


HAMILTON TOWNSHIP SCHOOL DISTRICT
REGISTRATION CHECKLIST

NAME OF PUPIL: _____
LAST NAME FIRST NAME M.I.

GRADE: _____ DATE OF BIRTH: ____/____/____



REVIEW THIS PACKET AND THE REQUIRED DOCUMENTATION TO REGISTER YOUR CHILD

ONLY THE PARENT/LEGAL GUARDIAN CAN REGISTER THE CHILD

PROOF OF RESIDENCY

PLEASE BRING IN THE APPROPRIATE PROOF OF RESIDENCY FOR YOUR FAMILY

- _____ (OWNER) Deed, Mortgage, or Tax Bill in parent's/guardian's name
 - _____ (RENTER) Lease or Tenant Agreement in parent's/guardian's name
 - _____ (LIVES W/OWNER) Deed/Tax Bill of owner with whom you reside & Resident's Affidavit**
 - _____ (LIVES W/RENTER) Renter's Lease with who you reside with & Resident's Affidavit**
 - _____ **RESIDENT'S AFFIDAVIT - FILLED OUT AND NOTARIZED
- **Resident's Affidavit is available at the Registration Office and at hamiltonschools.org/registration*

(2) FORMS OF ID WITH THE PARENT'S/LEGAL GUARDIAN'S NAME WITH CURRENT MAYS LANDING ADDRESS

- _____ DRIVER'S LICENSE
- _____ UTILITY BILL
- _____ VOTER REGISTRATION CARD
- _____ PAYCHECK STUB
- _____ BANK STATEMENT
- _____ ANY FORMAL/LEGAL DOCUMENTATION WITH NAME AND CURRENT ADDRESS

CHILD'S DOCUMENTATION

- _____ ORIGINAL BIRTH CERTIFICATE
- _____ COURT DOCUMENTATION OF GUARDIANSHIP (if applicable)
- _____ CUSTODY DOCUMENTATION IF DIVORCED (if applicable)
- _____ STATE AGENCY PLACEMENT DOCUMENT OF GUARDIANSHIP (if applicable)

GRADE PLACEMENT DOCUMENTATION

- _____ TRANSFER CARD FROM PREVIOUS SCHOOL
- _____ REPORT CARD FROM PREVIOUS SCHOOL
- _____ IMMUNIZATION RECORDS (MANDATORY FOR ALL GRADES)
- _____ PHYSICAL FORM FILLED OUT BY DOCTOR (MANDATORY FOR PRE-K, KINDERGARTEN,
OR GRADES 1-8 TRANSFERRING FROM ANOTHER STATE OR COUNTRY)

HAMILTON TOWNSHIP SCHOOL DISTRICT
REGISTRATION CHECKLIST



TODAY'S DATE: _____

Dear Parent/Guardian:

This package includes all documents necessary to register your child/children in the Hamilton Township School District.

Please sign below to attest that all the information you provide on these documents is accurate and that you are aware that falsification on your part will be considered falsifying a government document.

SIGNATURE

PRINTED NAME

____/____/_____
DATE

**HAMILTON TOWNSHIP SCHOOL DISTRICT
REGISTRATION CARD**

DATE: _____

| | | |
|---|---------------|-----------|
| *Has this child been registered at Hamilton Township Before? | YES | NO |
| <i>If YES, please provide the approximate date the last attended (month/year)</i> | _____ / _____ | |
| *Have you or your family been displaced? | YES | NO |

NAME OF PUPIL: _____
 LAST NAME FIRST NAME M.I.

PHYSICAL ADDRESS: _____
 STREET MAYS LANDING, NJ 08330

EXACT LOCATION: _____
nearest intersection and neighborhood/subdivision if applicable

HOME PHONE: _____ **CELL PHONE:** _____

EMERGENCY NAME: _____ **EMERGENCY PHONE:** _____

GRADE: _____ **GENDER:** _____ **DATE OF BIRTH:** _____ / _____ / _____

COUNTRY OF BIRTH: _____ **CITY OF BIRTH:** _____

LANGUAGE(S) SPOKEN @ HOME: _____ **STATE OF BIRTH:** _____

MIGRANT? YES NO

IF COUNTRY OF BIRTH IS NOT U.S., PLEASE PROVIDE DATE ENTERED THE U.S. _____ / _____ / _____

IF COUNTRY OF BIRTH IS NOT THE U.S. PLEASE PROVIDE NUMBER OF YEARS IN AMERICAN SCHOOLS _____

PREVIOUS SCHOOL INFORMATION

FROM CITY/STATE: _____ **LAST GRADE ATTENDED:** _____

NAME OF PREVIOUS SCHOOL: _____

ADDRESS OF PREVIOUS SCHOOL: _____ **CITY, STATE:** _____

PHONE NUMBER OF PREVIOUS SCHOOL: _____ **FAX:** _____

PARENT/ LEGAL GUARDIAN INFORMATION

Documented Legal Custody/Court Related Issues?

****ONLY Parents/Legal Guardians can register students***

YES NO *If YES, date of documents:* _____

GUARDIAN 1

GUARDIAN 2

NAME: _____
RELATIONSHIP: _____
OCCUPATION: _____
PLACE OF EMPLOYMENT: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL ADDRESS: _____

NAME: _____
RELATIONSHIP: _____
OCCUPATION: _____
PLACE OF EMPLOYMENT: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL ADDRESS: _____

NAME OF CHILDREN IN FAMILY/OTHER CHILDREN IN HOME

| Name | Date of Birth | Name | Date of Birth |
|----------|---------------|----------|---------------|
| 1) _____ | _____ | 4) _____ | _____ |
| 2) _____ | _____ | 5) _____ | _____ |
| 3) _____ | _____ | 6) _____ | _____ |

ADDITIONAL INFORMATION

Did your child participate in: *If YES, how many years?*

SPEECH YES _____

BILIGUAL/ESL/ELL YES _____

504 Plan YES _____

Basic Skills YES _____

Special Education/ Resource/Self Contained YES _____

| | |
|--------------------------|------------------------|
| REGISTRATION DATE: _____ | OFFICE USE ONLY |
| START DATE: _____ | |
| BUS NUMBER: _____ | |
| STATE ID: _____ | |
| GENESIS ID: _____ | |
| LUNCH PIN: _____ | |

HAMILTON TOWNSHIP SCHOOL DISTRICT
EMERGENCY CONTACT INFORMATION

DATE: _____

PLEASE CHECK THIS BOX IF THERE HAS BEEN A CHANGE OF PARENT/GUARDIAN, ADDRESS, OR TELEPHONE

NAME OF PUPIL:

LAST NAME

FIRST NAME

M.I.

PHYSICAL ADDRESS:

STREET

MAYS LANDING, NJ 08330

GRADE: _____

GENDER: _____

DATE OF BIRTH: _____/_____/_____

SCHOOL: _____

TEACHER/H.R. _____

PARENT/ LEGAL GUARDIAN INFORMATION

To serve your child in case of an accident or sudden illness, it is necessary that you give the following information for emergencies

GUARDIAN 1

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

GUARDIAN 2

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

ADDITIONAL EMERGENCY INFORMATION

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

EMERGENCY 1

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMERGENCY 2

NAME: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY, STATE: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

OTHER FAMILY INFORMATION

Please list other children living with you who attend New Jersey Public Schools (Name, School)

Name

School

1) _____

2) _____

3) _____

HAMILTON TOWNSHIP SCHOOL DISTRICT
ETHNICITY

NAME OF PUPIL: _____

LAST NAME

FIRST NAME

M.I.



GRADE: _____

DATE OF BIRTH: ____/____/____

FOR FEDERAL AND STATE REPORTING ONLY

PLEASE INDICATE YOUR CHILD'S ETHNIC GROUP BY CIRCLING THE APPROPRIATE LETTER

| | | |
|----------|---|---|
| A | ASIAN | <i>A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea Malaysia, Pakistan, the Phillippine Islands, Thailand, or Vietnam</i> |
| B | BLACK/AFRICAN AMERICAN | <i>A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American"</i> |
| I | AMERICAN INDIAN OR ALASKA NATIVE | <i>A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment</i> |
| P | NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER | <i>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</i> |
| H | HISPANIC OR LATINO | <i>A person of Cuban, Mexican, Puerto Rican, Sout or Central American or other Spanish culture or origian, regardless of race.</i> |
| W | WHITE | <i>A person having origins in any of the original peoples of Europe, Middle East, North Africa.</i> |
| M | MULTI-RACIAL | <i>Please check below all that apply.</i> A ____ B ____ I ____ P ____ H ____ W ____ |

SIGNATURE

PRINTED NAME

____/____/____

NAME OF PUPIL:

LAST NAME

FIRST NAME

M.I.



GRADE:

DATE OF BIRTH:

PARENT/GUARDIAN'S NAMES:

FOR STUDENT RECORD AT SCHOOL

Dear Parents

We need you to fill out this form and return it to your child's school where it will be filed. Thank you.

1) WHAT LANGUAGE DID YOUR CHILD LEARN TO SPEAK FIRST? PLEASE CHECK THE LANGUAGE.

- | | |
|------------------|--------------------|
| _____ ENGLISH | _____ URDU |
| _____ SPANISH | _____ PASHTO |
| _____ FRENCH | _____ HINIDI |
| _____ CANTONESE | _____ GUAJARATI |
| _____ VIETNAMESE | _____ CREOLE |
| | _____ OTHER: _____ |

2) NATIONALITY: _____

3) WHAT LANGUAGE IS SPOKEN IN YOUR HOME OF THE TIME _____

4) IN WHAT LANGUAGE DO YOU READ AND WRITE? _____

5) IN WHAT LANGUAGE DOES YOUR CHILD READ AND WRITE? _____

6) IN WHAT COUNTRY WAS YOUR CHILD BORN? _____

7) IF OTHER THAN THE UNITED STATES, WHAT YEAR DID YOUR CHILD COME TO THE UNITED STATES? _____

SIGNATURE

PRINTED NAME

_____/_____/_____
DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT
STUDENT HEALTH INSURANCE/HISTORY

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL

NAME OF PUPIL: _____
LAST NAME FIRST NAME M.I.
GRADE: _____ GENDER: _____ DATE OF BIRTH: ____/____/____
SCHOOL: _____ TEACHER/H.R. _____



DOES YOUR CHILD HAVE HEALTH INSURANCE?

circle one

YES *If YES, please provide the name of the insurance company on the line below:*

NO *If NO, please review the following information and sign below:*
NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.
You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

SIGNATURE PRINTED NAME DATE

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

LIST ANY MEDICAL/SURGICAL CARE YOUR CHILD HAS RECEIVED DURING THE PAST YEAR:

PLEASE PROVIDE THE FOLLOWING HEALTH INFORMATION IN REGARDS TO YOUR CHILD'S HEALTH

DATE OF LAST DENTAL EXAM: _____ DOES YOUR CHILD HAVE BRACES? YES NO
DATE OF LAST EYE EXAM: _____ DOES YOUR CHILD WEAR EYE GLASSES YES NO
EYE CONTACTS? YES NO

ALLERGIES: _____
If your child has had allergies, please describe the type of reaction and date of last reaction (if applicable)

IMMUNIZATIONS/TETANUS SHOT DATES: _____

MEDICATIONS? _____

RESTRICTIONS? _____

DOCTOR: _____ PHONE: _____

DENTIST: _____ PHONE: _____

HOSPITAL: _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

SIGNATURE PRINTED NAME DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT
STUDENT HEALTH INSURANCE/HISTORY

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL



NAME OF PUPIL: _____
 LAST NAME FIRST NAME M.I.
 GRADE: _____ GENDER: _____ DATE OF BIRTH: ____/____/____
 SCHOOL: _____ TEACHER/H.R. _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|-----------------|-------|-------|-----------------|-------|-------|
| CHICKEN POX | _____ | _____ | STREP INFECTION | _____ | _____ |
| SCARLET FEVER | _____ | _____ | HEPATITIS | _____ | _____ |
| RHEUMATIC FEVER | _____ | _____ | MENINGITIS | _____ | _____ |
| KIDNEY PROBLEMS | _____ | _____ | SEIZURES | _____ | _____ |
| EAR INFECTIONS | _____ | _____ | NOSEBLEEDS | _____ | _____ |
| DIABETES | _____ | _____ | ASTHMA | _____ | _____ |
| PNEUMONIA | _____ | _____ | LYMES | _____ | _____ |
| MONONUCLEOSIS | _____ | _____ | HEART DISEASE | _____ | _____ |

ALLERGIES:

MEDICATION ALLERGIES: _____
 FOOD ALLERGIES: _____
 ENVIRONMENTAL ALLERGIES (LATEX, BEES, SEASONAL, ETC.) _____

HAS YOUR CHILD...

| | YES | NO |
|--|-------|-------|
| 1) HAD MORE THAN SIX COLDS OR THROAT INFECTIONS EACH YEAR? | _____ | _____ |
| 2) HAD MORE THAN THREE EAR INFECTIONS? | _____ | _____ |
| 3) HAD TROUBLE HEARING? | _____ | _____ |
| 4) EVER HAD TUBES INSERTED IN EARS SURGICALLY? YEAR _____ | _____ | _____ |
| 5) EVER WORN HEARING AIDS? | _____ | _____ |
| 6) EVER HAD TROUBLE SEEING? | _____ | _____ |
| 7) EVER WORN CONTACT LENSES? | _____ | _____ |
| 8) EVER WORN GLASSES? | _____ | _____ |
| 9) HAD ANY TROUBLE WITH HIS/HER TEETH? | _____ | _____ |
| 10) SEEN A DENTIST RECENTLY? LAST VISIT _____ | _____ | _____ |
| 11) INABILITY TO CONTROL BOWEL OR BLADDER? | _____ | _____ |
| 12) EVER HAD A CONVULSION OR FAINTING SPELL? | _____ | _____ |
| 13) HAD ANY OTHER DISEASE OR ILLNESS? IF YES, PLEASE LIST: _____ | _____ | _____ |
| 14) HAD TO STAY IN A HOSPITAL OVERNIGHT? IF YES, PLEASE DATE AND DESCRIBE: _____ | _____ | _____ |

15) HAS YOUR CHILD EVER HAD ANY SERIOUS ACCIDENTS? (burns, poisoning, broken burns, serious cuts)

THIS FORM IS TO BE SUBMITTED TO THE SCHOOL NURSE BY OFFICE PERSONNEL

16) HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING A HEART PROBLEM OR HEART MURMUR? YES NO



17) HAD YOUR CHILD EVER HAD:

WHEEZING YES NO SINUS PROBLEMS YES NO
ECZEMA REACTION TO MEDICATION
HIVES REACTION TO INJECTIONS
ASTHMA REACTION TO INSECT BITES
HAY FEVER

18) HAS YOUR CHILD EVER BEEN TREATED FOR ALLERGIES? YES NO

DOES YOUR CHILD HAVE OTHER ILLNESSES OR PROBLEMS THAT WE SHOULD BE AWARE OF?

(Please describe if applicable)

DOES YOUR CHILD TAKE ANY MEDICATION?

(Please describe if applicable)

DO YOU HAVE HEALTH INSURANCE? YES NO
DO YOU HAVE DENTAL INSURANCE?
DO YOU HAVE VISION INSURANCE?
WOULD YOU LIKE INFORMATION ON NJ FAMILY CARE INSURANCE?

The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency this information can be shared with emergency personnel.

YES, please share information NO, please call to discuss
INITIAL INITIAL

I give permission for my child to receive the annual health screenings as required by the New Jersey Department of Education.

SIGNATURE PRINTED NAME DATE

NAME OF CHILD'S PEDIATRICIAN:

**HAMILTON TOWNSHIP SCHOOL DISTRICT
PERMISSION TO RELEASE RECORDS**



NAME OF PUPIL: _____
 LAST NAME FIRST NAME M.I.

GRADE: _____ **DATE OF BIRTH:** ____/____/____

PREVIOUS SCHOOL: _____

SCHOOL ADDRESS: _____

ATTENTION TO: _____

PHONE: _____ **FAX:** _____

PERMISSION TO RELEASE ALL RECORDS TO THE APPROPRIATE SCHOOL AND GRADE LEVEL SECRETARY

| | | |
|--|---|-------------------|
| <u>KINDERGARTEN AND 1ST GRADE</u> | CONTACT INFORMATION | |
| JOSEPH C. SHANER SCHOOL | <input type="checkbox"/> <i>ATTN: Dianne Valiante</i> | |
| 5801 Third St. Mays Landing, NJ 08330 | Phone: 609-476-6141 | Fax: 609-625-8346 |

| | | |
|---|---|-----------------------|
| <u>PRE-K, 2ND - 5TH GRADE</u> | CONTACT INFORMATION | |
| GEORGE L. HESS SCHOOL | <input type="checkbox"/> PRE-K, 2nd THRU 5th: | <i>Cathie Palmeri</i> |
| 700 Babcock Rd., Mays Landing, NJ 08330 | Phone: 609-476-6116 | Fax: 609-476-6110 |
| | <input type="checkbox"/> 2nd THRU 5th: | <i>Diane Manno</i> |
| | Phone: 609-476-6125 | Fax: 609-476-6112 |

| | | |
|-----------------------------------|---|-----------------------|
| <u>6TH, 7TH, 8TH GRADE</u> | CONTACT INFORMATION | |
| WILLIAM DAVIES MIDDLE SCHOOL | <input type="checkbox"/> 6TH GRADE | <i>Kristina Morey</i> |
| 1876 Dr. Dennis Foreman Dr., | 7th GRADE LAST NAMES (M-Z) | |
| Mays Landing, NJ 08330 | Phone: 609-476-6254 | Fax: 609-625-2267 |
| | <input type="checkbox"/> 7TH GRADE LAST NAMES (A-L) | <i>Dawn Leek</i> |
| | 8TH GRADE | |
| | Phone: 609-476-6263 | Fax: 609-476-6251 |

I give permission for you to release the records for the student indicated above (note: Permission not required under (NJAC). I understand the Federal NO Child Left Behind Act requirements, I must now authorize the release of my child's discipline records to be included with the release of my child's permanent records, and my signature below indicates my authorization and permission to release the records to the above mentioned school as soon as possible.

According to New Jersey Administrative Code 6:3-2.1 to 2.8, "Mandated pupil records shall be forwarded to the receiving district..." Please send the cumulative folder, the health records, grade-to-date, child study team records and any mandated records on the pupil listed above as soon as possible.

SIGNATURE

PRINTED NAME

____/____/____
DATE

HAMILTON TOWNSHIP SCHOOL DISTRICT
CERTIFICATE OF TRANSPORTATION



NAME OF PUPIL: _____
LAST NAME FIRST NAME M.I.

GRADE: _____ DATE OF BIRTH: ____/____/____

PHYSICAL ADDRESS: _____
STREET MAYS LANDING, NJ 08330

GUARDIAN 1

NAME: _____
RELATIONSHIP: _____
WORK PHONE: _____
CELL PHONE: _____

GUARDIAN 2

NAME: _____
RELATIONSHIP: _____
WORK PHONE: _____
CELL PHONE: _____

TO & FROM HOME TRANSPORTATION

Please fill out this section of the form if your child will be transported both TO and FROM home ONLY.

My child _____, who will be in grade _____ at the _____ school, should be transported to and from our home during the _____ school year.
Our permanent home address is: _____.

TO & FROM A LOCATION OTHER THAN HOME (ex. BABYSITTER/DAY CARE CENTER)

Please complete this section of the form if your child will be transported to or from school OTHER THAN HOME.

IMPORTANT NOTE: Requests are granted on a 5-Day Basis
(The Bus stop location must be the same for all 5 days of the week. If there is not an established stop at the location of your child is to be transported, he or she will be transported to the stop nearest the babysitter/day care)

PERMISSION IS HEREBY GRANTED TO _____ Grade _____
STUDENT'S NAME GRADE LEVEL

WHO PERMANENTLY RESIDES AT _____
HOME ADDRESS

TO BE TRANSPORTED TO SCHOOL FROM _____
STARTING LOCATION

AND TRANSPORTED FROM SCHOOL TO _____
ENDING LOCATION

EFFECTIVE DATE: ____/____/____ REASON FOR REQUEST: _____

BABYSITTER/DAY CARE CENTER

NAME: _____ CONTACT PHONE: _____

As a matter of extreme importance to the school, the telephone information as listed at the top of this notice is to be made known. If all information is not provided this form will be returned to you and that will delay the start of this change.

I, the undersigned, release and discharge the Board of Education, its agents, servants, and employees of and from any liability arising from the requested change in bus stop. I have read this Certificate of Transportation Change and understand all its terms. I hereby execute it voluntarily with full knowledge of its significance.

SIGNATURE PRINTED NAME DATE