Irvington Public Schools
Early Childhood Department
97 Augusta Street, Second Floor, Suite 219, Irvington, New Jersey 07111
Phone: 973-399-3942 x1512 Fax: 973-399-7873
Tawana Moreland, Director Registration: 973-399-3942 ext. 1514

To register for the September 2020-2021 Preschool Program, the child must be 3 or 4 years old on or before October 1st.

****MUST BE AN IRVINGTON RESIDENT TO BE ELIGIBLE****

The following items must be submitted to complete your child's registration:

Scan image with your phone's camera for more information

1. **Birth Certificate/Passport/Visa/Green Card**
2. **Immunization Record**
3. **Physical Health Form *(Completed, Dated, Signed/Stamped By Physician)***
4. **Lead Level Test with date and results of test – *AFTER AGE 2***
5. **Current Proof of Residency (ONLY ONE PROOF IS NEEDED FROM THE LIST BELOW):**

Select one of the following proofs of residency

- ☐ **Current PSE&G Bill**
- ☐ **Current Cable Bill**
- ☐ **Homeowner's Tax Bill**
- ☐ **Current Mortgage Statement**
- ☐ **Current Year Lease**
- ☐ **Notarized letters are accepted from the person with whom you reside along with current proof of address for that person.**
  - ***Must be signed and dated by Landlord and Tenant***
  - ***If parent or guardian's name is different on child's birth certificate or proof of resident, please bring in birth certificate, marriage certificate or supporting document for verification.***
  - ***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.***

Please submit any address changes to the Office of Early Childhood Registration Department located at 97 Augusta Street, Irvington, NJ 07111.

Application, Medical Health Form, and Centers are available on the District Website:

www.irvington.k12.nj.us

- **Choose Department and click Early Childhood**
- ***Click Registration***
- ***Click form and download enrollment packet***

REGISTRATION: MONDAY – THURSDAY 9:00 AM TO 12:30 PM

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ENROLLMENT FORMS CHECKLIST

SCHOOL YEAR 2020-2021

The following items must be submitted to complete your child's Registration application

1. *	Birth Certificate / Passport / Visa / Green Card	
2. *	Immunization Record	
3. *	Physical / Examination-Health (Must be Completed, Dated, Signed and Stamped By Physician)	
4. *	Lead Test with Date and Results (**after 2 years old)**	
5. *	Current Proof Residency: PSE&G, Mortgage Statement, current year Lease, current month to month Lease, Cable Bill, Homeowner's Tax Bill or Notarized Letter from whom you reside with along with their current proof of residency.	
6.	Custody Papers (if Applicable)	
7.	Registration and Background Information Form	
8.	Medical Emergency Release Form	
9.	Health History / Consent	
10.	Record Voice or Image Release Form	Y N
11.	Emergency Contact Information Form	
12.	Home Language Survey	

*** Required Documents for Registration**

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Preschool Attendance Policy: Parents must contact the school by 9:00 am if your child will be absent. Schools must attempt to contact parent/guardian within 2 hours after it has been determined that their child is not in attendance and the school has not been notified. Family workers/social workers/teachers will contact families and document the call. After the second unexcused absence, parent/guardian will meet with the Director/Administrator. The Director/Administrator's role is to explain the importance of students attending school daily and the valuable instruction that is lost when their child is absent. The Director will explain that they are required to drop students from the program after (ten) 10 consecutive days of absences. This does not include students with medical issues.

Parent Signature: _____ Date:_____

In order to help us meet your child's educational needs, please complete the following questions:
Pou ede nou reponn a bezwen edikasyonèl pitit ou, tanpri reponn kesyon sa yo:
Para ayudarnos con las necesidades educativas de su hijo, complete las siguientes preguntas:

Child's Primary Language: _____
(Idioma primaria de su niño)
(Langaj primodial timounn nan)

Are there any additional languages spoken in the home? Yes _____ No _____
(Hablan otro idioma adicional en la casa?)
(Èske gen oken lang tradisyonel ki pale nan kay la?)

Does your child wear diapers/pull-ups: Yes_____ No_____
(Está usando su niño pañales?)
(Èske ti mounn nan mete diapè?)

Has your child previously attended a daycare or preschool? Yes _____ No _____
(Ha estado su niño en daycare o preescolar anteriormente?)
(Èske pitit ou te nan daycare ou byen preskolè avan)

Name of School: _____ Years attended: _____

Is your child currently in Early Intervention? Yes _____ No _____
(Está recibiendo su niño Intervención temprana actualmente?)
(Èske pitit ou aktyèlman nan Early Intervention?)

Does your child have any siblings currently enrolled in IPS? Yes _____ No _____
(Èske pitit ou gen frè ak sè ki aktyèlman nan Lekòl Piblik Irvington?)
(Tiene su niño hermanos actualmente en las escuelas de Irvington?)

School_____ Lekòl Escuela	Grade_____ Klas Grado	School_____ Lekòl Escuela	Grade_____ Klas Grado
School_____ Lekòl Escuela	Grade_____ Klas Grado	School_____ Lekòl Escuela	Grade_____ Klas Grado

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Preschool Program Uniform Preschool Enrollment Form
2020 – 2021 School Year - English/Spanish/French Version

ABOUT THE CHILD / SOBRE EL NIÑO/ AU SUJET DE L'ENFANT

1. **Last Name of Child / Apellido del Niño/a *Required Field/ Información necesaria/ Dernier nom d'enfant**

2. **First Name of Child / Nombre del Niño/a *Required Field/ Información necesaria/ Prénom d'enfant**

3. **Middle Name of Child** – If applicable. **/ Segundo Nombre** – Si es aplicable./ **Deuxième prénom d'enfant**

4. **Generation Code or Suffix** – If applicable, for example: Jr., Sr., III.
   Código de clasificación de la generación o Sufijo – Si es aplicable, por ejemplo: Jr., Sr., III.
   Code ou suffixe de génération - si c'est approprié, par exemple : Jr., Sr., III.

5. **Address of Child/Dirección del Niño/a *Required Field/ Información necesaria**
   Street/ Calle/ Adresse d'enfant

   Apartment/Apartamento/ Appartement

   City, State, Zip/Ciudad, Estado, Codigo Postal/ Ville, État, Code Postal

6 **Birth Date of Child** (Month/Day/Year) **/Fecha de Nacimiento del Niño/a** (Mes/Día/Año)
   ***Required Field/ Información necesaria**
   Date de naissance d'enfant (Month/Day/Year)

   - -

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7. **Place of Birth of Child**
País de nacimiento del niño
Pays natal d'enfant

	United States of America Los Estados Unidos de América Les Etats-Unis d'Amérique	City Ciudad Ville	State Estado État
	Other (Print Country)	Otro (País De la Impresión)	Autre (Pays D'Impression)

8. **What is the child's sex?** Mark one box.
¿Cuál es el sexo del niño/a? Marque una respuesta.
Quel est le sexe de l'enfant ? Marquez une boîte.

	Female	Femenino	Femelle
	Male	Masculino	Mâle

9. **Is the child Spanish, Hispanic or Latino?** Mark one or more groups to indicate the child's Spanish/Hispanic/Latino origin.
¿Es el niño Español, Hispano o Latino? Marque uno o más grupos para indicar el origen Español, Hispano o Latino del niño.
L'enfant est-il de l'Espagnol, l'hispanique ou le Latino ? Marquez un ou plusieurs groupes pour indiquer l'enfant Origine de Spanish/Hispanic/Latino.

	No, not Spanish/Hispanic/Latino.	No, no es Español/Hispano/Latino.	Non, pas Spanish/Hispanic/Latino.
	Yes, Mexican, Mexican American, Chicano	Sí, Mejicano, Mejicano-Americano, Chicano	Oui, Mexicain, Américain Mexicain, Chicano
	Yes, Puerto Rican	Sí, Puertorriqueño	Oui, Puerto Rican
	Yes, Cuban	Sí, Cubano	Oui, Cubain
	Yes, other Spanish/Hispanic/Latino (Print group.)	Sí, Español/Hispano/Latino de otro grupo (Indique en letra de imprenta el grupo)	Oui, l'autre Spanish/Hispanic/Latino (copie groupe.)

10. **What is the child's race? Mark one or more races to indicate the child's race.**
¿Cual es la raza del niño/a? Marque uno o más de una respuesta para indicar la raza de su hijo/a.
Quelle est la course de l'enfant ? Marque une ou plusieurs courses pour indiquer la course de l'enfant.

	White	Blanco	Blanc
	Black or African American	Negro o Americano Africano	noir ou Afro-Américain
	American Indian or Alaska Native	Indio Nativo de América o Nativo de Alaska	Indien d'Amerique ou indigène de l'Alaska
	Asian or Pacific Islander	Nativo de la Isla de Asia o del Pacífico	Insulaire asiatique ou Pacifique
	Some other race (Print race.)	Otra raza (Indique la raza.)	Une autre course(Identite Racial)

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11. What language does the child speak most at home? Mark one box.
¿Qué lenguaje habla su hijo/a habla en la casa? Marque una respuesta.
Quelle langue l'enfant parle-t-il le plus à la maison ? Marquez une boîte.

	English	Inglés	Anglais
	Spanish	Español	Espagnol
	Arabic	Arabe	Arabe
	Chinese	Chino	Chinois
	Creole (Haitian)	Creole (Haitiano)	Créole (Haïtien)
	Gujarati	Gujarati	Gujarati
	Korean	Coreano	Coréen
	Polish	Polaco	Poli
	Portuguese	Portugués	Portugais
	Russian	Ruso	Russe
	Urdu	Urdu	Urdu
	Some other language (Print language.)	Otro lenguaje (Indique el lenguaje.)	Une autre langue (Indiquer la Langue)

12. Does the child have any chronic medical problems, special needs, or handicapping conditions? Mark one box.
¿Padece el niño de algún problema médico crónico, de necesidades especiales o algún tipo de incapacidad? Marque una respuesta.
Fait l'enfant ont tous les problèmes médicaux chroniques, les besoins spéciaux, ou handicapage des conditions ? Marque une boîte.

	No	No	Non
	Yes (Print problem or condition.)	Sí (Indique en letra de imprenta el problema o condición.)	Oui (problème ou état d'impression.)

13. What kind of health insurance does the child have? Mark one box.
¿Qué clase de seguro médico tiene el niño? Marque una casilla.
Quel genre d'assurance médicale maladie l'enfant a-t-il ? Marquez une boîte.

	Private or employment-based health insurance	Seguro de salud privado o basado en el empleo	Assurance médicale maladie privée ou emploi-basée
	Medicaid	Medicaid	Medicaid
	New Jersey FamilyCare	New Jersey FamilyCare	New Jersey FamilyCare
	Some other health insurance	Otro tipo de seguro médico	Une autre assurance médicale maladie
	Uninsured	No tiene seguro.	Non assuré

14. Who does the child live with?
¿Con quién el niño vivo?
Avec qui l'enfant de phase ?

	Mother and Father	Madre y padre	Mère et père
	Mother Only	Madre Solamente	Mère Seulement
	Father Only	Padre Solamente	Père Seulement
	Grandmother	Abuela	Grand-mère
	Grandfather	Abuelo	Grand-père
	Other (Specify)	Otro (Especifique)	Autre (Indiquez)

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15. How did you find out about our Program?
Cómo le hizo para descubrir alrededor ¿nuestro programa?
Comment vous a fait pour découvrir environ notre programme ?

	Newspaper Ad	Anuncio De Periódico	Annonce Petite
	Friend	Amigo	Ami
	School	Escuela	École
	District Website Page	Página del Web site del districto	Page de site Web de zone
	Flyers/Posters	Aviadores/carteles	Insectes/affiches
	Other Please Specify):	Otro (Especifique Por favor)	Autre (Indiquez Svp)
	Cable Television		
	Bus Advertisement		
	Street Banner/Signs		

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MEDICAL EMERGENCY RELEASE/TREATMENT FORM

MEDICAL INFORMATION:

Existing Medical Problems/Problemas Medico: Yes/Si ( ) or No ( )
If yes please explain/Explicar_____

Allergies to Food/Medicine etc/Allergias a Comida o Medicina: Yes/Si ( ) or No ( )
If yes please explain/Explica_____

Does your child take Medication? Su hijo(a) toma Medicina Yes/Si ( ) or No ( )
If yes give name of medication (s)/Nombre Medicina_____

Child's Doctor/Clinic Name_____ Phone_____
Nombre del Doctor o Clinica _____ Telefono _____

Choice of Hospital when possible/Nombre de Hospital_____ Phone/Telefono_____

Date of child's last tetanus shot/Ultima Vacuna_____Medicaid number, if applicable_____

Medical Insurance Co./Seguro Medico_____ ID#_____

Subscriber's Name/Nombre de Subscridor_____

It is understood that every effort will be made to notify me or_____ at_____ before such action is taken, but if not possible to locate me or the above person, the uninsured expense of this service will be accepted by me.

I authorize the child care provider to arrange transportation in case of emergency or acute illness and to arrange for possible medical and/or surgical care at (1) the closest hospital available in case of dire emergency or (2) the hospital of my choice.

_____ _____
Parent/Guardian's Signature/Firma Del Padre Date/Fecha

THE SCHOOL MUST BE NOTIFIED OF ANY CHANGES
LA ESCUELA DEBE SER NOTIFICADA DE CUALAQUIER CAMBIO

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HEALTH HISTORY
HISTORIA DE SALUD

Child's Name/Nombre del niño(a)_____
Last Name/Apellido First/Nombre Middle Initial
Date of Birth/Fecha Naciemiento_____Age/Edad _____Phone/Telefono _____

Father's Name/Nombre Padre_____Mother's Name/Nombre Madre_____

Guardian's Name

1. How many Adults in the household_____This child is___in the family Brothers___Sister___Cuantos Adultos viven en la casa___
2. With whom does the child live?/Con quien vive su hijo(a) _____(mother, father, grandparent, guardian, etc.)
3. How is health care provided for this child?/Que seguro tiene? Private Insurance/Privado ( ) Social Security ( ) Medical/Medicaid ( ) Other/Otro ( )_____
4. Name of Physician/Clinic/Nombre del Doctor_____ Address/Dirreccion_____ Phone/telefono_____
5. Does your child have or has your child had a health problem (check all that apply):
   Su hijo (a) tiene una de estas conficiones medica (marque todo que le applique)

CONDITION	YES	NO	COMMENT
Allergies/Allergias			
Asthma/Asma			
Cancer			
Change in Eating Habits/Cambios en la comida			
Chicken Pox/Viruelas			
Chronic Fatigue/Tiredness/Fatiga/Cansancio			
Clumsiness/Cordinacio			
Congenital Heart Disease/Problems del Corazon			
Diabetes/Diabetis			
Dry or Hacking Cough/Tos Cronica			
Earache or Ear Infections/Infeccion al Oido			
Eczema			
Epilepsy or Convulsions/Convulsions o Epilepsia			
Eye or Vision problems/Problems de Vision			
Fractures or dislocation of Bones/Fracturas de Hueso			
Headache/Dolor de Cabeza			
Hearing problems/Problems de Escuchar			
Heart Murmur/Murmores del Corazon			
High Blood Pressure/Pression Alta			
HIV			
Kidney Disease/Problemas del rinon			
Lead Poisoning/Plomo			
Loss of Weight/Over Weight/Aumento O Perdida de Peso			
Mononucleosis/Monocluosis			
Mumps/Papera			
Nose Bleeds/Sangre por la Nariz			
Rheumatic Fever/Fiebre Reamatica			
Ring Worm "Teetis"/Ronchas			
Rubella			
Scarlet Fever/Fiebre Alta			

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CONDITION	YES	NO	COMMENT
Sickle Cell Anemia/Anemia			
Sleeplessness/Cansancio			
Surgery/Cirujia			
Toothache or problems/Dolor a los dientes o problemas			
Tuberculosis (TB)			
Ulcers or Stomach problems/Ulceras			
Other (specify)/Otro(specifique)			

6. Does any close relative in the child's family have a history of : (check all that apply):
Si su Hijo(a) tiene familia con Historia Medica: (Marque Todo lo que applique)
Anemia____Asthma/Asma_____Birth Defect/Naciamiento___Cancer _____Diabetes/Diabetis_____Epilepsy/Epilepcia _____
Heart Disease/Condicion Corazon _____Learning Problems/Problemas de aprender_____Mental Impairment /Problemas Mentales_____
Sickle Cell Anemia___Other/Otro_____

7. During the pregnancy with this child, did the mother have any medical problem? Durante su embaraso tuvo problemas medicos? (e.g. High Blood pressure, kidney infection or exposure to other infectious diseases)? Ye/Sis ( ) or No ( ) If yes, explain/Explique_____
_____

8. During the pregnancy with this child, did the mother smoke cigarettes? Yes/Si ( ) or No ( ) Did the mother consume alcohol,? Yes ( ) or No ( ) Consume any substance (Drugs or any medication other than vitamins or iron? Durante su embaraso fumaba? Consumia Bebidas Alcolicas? Tomaba Medicians Yes/Si ( ) or No ( ) _____

9. Were there any problems during labor or delivery? Tuvo complicaciones durante embaraso? Yes/Si ( ) or No ( )
Comments/Commentarios_____

10. How long did labor last?Cuanto Duro el Parto?_____Was the child's breathing normal?Su hijo (a) Respira normal al nacer Yes/Si ( ) or No ( ) Birth Weigh:_____

11. How long did the child remain in the hospital?Cuanto tiempo estuvo en el Hospital_____Did the child leave the hospital with his/her mother/Su jiho salio del hospital con sus madre Yes/Si ( ) or No ( )

12. What age did you child: Walk alone/Que edad camino_____Talk/Hablar (2 words together)?_____Become potty trained?/Fue al bano _____Is bed wetting a problem?/Se horina en cama ?Yes/Si ( ) or No ( ) if yes, please explain_____
_____

13. Has the child been hospitalized for any reason since birth? Su hijo(a) estado en el hospital? Yes/Si ( ) or No ( ) If yes, When_____
Why/Porque_____

14. Are there any problems in the home, which might affect your child's learning?Hay algun problema en casa que afectar a su hijo(a) aprender? Yes/Si ( ) or No ( ) Explain/Explique_____

15. Is there anything more about the child's health that you think is important for us to know? Yes/Si ( ) or No ( ) Explain/Explique
Hay algo que debemos saber de su hijo(a) condicion medica que usted crea ser importante?

_____

_____

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PERMISSION FOR RELEASE OF RECORDS AND HEALTH SCREENINGS

I agree or permit that my child_____, may participate in the following health activities:

Height/Alutra Yes/Si ( ) or No ( ) Weight/Peso Yes/Si ( ) or No ( ) Vision Screening/Examen Visual Yes/Si ( ) or No ( ) Hearing Screening/Examen de Escuchar Yes/Si ( ) or No ( ) Dental Screening/Examen Dental Yes/Si ( ) or No ( )

If you wish to be present during any screening, please contact school. Parents are notified if a child needs further evaluation. If for some reason a parent is unable to provide for further services, please contact the school.
Si usted quisasra estar presente durante el exame por favor contactar la escuela. Los padres seran notificados si necesitan mas evaluacion. Si por cualquier razon los padres no pueden producer mas information por favor liame a la escuela.

My signature indicates that I have the legal right to authorize the release of any medical information to process this application.
My firma indica que yyo tengo todo el derecho para autorizar la libertad de toda informacion medica para procesar esta applicacion.

Parent/Guardian's Signature_____ Date_____

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RECORDED VOICE OR IMAGE RELEASE

The undersigned, hereby grant full permission to the Irvington Board of Education, Irvington, New Jersey, to record the image of or voice of the herein listed individual while that individual is participating in any school related or sponsored activity. I authorize the copyright, use distribution without limitation of these recordings and their derivatives for the use of the Irvington Board of Education.

Child's Name_____
Please Print

Address_____
Please Print

_____
Please Print

Parent Signature_____ Date_____

I certify that I have the legal right to sign for the above mentioned underage individual.

Parent's Name_____

Address_____
Please Print

_____

_____

Parent Signature_____ Date_____

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SCHOOL YEAR: **2020-2021** D.O.B.: _____

EMERGENCY CONTACT INFORMATION FORM

Name: _____ Homeroom: _____Grade: _____Teacher: _____
Last Name First Name

Home Address: _____Telephone Number(s): _____
_____ _____

Mother's Name: _____
Home Address **(if different from student):** _____
_____
_____
Place of Business: _____
Business Address: _____
_____
Business Telephone #: _____
E-mail address: _____

Father's Name: _____
Home Address **(if different from student):** _____
_____
_____
Place of Business: _____
Business Address: _____
_____
Business Telephone #: _____
E-mail address: _____

***ALLERGIES** (Please List All): _____
_____

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

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Child's Name_____

Contact #1
Name: _____ Telephone #: _____
Address: _____

Contact #2
Name: _____ Telephone #: _____
Address: _____

Contact #3
Name: _____ Telephone #: _____
Address: _____

Contact #4
Name: _____ Telephone #: _____
Address: _____

Contact #5
Name: _____ Telephone #: _____
Address: _____

Contact #6
Name: _____ Telephone #: _____
Address: _____

Other Instructions: _____
_____

Signature of Parent/Guardian: _____ Date: _____

Information must be updated as necessary for the safety of your child.

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OFFICE USE ONLY

TEACHER COPY

CHILD'S NAME: _____ SCHOOL: _____

TEACHER:_____

POWER SCHOOL ID #: _____

DATE OF BIRTH: _____ AGE_____M_____F_____

PRIMARY LANGUAGE:_____

SECONDARY LANGUAGE:_____

DAYCARE, NURSERY SCHOOL, OR PRESCHOOL PREVIOUSLY ATTENDED:

_____

Received Early Intervention Services? Y_____N_____

Number of years:_____

Wears diapers/pull-ups: Yes_____ No_____