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
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>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Date of Birth: (M)/ (D)/ (Y)  Age: ______ Gender: ______ Grade: ______

Student Street Address  Town  Zip Code

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 School & 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.)

Last Name: ____________________
First Name: ____________________
Address: ______________________
City: ______________________ State: ______ Zip: ______

Parent Preferred E-mail Address: ____________________
Home Phone #: (   ) ____________________
Cell Phone #: (   ) ____________________
Business #: (   ) ____________________
Occupation: ____________________
Employer’s Name: ____________________
Employer’s Address: ____________________

Please Circle: Parent Guardian Other ☐ ☐ ☐

(Ms.) (Mrs.) (Mr.) (Dr.)

Last Name: ____________________
First Name: ____________________
Address: ______________________
City: ______________________ State: ______ Zip: ______

Parent Preferred E-mail Address: ____________________
Home Phone #: (   ) ____________________
Cell Phone #: (   ) ____________________
Business #: (   ) ____________________
Occupation: ____________________
Employer’s Name: ____________________
Employer’s Address: ____________________

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 6/2019
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 # __________________________
**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#: ________________________________

---

**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. NUTRITIONAL HISTORY

1. Does your child have frequent stomachaches?  
   - Yes □ No □

2. Problem with diarrhea or constipation?  
   - Yes □ No □

3. Has your child recently had a significant weight loss or gain?  
   - Yes □ No □
   
   Please explain: __________________________________________

### B. INFECTIONS AND ILLNESS

1. Hearing problems  
   - Yes □ No □
   
   Hearing test (if yes, by whom) ________________________________

2. Vision problems  
   - Yes □ No □
   
   Please explain: __________________________________________

   Glasses/Contact lenses: (please circle)

3. **Circle** any of the following which child has had (indicate age)
   - Chicken Pox____ Measles____ Mumps____ Seizures/Convulsions____
   - Tuberculosis____ Strep____ Lyme Disease____ Arthritis____
   - Pneumonia____ Migraines____ Hepatitis____
   - Other __________________________________________

4. List serious accidents (i.e. head injury, etc.) ____________________________
   
   Operations __________________________________________
   
   Hospitalizations/Emergency Room visit:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
5. Has your child ever been treated for a medical condition/or mental illness?  
   Yes ☐ No ☐
   If yes, state illness_____________________
   Duration of illness_____________________
   Type of medication given__________________________

6. Does your child have difficulty concentrating and/or short attention span?  
   Yes ☐ No ☐
   Medication? _______________________________________

7. Is there a language other than English spoken at home?  
   Yes ☐ No ☐
   If yes, please list_____________________________________

C. **ASTHMA/ALLERGIES**
1. Does your child have asthma?  
   Yes ☐ No ☐
   If so, indicate any possible triggers_____________________

2. Does your child take asthma medication daily?  
   Yes ☐ No ☐
   As needed? Yes ☐ No ☐

3. Please indicate name of medication? ___________________________

4. Does your child have any allergies?  
   Yes ☐ No ☐
   Please indicate:_________________________________________

5. Does your child require an Epinephrine?  
   Yes ☐ No ☐
   Reason: (be specific)_____________________________________

6. Does your child have any skin condition? (I.e. eczema, etc.)  
   Yes ☐ No ☐
   Please explain:_________________________________________

7. Please write any other information you wish to share with the school which might be beneficial to your child and helpful to the school.___________________________
   _______________________________________________________
   _______________________________________________________

Parent_________________________________________  Date____________________________________
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 √ (check) in the appropriate column.</th>
<th>Specify and Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES</td>
<td></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>
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</tr>
<tr>
<td>HEARING</td>
<td></td>
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<tr>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEETH/MOUTH</td>
<td></td>
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</tr>
<tr>
<td>NOSE</td>
<td></td>
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</tr>
<tr>
<td>THROAT</td>
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</tr>
<tr>
<td>LYMPH GLANDS</td>
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</tr>
<tr>
<td>THYROID</td>
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<tr>
<td>HEART</td>
<td></td>
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<tr>
<td>LUNGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABDOMEN</td>
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<tr>
<td>HERNIA</td>
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<td></td>
</tr>
<tr>
<td>GENITO-URINARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORTHOPEDIC (STRUCTURAL)</td>
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<td></td>
</tr>
<tr>
<td>SCOLIOSIS SCREENING</td>
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<tr>
<td>SKIN</td>
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<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>
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<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>Date</th>
</tr>
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<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 1st birthday)</td>
<td></td>
</tr>
<tr>
<td>Mumps (on or after 1st birthday)</td>
<td></td>
</tr>
<tr>
<td>Rubella (on or after 1st 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 1st birthday)</td>
<td></td>
</tr>
<tr>
<td>Meningococcal (after 10th 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: _______________________

____________________

____________________

____________________

Nurses Manual
Chapter 2 Rev: 6/2019