Welcome to East Brunswick Public Schools! Please use the checklist below to ensure all necessary documents are completed and ready for your appointment with the District Registration office. If you have any questions, please call 732-613-6980.

**REGISTRATION CHECKLIST**

- **Proof of Residency**
  Documents must be in the name of the parent/guardian. A copy of the Deed, a currently dated mortgage statement or lease agreement **must be provided** at time of registration. **TWO** additional **UTILITY** bills must also be provided to complete the residency requirement within 30 days of registration. If the home is not in the name of parent/guardian, please call 732-613-6750 for instructions.

- **Parent/Guardian Photo ID**

- **Student's Original Birth Certificate** or other proof of identity

- **Student's current immunization record**

- **NJ Transfer Card for students transferring from another NJ public school**

- **For grades K-8 current/previous school report cards**

- **For grades 9-12 a copy of unofficial transcript**

- **IEP/504 Plan** if applicable

- **Custody Documentation** if applicable

- **Registration Packet** printed and completed **PRIOR** to appointment (one packet per student)
  - **Registration Data Sheet**
  - **Emergency Contact Information**
  - **Home Language Survey**
  - **Student Health History**
  - **Student Services Screening Approval**
  - **Student Physical Exam Form** (must be provided within 30 days of registration)
### EAST BRUNSWICK PUBLIC SCHOOLS
#### EARLY LEARNING ACADEMY REGISTRATION DATA SHEET

**SCHOOL __________________________**  
**DATE ______________**  
**STUDENT ID _____________**

**PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETED**

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>Student First Name (Legal)</th>
<th>M. I.</th>
<th>Nickname</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth: (M)/ (D)/ (Y)</th>
<th>Age:</th>
<th>Gender:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student Street Address</th>
<th>Town</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Student resides with (Relationship): ____________________________________________  
Parent Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐

If divorced or separated, who has legal custody? ____________________________  
Who has residential custody? ____________________________

Student’s previous Address & Telephone #: ____________________________________________

If you have a residence elsewhere, what is the address and when do you live there? ____________________________________________

Student’s previous Preschool/Daycare Address: ____________________________________________

Do you have other children attending East Brunswick Public Schools?  
Yes ☐ No ☐ (List Full Names Below)  
(1) ____________________________ (2) ____________________________ (3) ____________________________ (4) ____________________________

First U.S. School Entry Date: (M) _______ (D) _______ (Y) _______  
Original U.S. Entry Date: (M) _______ (D) _______ (Y) _______

**SPECIAL EDUCATION: Yes ☐ No ☐ IEP? Yes ☐ No ☐ In Basic Skills? Yes ☐ No ☐ Have a 504 Plan? Yes ☐ No ☐**

**Required for State/Federal Reports:** (these questions must be answered)

- Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native  
- **Ethnicity:** Hispanic  
- Yes ☐ No ☐

**PARENT/GUARDIAN INFORMATION**

**Please Circle: Parent Guardian Other __________**  
(Ms.) (Mrs.) (Mr.) (Dr.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Address</th>
<th>City: ____________________________ State: ______ Zip: ______</th>
</tr>
</thead>
</table>

Parent Preferred E-mail Address: ____________________________

<table>
<thead>
<tr>
<th>Home Phone #: ( )</th>
<th>Cell Phone #: ( )</th>
<th>Business #: ( )</th>
<th>Occupation: ____________________________</th>
</tr>
</thead>
</table>

Employer’s Name: ____________________________

Employer’s Address: ____________________________

Parent Preferred E-mail Address: ____________________________

<table>
<thead>
<tr>
<th>Home Phone #: ( )</th>
<th>Cell Phone #: ( )</th>
<th>Business #: ( )</th>
<th>Occupation: ____________________________</th>
</tr>
</thead>
</table>

Employer’s Name: ____________________________

Employer’s Address: ____________________________

A non-refundable registration fee of $50 is required for registration ($25 if registering prior to June 1, 2020).

- ☐ Full Day ($743/month)  
- ☐ Half Day Morning only ($367/month)  
- ☐ Half-day Afternoon only ($367/month)

- ☐ AM added to PM General Education Inclusive Preschool ($377/month)  
- ☐ Mid-day extension ($80/month)

- ☐ PM added to AM General Education Inclusive Preschool ($377/month)  
- ☐ ELA PM Extension ($105/month)

**Location:** Hammarskjold Middle School  
**Start Date Requested __________**

Revised 3/03/2020
Medical Information (If a field is not applicable, enter N/A.)

List relevant information about your child’s behavior, educational, or medical needs including allergies:

___________________________________________________________________________________________________________

List any medications your child is using on a daily basis __________________________________________________________

Child’s physician ___________________________________________ Phone: __________________________

In extreme emergency, which hospital do you prefer to have your child be transported to for emergency medical care?

____________________________________________________________________________________

I hereby give permission to East Brunswick Public Schools personnel to obtain medical treatment for my child in the event of an emergency when I cannot be contacted. This permission authorizes medical personnel to perform emergency treatment including the administration of drugs, blood transfusions or other medically necessary procedure except as follows: ________________________________

Health Insurance Information

Subscriber’s Name __________________________ Health Plan __________________________

Member ID# __________________________ Group ID# __________________________

PHOTO/IMAGE PERMISSION

I/We GRANT permission for this student’s name, photo/image and all other personal identifiers described above to be published on the school and/or district’s public internet site and any social media sites run by the district. This permission also allows for the same name, photo/image and personal identifiers to be used in newsletters, presentations, flyers and press releases, on EBTV, and in outside and news publications and broadcasts as described above. NOTICE: FAILURE TO SUBMIT AN ANSWER WILL RESULT IN YOUR GRANTING PERMISSION FOR PUBLICATION.

District Media and Internet Publicity Permissions:

☐ Grant
☐ Do Not Grant

Registration:

In-person registrations only accepted. Applications accepted on a first-come, first-served basis. An annual registration fee and the first monthly payment must be received at time of registration. Make checks payable to East Brunswick Public Schools. Child’s full name must be noted on all checks. Credit card payments are also accepted.

Fees:

Fees are due on a monthly basis and billed through the online system. A late fee of $20 per month will be assessed if payment is received after the 15th of each month. If the June payment is not received by May 15, students will be unable to attend in June. A fee of $20 will be charged and is due in cash for each returned check. If payment is overdue for two months, the student will no longer be able to attend, and legal action will be taken. Should you need to suspend the program and re-enroll during the year; a fee of $20 will be charged for each reenrollment. If it is necessary to make a program change (i.e. change from a Full-day to Half-day, adding programs, etc.), there will be a $40 fee charged beginning with the second change. To pay online, please visit www.ebnet.org/registrationandpayment.

Withdrawal from the Program:

Should withdrawal from the program be necessary, 30 days notice in writing to the Financial Services office is required by email to ebonlinepayments@ebnet.org or fax (732) 698-9624. Failure to provide this notice will result in being charged for the next month.

☐ I have read and understand the contents of the Community Programs Handbook.

I certify that the foregoing statements made by me are true. I am aware that if any of them are willfully false, I will be subject to legal action. As per State Law and Board Policy, if it is discovered that my child (children) is (are) illegally attending the East Brunswick Schools and not living in East Brunswick, I will be responsible for the payment of all accrued tuition fees. In addition, I acknowledge that I will be responsible for any legal expenses incurred by the East Brunswick Board of Education in relation to the situation.

Print Name __________________________ Signature __________________________ Date __________

Revised 3/03/2020
FOR OFFICE USE ONLY

Registration Date: ______________________
Name of Student: ____________________________________________________________

Student Number: ______________________ Enrollment/Transfer Code: ______________________

Home School: ______________________ Placement School: ______________________ Grade: ______

New Registration: □ Transfer: □ Change: □ Home Instruction: □ Withdrawal: □ Homeschooling: □ Drop out: □ Re entry: □

Reason For: ___________________________________________________________________

Effective Date: __________________________________________________________________

Place of Birth (Country) ______________________ (City) ______________________ (State) ______________________

Ethnicity: Yes □ No □
Race Selection: Yes □ No □
Native (Home) Language*: ______________________ Test for ESL: Yes □ No □ Placed in ESL: □

Placed in Sp. Ed. □ IEP: Yes □ No □ Instructional Setting Code: __________ 504 Plan: Yes □ No □

Academic Records: Yes □ No □ Birth Certificate: Yes □ No □
Medical Records: Yes □ No □ Immunization Records: Yes □ No □
Custody Documentation Yes □ No □

Proof of Residence: Yes □ 3 Proofs required - 1 2 3  If less than 3 follow up REQUIRED □
(1) Mortgage/deed or lease contract (2) Property tax bill if you own your home (3) one recent utility bill or two if leasing (4) Other

Residency Forms completed in Assistant Superintendent’s Office
_____ Affidavit (Student living with East Brunswick resident due to hardship)
_____ Temporary Residency (Parent and Student living with East Brunswick resident)

Assigned to: Homeroom: ________ Teacher: ___________________________ Counselor: ___________________________

TRANSPORTATION

Eligible for bus transportation? Yes □ No □

Copies to: □ Transportation □ Nurse □ Primary Ed. □ Basic Skills □ ESL □ Sp. Ed □ Attendance □ Administrator

Revised 3/03/2020
**EMERGENCY CONTACT INFORMATION**

Student’s Name: ________________________________________________________________

Please indicate the names of at least two individuals other than parent/guardian who may be contacted in the event of an emergency. These individuals will only be contacted when parent/guardian cannot be reached. Please be advised that these individuals will need to present identification in order to pick up your child.

<table>
<thead>
<tr>
<th></th>
<th>Name: ____________________________</th>
<th>Telephone Number: ____________________________</th>
<th>Relationship to Student: ____________________________</th>
<th>Child may be released to this person (circle one)</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>2</td>
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<td>3</td>
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</tbody>
</table>

Office Use:

Student ID # ____________________________
East Brunswick Public Schools Home Language Survey

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with “Question 1” and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Name: ________________________________________ Student Birth Date: _______________ __________

Parent Signature: ____________________________________ Student ID#: (office use ______________________

Survey Questions

Question 1
What was the first language used by the student?

A language other than English. Proceed to question 2a.

English. Proceed to question 2b.

Question 2a
At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question seven.

No. Proceed to question four.

Question 2b
At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question four.

No. Proceed to question three.

Question 3
Does the student understand a language other than English?

Yes. Proceed to question four.

No. Proceed to question nine.

Question 4
When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

Yes. Proceed to question seven.

No. Proceed to question five.

Question 5
When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

Yes
No

Question 6
Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

Yes
No

Question 7
What are the home languages spoken? ______________________________________________________ Proceed to 8.

8. Proceed to Step 2: Records Review Process. Home Language Survey is complete. (Contact information will be provided.)

9. Do not proceed to Step 2: Records Review Process. Home Language Survey is complete. Student is not an English Language Learner (ELL).
It is necessary that the following confidential information concerning the health history, growth and development of your child be completed. This information is essential for a total understanding of each child as an individual. It also assists in planning the child's individual educational plan.

Date: ______________ School: ___________________________ Grade: ____________
Student Name: ___________________________ Date of Birth: ______________
Parent Name: ____________________________________________

A. DEVELOPMENTAL HISTORY
1. Was pregnancy normal? __________ Number of months__________
2. If mother was ill during pregnancy, state illness, the month in which it occurred, the type of treatment received, drugs and/or medication taken, and the duration of the illness.
   ______________________________________________________

3. Type of delivery (check one): Spontaneous_____ Breech_____ Caesarean___ Other________
4. Condition of infant at birth: Weight:___ Cord around neck:_____ Require transfusion:____
   Jaundiced____ Rh or other blood condition____ Require oxygen____ Special nursery:____
   How Long:____ Congenital birth defects:________________________________________
   Was child discharged from the hospital with mother?_______________________________

5. Age at which your child:
   Crawled_____ Walked Alone_____ Talked_____ Toilet Trained_____ Dressed Self____


7. Language spoken at home____________________ Does your child speak English_____?

B. FAMILY HISTORY
1. List information on brothers and sisters:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>M/F</th>
<th>General Health</th>
</tr>
</thead>
</table>

   ______________________________________________________

   ______________________________________________________

2. Is there a history of any of the following diseases in your immediate family? (List the person)
   Diabetes___________ Seizures__________
   High Blood Pressure___________ Asthma/Allergies__________
   Cancer___________ Heart Disease__________
   Mental Illness___________ Substance Abuse__________

C. SLEEP PATTERN
1. How many hours of sleep does your child get each night? _____________________

2. Please circle any problems with the following:
   Falling asleep   Staying asleep   Insomnia   Sleepwalking   Bedwetting   Nightmares
**D. FEEDING AND DIGESTION**

1. Is the child’s appetite usually good?  
   Yes _____  No _____

2. Do any foods disagree with him/her?  
   Yes _____  No _____

3. Problem with diarrhea or constipation?  
   Yes _____  No _____

4. Does he/she have frequent stomachaches?  
   Yes _____  No _____

**E. INFECTIONS AND ILLNESSES**

1. Frequent Colds  
   Yes _____  No _____

2. Hearing Problems  
   Yes _____  No _____

3. Frequent Earaches/Tubes  
   Yes _____  No _____

4. Hearing Test  
   Yes _____  No _____
     
     If yes, by whom__________________ Results_______________________

5. Vision Problems  
   Yes _____  No _____

   Results of eye exam_______ Glasses  
   Yes _____  No _____

6. Urinary infections or related problems  
   Yes _____  No _____

7. High Fevers  
   Yes _____  No _____

8. Convulsions  
   Yes _____  No _____

9. Eczema  
   Yes _____  No _____

10. Hives  
    Yes _____  No _____

11. Wheezing  
    Yes _____  No _____

12. Asthma  
    Yes _____  No _____
    Asthma Triggers: _______________________________________________________

**Identify substances which might cause allergies:**

- Foods: __________________________ Reaction __________________________
- Environmental: __________________________ Reaction __________________________
- Treatment:

**Circle any disease your child has had and indicate age:**

- Chicken Pox________  Strep________  Lyme’s Disease________
- Pneumonia________  Heart________  Neuromuscular________

**List of serious injuries:**

- Operations: __________________________ Reason __________________________ Age:
- Hospitalizations: __________________________ Reason __________________________ Age:

**F. BEHAVIOR**

1. Circle all that apply: Nail biting  Fears  Thumb Sucking  Speech Problems  Tantrums  Other:  
   ____________________________________________

2. Does your child have difficulty concentrating and/or short attention span?  
   __________________________  
   Medication?  
   __________________________

3. What are your child’s strengths?  
   __________________________

4. Do you anticipate any difficulties for your child in school?  Please explain:  
   __________________________

5. Please write any other information you wish to share with the school which might be beneficial to your child’s education:  
   __________________________

Parent  

Date  

---

Nurses Manual  
Chapter 2 Rev: 6/2019
East Brunswick Public Schools
Students Services Department

Parent or Guardian: ___________________________ Date: ________________

Screening procedures are conducted on students in the East Brunswick Public Schools according to the following regulations and Board of Education policies. PLEASE READ AND SIGN this form to indicate your approval of these procedures for your child. This form will become part of the student’s permanent health record. The school nurse will answer any questions you may have concerning these procedures.

**AUDIOMETRIC SCREENING: NJAC 6A:16-2.2, NJSA 18A:40-4**

Audiometric screening for hearing acuity is done annually for all students in preschool programs, grades K-3, 7 and 11, students new to the district with no available record of audiometric screening, students referred to the Child Study Team for evaluation, students at risk of hearing impairment and those referred by teacher, parent or self.

**VISION SCREENING: NJAC 6A:16-2.2**

This is done annually on students in preschool programs, grade K-1, 3, 5-8 and 10, students referred to the Child Study Team for evaluation or review, students entering the district with no available record of vision screening and those referred by teacher, parent or self.

**SCOLIOSIS SCREENING: NJSA 18A:40-4.3**

Students in grades 5, 7, 9 and 11 will be examined for Scoliosis.

**HEIGHTS, WEIGHTS AND BLOOD PRESSURE**

Will be done annually on all students in grades K-12.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Grade</th>
<th>Parent/Guardian Signature</th>
</tr>
</thead>
</table>

---

HS lb
Revised 8/2014
Student Physical Examination Form

Student Name: ___________________________ Date of Birth: __________

School: ________________________________ Date: __________________

School Address: _______________________________________________________

Dear Parent:

Please present this form to your physician at the time of your child’s examination. Upon completion, please return this form within 30 days of student’s registration. Thank you.

Height: ______ Weight: ______ B.P.: ______ Pulse: ______

Vision-Right: ______ Left: ______ Both: ______

Glasses-Right: ______ Left: ______ Both: ______

<table>
<thead>
<tr>
<th>Physical Findings</th>
<th>Please indicate with a ✓ in the appropriate column.</th>
<th>Specify and Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES</td>
<td>Normal     Abnormal</td>
<td></td>
</tr>
<tr>
<td>VISION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COLOR PERCEPTION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EARS - OTOSCOPIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEARING</td>
<td>Left       Right</td>
<td></td>
</tr>
<tr>
<td>TEETH/MOUTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THROAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LYMPH GLANDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THYROID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUNGS</td>
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<td></td>
</tr>
<tr>
<td>ABDOMEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERNIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENITO-URINARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORTHOPEDIC (STRUCTURAL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCOLIOSIS SCREENING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUTRITION</td>
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<tr>
<td>NERVOUS SYSTEM</td>
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<tr>
<td>SPEECH</td>
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<tr>
<td>OTHER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENERAL APPEARANCE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Student Physical Examination Form

Student Name: _____________________________________________

DATE OF MOST RECENT MANTOUX TUBERCULIN:

TEST: _______ RESULT: _______ FOLLOW-UP: __________________

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT/DTaP</td>
<td></td>
</tr>
<tr>
<td>Tdap (Grade 6)</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
</tr>
<tr>
<td>Measles (on or after 1(^{st}) birthday)</td>
<td></td>
</tr>
<tr>
<td>Mumps (on or after 1(^{st}) birthday)</td>
<td></td>
</tr>
<tr>
<td>Rubella (on or after 1(^{st}) birthday)</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (min spacing intervals)</td>
<td></td>
</tr>
<tr>
<td>Varicella (on or after 1(^{st}) birthday)</td>
<td></td>
</tr>
<tr>
<td>Meningococcal (Grade 6)(after 10(^{th}) birthday)</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (Pre-School)</td>
<td></td>
</tr>
<tr>
<td>Influenza (Pre-School)</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE LIST ANY HEALTH PROBLEMS WHICH MIGHT INTERFERE WITH THE STUDENT’S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR PHYSICAL EDUCATION PROGRAM:

INDICATE ANY RESTRICTIONS:

COMMENTS:

DATE OF EXAMINATION: _________________________

SIGNATURE OF PHYSICIAN: __________________________

PRINTED NAME, ADDRESS AND TELEPHONE: __________________________