IRVINGTON PUBLIC SCHOOLS
DISTRICT REGISTRATION REQUIREMENTS AND FORMS

Residency Identification - Information Accepted (1 Form Required):
(Document 1-4 must be dated within the last three (3) months)
1. PSE&G Bill
2. Cable Bill
3. Homeowner’s Tax Bill
4. Mortgage Statement
5. Current Signed Lease or Notarized Letter from a Family Member
*Please note: Residency checks will be initiated for any notarized letter from a family member. A family member who signs a notarized letter will be held liable for tuition if it is found that the child does not reside at the address listed on the notarized form. Proof of residency is needed for any person who writes a letter that is notarized.

Information Not Accepted
1. Credit Cards Bills
2. Income Tax Statement
3. Pay Stubs
4. Home Phone, Cell Phone, etc. bills

Student Records: (You must have these items along with the residency information noted above)
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 applicable)
6. Proof of Legal Guardianship (if applicable)

District/School Forms:
(All forms must be completed before registration is accepted)
1. Registration Requirements and Forms Sheet
2. a-c District / School Registration Forms
3. a-d Emergency Medical Information
4. District / School Physician(s) Physical Examination Consent Form
5. Request for Student’s Records from Previous School
6. a-b Home Language Survey

Special Services Department Forms
1. Authorization to Obtain Information
2. Authorization to Release Information
3. Special Class Pupil’s Emergency Information
4. Transfer Permission Form
5. Medicaid Annual Notification Regarding Parental Consent
6. Special Education Medicaid Initiative (SEMI) Parent Consent Form

11/18/14
IRVINGTON PUBLIC SCHOOLS

DISTRICT / SCHOOL REGISTRATION FORM –PLEASE PRINT

<table>
<thead>
<tr>
<th>OFFICE USE ONLY</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE ID # _______________________________</td>
<td>□ Proof of Residency ___________</td>
</tr>
<tr>
<td>REGISTRATION DATE /ENTRY DATE _______________________________</td>
<td>□ Birth Certificate/Passport ___________</td>
</tr>
<tr>
<td>GRADE-SECTION _______________________________</td>
<td>□ Proof of Guardianship ___________</td>
</tr>
<tr>
<td>HOMEROOM TEACHER _______________________________</td>
<td>□ Transfer Card ___________</td>
</tr>
<tr>
<td>HOME SCHOOL _______________________________</td>
<td>□ Report Card/Transcript ___________</td>
</tr>
<tr>
<td>SECRETARY’S SIGNATURE _______________________________</td>
<td>□ Immunizations ___________</td>
</tr>
<tr>
<td>NURSE’S SIGNATURE _______________________________</td>
<td>□ Test Scores ___________</td>
</tr>
<tr>
<td>GUIDANCE COUNSELOR’S SIGNATURE _______________________________</td>
<td>□ IEP ___________</td>
</tr>
</tbody>
</table>

I. STUDENT INFORMATION

LAST NAME: _______________________________ FIRST NAME: _______________________________ MI: _______
HOME ADDRESS: _______________________________ Apt. _______
RENT: _______ OWN: _______ SHARE: _______ SHELTER: _______
PHONE#: _______________________________ CELL#: _______________________________ D.O.B: ___________
BIRTHPLACE CITY: _______________________________ AGE: ___________ GENDER: _______
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: _______________________________

As we anticipate offering a “Parent Portal” in the near future, to provide you with online access to grades and assignments, PLEASE be sure to indicate working email addresses, as they are needed for access to this valuable resource.
# II. PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>Father</th>
<th>Address</th>
<th>Apt.</th>
<th>Home #</th>
<th>Cell #</th>
<th>Work #</th>
</tr>
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<table>
<thead>
<tr>
<th>Email</th>
<th>Resides with student</th>
<th>Yes / No</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Mother</th>
<th>Address</th>
<th>Apt.</th>
<th>Home #</th>
<th>Cell #</th>
<th>Work #</th>
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<th>Email</th>
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<th>Yes / No</th>
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<table>
<thead>
<tr>
<th>Guardian</th>
<th>Address</th>
<th>Apt.</th>
<th>Home #</th>
<th>Cell #</th>
<th>Work #</th>
</tr>
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<tr>
<th>Email</th>
<th>Resides with student</th>
<th>Yes / No</th>
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</table>

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 Building)
- Hotel/Motel

# III. EMERGENCY CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Home #</th>
<th>Cell #</th>
<th>Work #</th>
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<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Home #</th>
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<th>Name</th>
<th>Relationship</th>
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<th>Work #</th>
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</table>
IV. OTHER MEMBERS OF HOUSEHOLD (Siblings)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>GENDER</th>
<th>SCHOOL/GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ M</td>
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<td></td>
<td>□ F</td>
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<tr>
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<td>□ M</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ F</td>
<td></td>
</tr>
</tbody>
</table>

V. EDUCATIONAL HISTORY

<table>
<thead>
<tr>
<th>GRADE</th>
<th>SCHOOL</th>
<th>DATE OF ATTENDANCE</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

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

VI. 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 ___________________________
Irvington Public Schools (IPS) may give my child’s Medicaid number to IPS health care providers so that the providers can bill Medicaid for services they provide my child.

Medicaid No. ______________________________________

_____ I do not wish to share my child’s Medicaid number with the school.
_____ Does not apply – my child is covered by other insurance.
_____ My child is currently not covered by insurance.

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 ____________________________
IRVINGTON PUBLIC SCHOOLS – MEDICAL OFFICE
EMERGENCY MEDICAL INFORMATION

School ___________________________________________ School Year _______________________

Last Name____________________ First Name ___________________ HR _______ Grade ______

Address of Student _____________________________ Tel. # _____________________________

Mother’s Name ________________________________ Place of Business ______________________

Business Address ______________________________ Business Tel. # ______________________

Address (if different from student) ___________________________ Cell # ______________________

Father’s Name ________________________________ Place of Business ______________________

Business Address ______________________________ Business Tel. # ______________________

Cell # _____________________________

Address (if different from student) ________________________________

Legal Guardian Name (if applicable) ________________ 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/Guardian ___________________________ Date ____________________
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 students who wish to participate in athletics on a school athletic squad. There is no charge for this examination. If parents 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 in lieu of the school 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 forms to be completed by the private examining physician. These forms are available in each school health office.

**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, and 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 parent or a pupil will also be receive audiometric screenings.

If a parent prefers to take his/her child to a private doctor/clinic, at the parent’s own expense, a signed letter must be sent to the school nurse. If the school does not receive a report from a private doctor by September 30th, the student will be screened in school.
<table>
<thead>
<tr>
<th>Child’s Last Name</th>
<th>First Name</th>
<th>D.O.B.</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address (number, street, city, zip code)</th>
<th>Tel. phone #</th>
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<table>
<thead>
<tr>
<th>Father’s Name</th>
<th>Mother’s Name</th>
<th>Guardian</th>
</tr>
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<tbody>
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</table>

Did your child ever attend an 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)

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent Colds</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Frequent Sore Throats</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Speech Difficulties</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Earaches</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Allergies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Anemia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Asthma</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Elevated Lead Level</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Food Allergies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hearing</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

List Allergies: ____________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Asthma</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
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<td>No</td>
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<tr>
<td>Elevated Lead Level</td>
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<td>No</td>
</tr>
<tr>
<td>Food Allergies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hearing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Kidney Disease</td>
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<td>No</td>
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<td>Rheumatic Fever</td>
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<td>No</td>
</tr>
<tr>
<td>Seizures</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vision Deficiencies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

Does your child take medication? Name of medication(s) _______________ Epipen Yes/No Inhaler Yes/No

Has your child had:

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor eating habits</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Eye Disease</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Head Injury</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>A Severe Fall</td>
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<td>No</td>
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<tr>
<td>Difficulty Sleeping</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Eye Injury</td>
<td>Yes</td>
<td>No</td>
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<td>Eye Glasses Prescribed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

Development: Age began walking ________________________ Age began talking ________________________
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
- Appendectomy
- Chickenpox
- Pneumonia
- Appendectomy
- Diabetes
- Rhematitic Fever
- Hernia
- Enuresis (bed wetting)
- Scarlet Fever
- Tonsils Removed
- Heart Disease
- Seizures
- Ear Operation
- Hernia
- Tonsils Removed
- Fractures
- Tonsilitis
- Other

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 believe is important for us to know?

Explain ____________________________________________________________
____________________________________________________________________________

Siblings’ Name(s): ___________________________ Age: ____________ School: ______________

____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________
____________________________________________________________________________

Parents/Legal Guardian’s Signature ___________________________ Date ___________________________
To Parents/Guardians:

While your child attends the Irvington Public Schools, 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. Please fill out the form below, and forward it to your child’s school nurse within ten days of receipt. A permanent notation of your choice will be made on your child’s medical record.

Be reminded that the notice below must be returned to your child’s 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.

______________________________  _____________________________
Signature of Parent/Guardian             Date

______________________________  _____________________________
Child’s name                          Grade                          Homeroom
IRVINGTON PUBLIC SCHOOLS
REQUEST FOR STUDENT RECORDS

School: __________________________________________________________

Principal: _______________________________________________________

Phone No.: ________________________ Fax No.: ________________________

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
√ DISCIPLINE RECORDS
√ OTHER __________________________________________________________

I give permission to release my child’s records to ________________________

Parent/Guardian’s Signature __________________________________________ Date ________________

NOTE: Federal Law 99.2: No parent signature is required for educational records sent to another educational agency.

First Request Date ____________
Second Request Date ____________
Third Request Date ____________

Date Received ________________

Please send requested information via: □ Fax (973) ____________
□ Mail ______________________
□ Phone (973) _______ ext. ______________________
□ E-mail: ____________________@ irvington.k12.nj.us
IRVINGTON PUBLIC SCHOOLS
HOME LANGUAGE SURVEY
Encuesta de los idiomas hablados en el hogar
Etude des langages pries a la maison

1. Student
   Estudiante
   First Name / Nombre / Prenom
   __________________________
   Etudiant
   Last Name(s) / Apellidos / Noms de Famille
   __________________________

2. Date of registration
   Fecha de inscripcion
   __________________________
   Date d'enregistrement
   __________________________

3. Language(s) spoken by the child
   Idioma(s) hablados por el nino
   __________________________
   Langage(s) pries par l'enfant
   __________________________

4. Date of Birth
   Fecha de nacimiento
   __________________________
   Date de naissance
   __________________________

5. City & Country of birth of the child
   Ciudad y Pais de nacimiento del nino
   __________________________
   Ville & Pays natal de l'enfant
   __________________________

6. Language spoken in the home by any member of the family
   Idiomas hablados en el hogar por cualquier miembro de la familia
   __________________________
   Languages pries dans la maison par tout membre de la famille
   __________________________

7. Address of residence / Dirección de la residencia / Adresse de residence
   __________________________
   Irvington, NJ 07111

8. Names of parents/guardians / Nombres de los padres/encargados / Noms de parents/tuteurs
   __________________________

9. Emergency Phone Number / Numero de telefono / Numbre de telephone
   __________________________

HLS - Page 1 of 2
FOR OFFICE USE ONLY:

This information is completed by school staff only:

Student Identification Number: __________________________

District Attendance Zone: _______________________________

Center/School: _______________________________________

Level/Grade (circle one): UN P3 P4 1 2 3 4 5 6 7 8 9 10 11 12

NOTES OF IMPORTANCE OR SPECIAL CIRCUMSTANCES:
In compliance with NJDOE a Home Language Survey must be on file for all students in district. If a second language is spoken at home the child must be tested for English Proficiency by a certified ESL Teacher using the appropriate district and state approved Diagnostic tests.

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