



East Brunswick Public Schools

Welcome to East Brunswick Public Schools. Please use the checklist below to ensure all necessary documents are compiled for student registration. **ALL of the requested items below are necessary to process registration.** Please understand that failure to provide requirements may delay registration. If you have any questions, please call 732-613-6980.

EARLY LEARNING ACADEMY 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 current 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 732-613-6751 for instructions.

_____ **Parent/Guardian Photo ID**

_____ **Student's Birth Certificate (copy – no originals)**

_____ **Student's current immunization record**

_____ **Custody Documentation** if applicable

_____ **Registration Packet** printed and all forms completed (one packet per student)

_____ **Registration Data Sheet**

All fields and check boxes must be filled in completely. Guardian boxes are for parents/legal guardians only. Please provide all contact information.

_____ **Emergency Contact Information**

Please provide the name of at least one individual (not parent/guardian).

_____ **Student Health History**

_____ **Student Physical Exam Form**

(must be completed by physician and returned to school nurse within 30 days of registration)

_____ **Registration steps 1 & 2 online (<https://www.ebnet.org/site/Default.aspx?PageID=6326>) **MUST** be completed for each student. Registration paperwork drop off information will be provided with the completion of step #2 (Student Registration Request).**

****Please DO NOT submit any form of payment with registration paperwork. Payment instructions will be sent via email once registration paperwork has been processed.****

**EAST BRUNSWICK PUBLIC SCHOOLS
EARLY LEARNING ACADEMY REGISTRATION DATA SHEET**

SCHOOL _____ DATE _____ STUDENT ID _____

PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETED

Student Last Name	Student First Name (Legal)	M. I.	Nickname
Date of Birth: (M)/ (D)/ (Y)	Age: _____	Gender: _____	Grade: _____
Student Street Address	Town	Zip Code	
Student resides with (Relationship): _____ Parent Status: Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Remarried <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/> (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 <input type="checkbox"/> No <input type="checkbox"/> IEP? Yes <input type="checkbox"/> No <input type="checkbox"/> In Basic Skills? Yes <input type="checkbox"/> No <input type="checkbox"/> Have a 504 Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Required for State/Federal Reports: (these questions must be answered)			
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native Ethnicity: Hispanic Yes <input type="checkbox"/> No <input type="checkbox"/>			

PARENT/GUARDIAN INFORMATION

<p>Please Circle: Parent Guardian Other _____</p> <p>(Ms.) (Mrs.) (Mr.) (Dr.)</p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Parent Preferred E-mail Address: _____</p> <p>Home Phone #: () _____</p> <p>Cell Phone #: () _____</p> <p>Business #: () _____</p> <p>Occupation: _____</p> <p>Employer's Name: _____</p> <p>Employer's Address: _____</p>	<p>Please Circle: Parent Guardian Other _____</p> <p>(Ms.) (Mrs.) (Mr.) (Dr.)</p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Parent Preferred E-mail Address: _____</p> <p>Home Phone #: () _____</p> <p>Cell Phone #: () _____</p> <p>Business #: () _____</p> <p>Occupation: _____</p> <p>Employer's Name: _____</p> <p>Employer's Address: _____</p>
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A non-refundable registration fee of \$50 is required for registration (\$25 if registering prior to June 1, 2022).

- | | | |
|---|--|--|
| <input type="checkbox"/> Full Day (\$788/month) | <input type="checkbox"/> Half Day Morning only (\$389/month) | <input type="checkbox"/> Half-day Afternoon only (\$389/month) |
| <input type="checkbox"/> AM added to PM General Education Inclusive Preschool (\$399/month) | <input type="checkbox"/> Mid-day extension (\$84/month) | |
| <input type="checkbox"/> PM added to AM General Education Inclusive Preschool (\$399/month) | <input type="checkbox"/> ELA PM Extension (\$111/month) | |
| <input type="checkbox"/> ASK 5-Day (\$274/month) | <input type="checkbox"/> ASK 3-Day (\$226/month) – Select 3 Days: <u> </u> M <u> </u> T <u> </u> W <u> </u> TH <u> </u> F | |
| <input type="checkbox"/> Early Morning Program (\$151/Month) | <input type="checkbox"/> Early Morning/ASK Combo (\$388/month) | |

Location: Please list your top 3 choices: 1) _____ 2) _____
3) _____ Teacher Request (if applicable) _____ Start Date Requested _____

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:

Registrations are only accepted via the documented registration process. Applications accepted on a first-come, first-served basis. An annual registration fee and the first monthly payment must be received in order to consider registration complete. Once instructed, payments can be made online either with credit card or via e-check.

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 _____

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.

1. Name: _____

Telephone Number: _____

Relationship to Student: _____

Child may be released to this person (circle one) yes no

2. Name: _____

Telephone Number: _____

Relationship to Student: _____

Child may be released to this person (circle one) yes no

3. Name: _____

Telephone Number: _____

Relationship to Student: _____

Child may be released to this person (circle one) yes no

Office Use:

Student ID # _____

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 education plan.

Student Name : _____ Date of Birth: _____

Preschool experience: Yes No Preschool attended: _____ How Long? _____

Primary language spoken at home: _____ Language(s) spoken by child: _____

Physician Name and Phone: _____

List siblings (name, age, general health):

Does your child have vision problems? Yes No If yes, please indicate: _____

Does your child wear glasses? Yes No Does your child wear contact lenses? Yes No

Does your child have hearing problems? Yes No If yes, please indicate: _____

Does your child have any allergies? Yes No If Yes, please indicate: _____

Does your child require Epinephrine? Yes No If Yes, please indicate reason: _____

Does your child have any skin conditions (eczema, etc.)? Yes No If yes, please indicate: _____

Does your child have difficulty concentrating and/or a short attention span? Yes No

If yes, list any medication given if applicable : _____

Has your child been treated for a medical condition/mental illness? Yes No List illness, duration, medications given: _____

List any serious accidents (i.e. head injury, etc), operations, hospitalizations, emergency room visits:

Infections/Illness	Circle One		Infections/Illness	Circle One	
Chicken Pox	Yes/ Age: _____	No	Strep	Yes/ Age: _____	No
Measles	Yes/ Age: _____	No	Lyme Disease	Yes/ Age: _____	No
Mumps	Yes/ Age: _____	No	Arthritis	Yes/ Age: _____	No
Seizures/Convulsions	Yes/ Age: _____	No	Pneumonia	Yes/ Age: _____	No
Tuberculosis	Yes/ Age: _____	No	Migraines	Yes/ Age: _____	No
Asthma	Yes/ Age: _____	No	Hepatitis	Yes/ Age: _____	No

List any information you wish to share with the school which might be beneficial to your child and helpful to the school:

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.

HEIGHTS, WEIGHTS AND BLOOD PRESSURE will be done annually on all students in grades K-12. **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** - Vision screening 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.

Parent/Guardian Signature: _____ Date: _____

East Brunswick Public Schools
East Brunswick, New Jersey 08816
Student Services

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: _____

Physical Findings	Please indicate with a √ (check) in the appropriate column.		Specify and Recommend
	Normal	Abnormal	
EYES			
VISION			
COLOR PERCEPTION			
EARS - OTOSCOPIC			
HEARING			
Left			
Right			
TEETH/MOUTH			
NOSE			
THROAT			
LYMPH GLANDS			
THYROID			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
GENITO-URINARY			
ORTHOPEDIC (STRUCTURAL)			
SCOLIOSIS SCREENING			
SKIN			
NUTRITION			
NERVOUS SYSTEM			
SPEECH			
OTHER			
GENERAL APPEARANCE			

Student Physical Examination Form

Student Name: _____

DATE OF MOST RECENT MANTOUX TUBERCULIN:

TEST: _____ RESULT: _____ FOLLOW-UP: _____

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

DPT/DTaP					
Tdap (Grade 6)					
Polio					
MMR					
Measles (on or after 1 st birthday)					
Mumps (on or after 1 st birthday)					
Rubella (on or after 1 st birthday)					
Hib					
Hepatitis B (min spacing intervals)					
Varicella (on or after 1 st birthday)					
Meningococcal (Grade 6)(after 10 th birthday)					
Pneumococcal (Pre-School)					
Influenza (Pre-School)					

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: _____

