do not have a valid record of a Mantoux Tuberculin Test within the past six months, all new students from another New Jersey public school required to test eighth grade pupils who do not have a history of having received a Mantoux Tuberculin test since entering school.

Scoliosis Screening – (to detect abnormalities of the spine) for students in Grades 5 – 12 and Special Education students 10 – 18 years of age will be conducted each year.

Vision Screening – is conducted each year for all students in grades K – 8

Audiometric Screening – (for hearing) shall be conducted for pupils enrolled in pre-school programs, students in grade K – 4, 6, 8, and 10th, and students entering the district with no record of recent hearing screening. Students at risk for hearing impairments, students referred to the Child Study Team for evaluation, and special requests from a teacher, a parents or a pupil will also be receive audiometric screenings..

If you would prefer to take your child to your private doctor/clinic, **at your own expense**, please send a signed letter to the school nurse. If we do not receive a report from your doctor by September 30, your child will be screened in school.

Child's Last Name	First Name	D.O.B.	School
_____	_____	_____	_____

_____ (____)_____
Address (number, street, city, zip code) **Tel. phone #**

Father's Name	Mother's Name	Guardian
_____	_____	_____

Did you ever attend and Irvington Public School? Yes _____ No _____

Last school attended: _____

When did your child last have a physical examination? Date _____

Name of Physician/Clinic _____ Telephone #_____

☐ Routine Check-Up ☐ Illness/Injury Specify reason_____

Is your child subject to (please circle yes or no)

Frequent Colds	Yes – No	Running ears	Yes – No
Bronchitis	Yes – No	Chronic cough	Yes – No
Frequent sore throats	Yes – No	Vision loss	Yes – No
Speech Difficulties	Yes – No	Poor Posture	Yes – No
Earaches	Yes – No	Emotional Problems	Yes – No
Allergies	Yes – No	Weight Problems	Yes – No

List Allergies: _____

Does your child have, or has he/she been treated for, any of the following health problems?

Anemia	Yes – No	Heart Condition	Yes – No
Asthma	Yes – No	Kidney Disease	Yes – No
Diabetes	Yes – No	Rheumatic Fever	Yes – No
Elevated Lead Level	Yes – No	Seizures	Yes – No
Food Allergies	Yes – No	Sickle Cell Anemia	Yes – No
Fracture	Yes – No	Vision	Yes – No
Head Injury	Yes – No		
Hearing	Yes – No		

Other _____

Does your child take medication? Name of medication(s) _____

Has your child had:

Poor eating habits	Yes – No	Difficulty Sleeping	Yes – No
Eye Disease	Yes – No	Eye Injury	Yes – No
Head Injury	Yes – No	Eye Glasses Prescribed	Yes – No
A Severe fall	Yes – No	Hearing Loss	Yes – No

Development: Age walked _____ Age talked _____

Family History: (please circle)

Tuberculosis	Kidney Condition	Asthma
Diabetes	Heart Disease	Deafness
Cancer	Allergies	High Blood Pressure

Does your child have a history of: (please circle – give dates if possible)

Allergy	High Fever	Tuberculosis
Asthma	Mononucleosis	Operations:
Chickenpox	Pneumonia	Appendectomy_____
Diabetes	Rhematic Fever	Hernia _____
Enurasis (bed wetting)	Scarlet Fever	Tonsils Removed_____
Heart Disease	Seizures	Ear Operation _____
Hepatitis	Tonsilitis	Other _____
Fractures		

Name of Current Medications: _____ **Epipen** _____ **Inhaler** _____

Has your child been hospital for any reason since birth? Yes or No

Explain _____

Please list other childhood diseases, accidents, problems or medical tests

_____

_____

Are there any problems in the home which might affect your child's learning?

Explain _____

Is there anything more about your child's health that you think is important for us to know?

Explain _____

_____

Siblings' Name(s):_____ Age:_____ School:_____

_____ _____ _____

_____ _____ _____

X_____

Parents/Legal Guardian's Signature

IRVINGTON PUBLIC SCHOOL DISTRICT

To Parents/Guardians:

While your child attends the public schools of this school district, he/she will be examined at specified intervals by one of our school physicians, as well as such time when the building principal requests a physical examination because it is suspected that a physical defect may be interfering with your child's academic progress.

As it is your choice to be present at your child's district physical examination(s), we would like to know whether or not you wish to be present when the examinations are given. If you do not want to be present, the school physician will report results upon request or if a medical condition is identified. So that we may know your intention, please fill out the form below, and forward it to our school nurse within ten days of receipt. A permanent notation of your choice will be made on your child's record.

Be reminded that the notice below must be returned to our school nurse within ten days of receipt.

(Tear off – Complete and return within 10 days of receipt)

To the School Nurse:

_____ I do not wish to be present _____I do wish to be present when my child, _____ is examined by the school doctor. Any future change to this decision will be submitted to the nurse's office in writing.

X_____ _____

Signature of Parent/Guardian Date

PREPARTICIPATION PHYSICAL EVALUATION
HEALTH HISTORY QUESTIONNAIRE

Name _____ Date of Physical _____ Age _____
Date of Birth _____ School _____ Sex _____
Sport _____ Home Phone _____ Grade _____
Physician _____ Phone # _____ Fax _____

Emergency Contact Information:

Name _____ Relationship _____ Phone: Work, Cell, Home (circle one) _____

Directions: Please answer the following questions about your medical history. Explain "yes" and answers at the bottom of the page. You must respond to all questions.

1-Have you had or do you currently have:

A- A sports physical for this school year? Y/N/Don't Know
B- An injury or illness since your last exam? Y/N/Don't Know
C- A chronic or ongoing illness (such as diabetes or asthma)? Y/N/Don't Know
  1- Use and inhaler or other prescription medicine to control asthmas? Y/N/Don't Know
D- Any prescribed or over the counter medications that you take on a regular basis? Y/N/Don't Know
E- Surgery, hospitalization or any emergency room visit(s) Y/N/Don't Know
F- Any allergies or medications? Y/N/Don't Know
G- Any allergies to bee stings, pollen, latex or foods? Y/N/Don't Know
  1- Type of reaction: rash, hives, or skin condition? Y/N/Don't Know
  2- Take any medication/epipen taken for allergy symptoms? (list below) Y/N/Don't Know
H- Any anemia or blood disorders? Y/N/Don't Know

2-Have you had or do you currently have any of the following ***head-related*** conditions since your last physical:

A- Concussion requiring a physician's evaluation? Y/N/Don't Know
  1- How often and when? (answer below)
B- Memory loss or been knocked out? Y/N/Don't Know
C- A seizure? Y/N/Don't Know
D- Frequent or severe headaches? Y/N/Don't Know

3-Have you had or do you currently have any of the following ***heart-related*** conditions since your last physical:

A- Chest pain? (when exercising)? Y/N Don't Know
B- Heart murmur? Y/N/Don't Know
C- High blood pressure or elevated cholesterol level? Y/N/Don't Know
D- Restriction from sports for heart problems? Y/N/Don't Know
E- Any family member or relative:
  1- Died of a heart problem before age 35? Y/N/Don't Know
  2- Died of heart problem before age 50? Y/N/Don't Know
  3- Died with no known reason? Y/N/Don't Know
  4- Died while exercising? During or after? Y/N/Don't Know
  5- Marfan's Syndrome? Y/N/Don't Know

Explain "**yes**" answers here *(include dates)*

_____
_____
_____

4-Have you had or do you currently have any of the following ***eye, ear, nose, mouth or throat*** conditions since you last physical:

- A- Vision problems? Y/N/Don't Know
  - 1- Wear contacts, eyeglasses or protective eye wear? (circle which type) Y/N/Don't Know
- B- Hearing loss or problems? Y/N/Don't Know
  - 1- Wear hearing aides or implants? Y/N/Don't Know
- C- Nasal fractures or frequent nose bleeds? Y/N/Don't Know

- D- Wear braces, retainer of protective mouth gear? Y/N/Don't Know
- E- Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y/N/Don't Know

5- Have you had or do you currently have any of the following ***neuromuscular/orthopedic*** conditions since your last physical:

- A- Been told you had a burner, stinger or pinched nerve? Y/N/Don't Know
- B- A sprain Y/N/Don't Know
- C- A strain Y/N/Don't Know
- D- Swelling or pain in muscles, tendons, bones or joints? Y/N/Don't Know
- E- A dislocated joint(s)? Y/N/Don't Know
- F- Low back pain? Y/N/Don't Know
- G- Fracture(s) or stress fractures(s)? Y/N/Don't Know
- H- Do you wear any protective braces or equipment for any prior injury? Y/N/Don't Know

6-Have you hard or do you currently any the following general or ***exercise related*** conditions since your last physical:

- A- Difficulty breathing? (during exercise) Y/N/Don't Know
  - 1- After running 1 mile Y/N/Don't Know
  - 2- Coughing, wheezing or shortness of breath in weather changes? Y/N/Don't Know
  - 3- Been told you have exercise induced asthma Y/N/Don't Know
    - a- Controlled with medication? Y/N/Don't Know
    - b- Experience dizziness, passing out or fainting? Y/N/Don't Know
- B- Viral infections (e.g. mono, hepatitis)? Y/N/Don't Know
- C- Become tired more quickly than your friends? Y/N/Don't Know
- D- Any if the following skin conditions: Y/N/Don't Know
  - 1- Acne, contact dermatitis, ringworm, warts, herpes? Y/N/Don't Know
  - 2- Sun sensitivity Y/N/Don't Know
- E- Weight gain/loss (greater than or less than 10 pounds)? Y/N/Don't Know
  - 1- Do you want to weigh more or less than you do now? Y/N/Don't Know
- F- Ever had feelings of depression? Y/N/Don't Know
- G- Heat related problems (dehydration dizziness, fatigue, headache)? Y/N/Don't Know
  - 1- Heat exhaustion? (cool, clammy, damp skin) Y/N/Don't Know
  - 2- Heat stroke? (hot, red, dry skin) Y/N/Don't Know

Expain "**yes**' answer here (include dates):

_____

_____

_____

I certify that the information provided herein is accurate as of the date of the signatures.

Parent/Guardian Signature X_____ Date_____