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>
</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**

<table>
<thead>
<tr>
<th>Please Circle: Parent Guardian Other</th>
<th>Please Circle: Parent Guardian Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Ms.) (Mrs.) (Mr.) (Dr.)</td>
<td>(Ms.) (Mrs.) (Mr.) (Dr.)</td>
</tr>
<tr>
<td><strong>Last Name:</strong> ____________________</td>
<td><strong>Last Name:</strong> ____________________</td>
</tr>
<tr>
<td><strong>First Name:</strong> ____________________</td>
<td><strong>First Name:</strong> ____________________</td>
</tr>
<tr>
<td><strong>Address:</strong> ______________________</td>
<td><strong>Address:</strong> ______________________</td>
</tr>
<tr>
<td><strong>City:</strong> __________</td>
<td><strong>City:</strong> __________</td>
</tr>
<tr>
<td><strong>State:</strong> __________</td>
<td><strong>State:</strong> __________</td>
</tr>
<tr>
<td><strong>Zip:</strong> __________</td>
<td><strong>Zip:</strong> __________</td>
</tr>
<tr>
<td><strong>Parent Preferred E-mail Address:</strong></td>
<td><strong>Parent Preferred E-mail Address:</strong></td>
</tr>
<tr>
<td><strong>Home Phone #: ( )</strong></td>
<td><strong>Home Phone #: ( )</strong></td>
</tr>
<tr>
<td><strong>Cell Phone #: ( )</strong></td>
<td><strong>Cell Phone #: ( )</strong></td>
</tr>
<tr>
<td><strong>Business #: ( )</strong></td>
<td><strong>Business #: ( )</strong></td>
</tr>
<tr>
<td><strong>Occupation:</strong> __________________</td>
<td><strong>Occupation:</strong> __________________</td>
</tr>
<tr>
<td><strong>Employer’s Name:</strong> ______________</td>
<td><strong>Employer’s Name:</strong> ______________</td>
</tr>
<tr>
<td><strong>Employer’s Address:</strong> __________</td>
<td><strong>Employer’s Address:</strong> __________</td>
</tr>
</tbody>
</table>

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#: (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>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</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__________________________
   Treatment: ______________________

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:_________ Age:_________
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 ___________________________

HSaae (elem.)
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 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</td>
<td>Abnormal</td>
</tr>
<tr>
<td>VISION</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>COLOR PERCEPTION</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>EARS - OTOSCOPIC</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>HEARING</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td></td>
<td>Left</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>TEETH/MOUTH</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>NOSE</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>THROAT</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>LYMPH GLANDS</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>THYROID</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>HEART</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>LUNGS</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>ABDOMEN</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>HERNIA</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>GENITO-URINARY</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>ORTHOPEDIC (STRUCTURAL)</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>SCOLIOSIS SCREENING</td>
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<td>Abnormal</td>
</tr>
<tr>
<td>SKIN</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>NUTRITION</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>NERVOUS SYSTEM</td>
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<td>Abnormal</td>
</tr>
<tr>
<td>SPEECH</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>OTHER</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>GENERAL APPEARANCE</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
</tbody>
</table>
Student Name: ____________________________________________________________

DATE OF MOST RECENT MANTOUX TUBERCULIN:

TEST: ________ RESULT: ________ FOLLOW-UP: ____________________________

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

<table>
<thead>
<tr>
<th>Disease</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 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 (Grade 6)(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: __________________________