



Brick Township Public Schools

Central Registration

101 Hendrickson Avenue

Brick, NJ 08724

(732) 785-3000 x1067 or 1068

KINDERGARTEN REGISTRATION REQUIREMENTS

ONLY THE NATURAL PARENT OR GUARDIAN MAY REGISTER
A STUDENT!! **PHOTO ID IS REQUIRED!**

- I. Proof of Residency (necessary before beginning any registration);
- A. Two (2) Proofs of Residency must be presented indicating the student lives in the sending district. Acceptable examples of proof are:
1. Tax bill, Deed, Contract of Sale, Closing or Mortgage Statement; or Lease/Rental receipt with address of property; and
 2. Utility bill or Digital Driver's License (Acceptable as second proof only!)
- B. In the event the student and parent are residing with a third party, the third party must prove residency as listed above. A "Third Party Residency Form" ("B" Form) must be completed and notarized by both the third party and the parent/guardian before the student will be registered. In addition, one proof of residency for the registering party is required.
- C. In the event the student is not residing with the parent/guardian, or does not have a court order indicating placement, then the registering party must apply for an Affidavit of Guardianship/Residency Agreement ("C" Form).
- II. Health Records (Immunizations): YOU MUST HAVE EXISTING IMMUNIZATION RECORDS (LISTING OF SHOTS) TO REGISTER.
Completed records are:
DPT (4 DOSES*), POLIO (3 DOSES*), MEASLES (2 DOSES**-PREFER MMR), RUBELLA**, MUMPS (1 DOSE**), HEPATITIS B (3 DOSES), VARICELLA (Or proof of chicken pox)
(*1 dose must be after 4th birthday ~ **Must be given after 1st birthday)
Physical exam must occur within one year of registration date, be in writing and signed by an M.D., D.O. or C.N.P. The physician must state: This is a well child without restriction; or list all medical restrictions and/or medications, etc.
Exemptions: **Medical:** Provide a valid note from a doctor. This must be renewed yearly.
Religious: Application for religious exemption must be submitted for legal review and renewed yearly.
- III. Original Birth Certificate with raised seal (Bureau of Vital Statistics)



BRICK TOWNSHIP PUBLIC SCHOOLS

STUDENT REGISTRATION FORM

Student Information: Please print/fill in all information for each student registering.

Student Name (First, Middle, Last):					
Date of Birth:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Placement:	
Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native/Other Pacific Islander					
Language Spoken at Home:					
Primary Language Spoken:					

Student Residential Address Information:

Home Address:		Apartment/Unit #	
City/Zip Code:		Third Party Residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Student Resides With/Head of Household:	<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother * <input type="checkbox"/> Father * <input type="checkbox"/> Guardian*
	* Do you have legal custody of the above-named child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Sole Custody <input type="checkbox"/> Joint Custody <input type="checkbox"/> Restricted Release - If there are any problems relating to custody and releasing your child, please be aware that the school must have a copy of the legal documents in our files.

Parent/Guardian #1:		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian			
Home Phone:		Cell Phone:		Business Phone:	
Marital Status:		Occupation:			

Parent/Guardian #2:		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian			
Home Phone:		Cell Phone:		Business Phone:	
Marital Status:		Occupation:			

If dual notification of Progress Reports and Report Cards are needed, please complete below: (Used for joint custody only)

Name:		Relationship to student:	
Mailing Address:		Contact Phone:	

Central Registration Office Use Only!

School to Attend:	<input type="checkbox"/> BCPLC <input type="checkbox"/> EEC <input type="checkbox"/> DP <input type="checkbox"/> EHY <input type="checkbox"/> HERB <input type="checkbox"/> LM <input type="checkbox"/> MID	Session:	<input type="checkbox"/> KA <input type="checkbox"/> KP <input type="checkbox"/> KAD
	<input type="checkbox"/> OSB <input type="checkbox"/> VMES <input type="checkbox"/> LRMS <input type="checkbox"/> VMMS <input type="checkbox"/> BTHS <input type="checkbox"/> BMHS	Year of Graduation:	
<input type="checkbox"/> Affidavit of Guardianship attached		Letter of Request/Approval Attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present Grade:		Enrollment Date:	
Student ID#		SID#	Family Code:
Registration Date:		Registrar:	

Emergency Contact Information: (Someone other than parent/guardian)

Name:		Phone:		Relationship to student:	
Name:		Phone:		Relationship to student:	
Name:		Phone:		Relationship to student:	

Sibling Information: Please list ALL children in the family from oldest to youngest. If additional room is needed, please list on back of page.

Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Does sibling attend school in Brick?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which school?		

Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Does sibling attend school in Brick?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which school?		

District Curricular Information:

Was the student previously enrolled in Brick Township Schools?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which school?	
Last school attended:			
My child was receiving the following assistance in his/her previous school:			
<input type="checkbox"/> Student seen by the CST	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Basic Skills	<input type="checkbox"/> 504 Plan
<input type="checkbox"/> Student referred to the CST	<input type="checkbox"/> ELL/Bilingual Education	<input type="checkbox"/> Math <input type="checkbox"/> Reading	
<input type="checkbox"/> Student classified by the CST	<input type="checkbox"/> Gifted & Talented	<input type="checkbox"/> Free or Reduced Lunch	<input type="checkbox"/> Student Retained

Health Information:

Current Health Insurance Status of your child	Coverage (YES) <input type="checkbox"/>	Coverage (NO) <input type="checkbox"/>
If "YES" Name of Health Insurance Company		
Date of your child's last medical examination		
Date of your child's last LEAD blood test	Lead Level	

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply on line. Brick Township Schools may release my name and address to NJ Family Care Program to contact me about health insurance.

*Signature**Printed Name**Date*_____
Name of Parent/Legal Guardian (Please Print)_____
Signature of Parent/Legal Guardian_____
Date



BRICK TOWNSHIP PUBLIC SCHOOLS

CONSENT TO EMERGENCY STUDENT TREATMENT

I _____, parent/legal guardian of the student named below, do hereby CONSENT (in advance) to any emergency treatment and/or hospital care rendered to the student at a Medical Center of Ocean County facility in the event that any situation should arise during school hours or during any school activities that would require emergency treatment or care rendered to the named student.

This consent is given at the request of the Brick Township Board of Education and the Medical Center of Ocean County so that prompt emergency treatment of the student may be rendered. This consent extends to the Hospital and its affiliated physicians, nurses, employees and administrative officer.

I understand that this consent will be lodged with the school that is attended by the student so that it will be immediately available for delivery to a Medical Center of Ocean County facility in the event that emergency treatment of the student is required.

I further understand that in the event of the rendering of any emergency treatment to the student by the Hospital that the Hospital will promptly communicate with me at the telephone number listed below in order to advise me of the emergency situation and treatment rendered to the student.

I further understand that any costs incurred as a result of Hospital treatment will be my responsibility and not that of the Brick Township Public School District.

AS TO THE STUDENT:

_____	_____
(Name)	(Age)
_____	_____
(Street Address – Town – State – Zip Code)	(Date of Birth)

ALLERGIES that the hospital and/ or emergency care provide would need to be aware of

AS TO THE PERSON SIGNING THE CONSENT:

_____	_____	_____
(Relationship to Student)	(Street Address – Town – State – Zip Code)	(Phone Number)
_____	_____	_____
(Signature of Person Giving Consent – Parent/Legal Guardian)	Date	

Copies: School Nurse – Athletic Office

HEALTH OFFICE/NEW ENTRANT QUESTIONNAIRE

Student's Name _____ ID# _____ D.O.B. _____

Birthplace _____ Age _____ Sex _____ Grade _____

Please check the following questions and explain any "Yes" answer on the space provided.

MEDICATIONS:

Does your child take any daily medications? Yes _____ No _____

If Yes, please list daily medications and doses: _____

Will your child require medication given in school? Yes _____ No _____

ALLERGIES: Is your child allergic to any of the following:

Medications: Yes _____ No _____

If Yes, please list: _____

Seasonal Allergies: Yes _____ No _____

If Yes, please explain: _____

Bee Sting/Insect Bites: Yes _____ No _____

If Yes, list medication needed for allergic reaction: _____

Food Allergies: Yes _____ No _____

If Yes, which foods? _____

Type of reaction? _____

Type of medication needed for reaction? _____

Asthma: Yes _____ No _____

If Yes, frequency of attacks? _____

Known triggers? _____

Current daily asthma medications? _____

Normal Peak Flow _____

HEART DISEASE/HEART MURMUR: Yes _____ No _____

If Yes, any limitations in activity? _____

Please note: A doctor's note is required stating there is no limitation of activity to participate in gym, sports, or recess.

KIDNEY DISEASE: Yes _____ No _____

If Yes, please list: _____

DIABETES: Yes _____ No _____

If Yes, we will discuss and formulate care plan for the school year.

Student's Name: _____

SEIZURES: Yes _____ No _____

Medications/Limitations: _____

Date of last seizure: _____ Type of seizure: _____

If current seizure disorder, we will meet and formulate care plan for the school year.

LYME DISEASE: Yes _____ No _____

If Yes, date of diagnosis: _____ Current medications/limitations? _____

GLASSES: Yes _____ No _____

If Yes, when are they to be worn? _____

HEARING DIFFICULTIES: Yes _____ No _____

If Yes, we please explain: _____

FREQUENT EAR INFECTIONS: Yes _____ No _____

If Yes, approximately how many infections and what age(s)? _____

FREQUENT STREP INFECTIONS: Yes _____ No _____

History of any of the following?

HEAD INJURIES: Yes _____ No _____

BROKEN BONES: Yes _____ No _____

HOSPITALIZATIONS: Yes _____ No _____

SURGERIES: Yes _____ No _____

If you answered Yes to any of the above, please give dates and explain: _____

Please list any other disabilities, limitations, or health concerns: _____

Previous School Attended: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

BRICK TOWNSHIP PUBLIC SCHOOLS
 Required Pre-School Physical Examination for Pupils Entering **KINDERGARTEN**

Child's Name: (Last, First, Middle) _____

Address: _____ City/State: _____ Phone: _____

Birth Date: _____ Birth Wt: _____ Male: _____ Female: _____

Parent's Name: _____

CODE: 0 – No Defect

1 – Slight Deviation

2 – Requires Attention

E.N.T. R _____ L _____	Heart _____	Spine _____	Height _____
Vision R _____ L _____	Lungs _____	Posture _____	Weight _____
Hearing R _____ L _____	Abdomen _____	Extremities _____	
Teeth _____	Hernia _____	B.P. _____	Glands _____

ILLNESSES:

Chicken Pox _____	Mumps _____	Pneumonia _____	Heart Disease _____
Measles _____	Convulsions _____	Allergies _____	T.B. Contact _____
German Measles _____	Diabetes _____	Scarlet Fever _____	Operations _____
Rheumatic Fever _____	Ear Trouble _____		

VACCINE TYPE	1 ST DOSE MO/DAY/YR	2 ND DOSE MO/DAY/YR	3 RD DOSE MO/DAY/YR	4 TH DOSE MO/DAY/YR	5 TH DOSE MO/DAY/YR	MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) (If Td, DtaP, or Dt*, (Indicate in corner box) One dose on or after fourth birthday.						
POLIO ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box) One dose on or after fourth birthday.						
MEASLES, MUMPS, RUBELLA (MMR) On or after first birthday						
MEASLES (Two doses required)				MEASLES SEROLOGY	DATE	TITER
RUBELLA				RUBELLA SEROLOGY	DATE	TITER
MUMPS				MUMPS SEROLOGY	DATE	TITER
HAEMOPHILUS B (HIB) **						
HEPATITIS B ***						
VARICELLA (Chicken Pox)						
INFLUENZA						
PNEUMOCOCCAL						
Mantoux Tuberculin Test – Date: Only as Required by State Law for Transfer Students						

Recommendations or restrictions concerning this student: _____

Physician's Signature: _____

Date of well child physical: _____

Physician's Stamp:



Brick Township Public Schools

<input type="checkbox"/> Brick Township High School	346 Chambers Bridge Road, Brick, NJ 08723
<input type="checkbox"/> Brick Township Memorial High School	2001 Lanes Mill Road, Brick, NJ 08724
<input type="checkbox"/> Lake Riviera Middle School	171 Beaverson Boulevard, Brick, NJ 08723
<input type="checkbox"/> Veterans Memorial Middle School	105 Hendrickson Avenue, Brick, NJ 08724
<input type="checkbox"/> Drum Point Elementary School	41 Drum Point Road, Brick, NJ 08723
<input type="checkbox"/> Emma Havens Young Elementary School	43 Drum Point Road, Brick, NJ 08723
<input type="checkbox"/> Herbertsville Elementary School	2282 Lanes Mill Road, Brick, NJ 08724
<input type="checkbox"/> Lanes Mill Elementary School	1891 Lanes Mill Road, Brick, NJ 08724
<input type="checkbox"/> Midstreams Elementary School	500 Midstreams Road, Brick, NJ 08724
<input type="checkbox"/> Osbornville Elementary School	218 Drum point Road, Brick, NJ 08723
<input type="checkbox"/> Veterans Memorial Elementary School	103 Hendrickson Avenue, Brick, NJ 08724
<input type="checkbox"/> Brick Community Primary Learning Center	224-260 Chambers Bridge Road, Brick, NJ 08723
<input type="checkbox"/> Educational Enrichment Center	107 Hendrickson Avenue, Brick, NJ 08723

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Name of Student: _____

Date of Birth: _____ Grade: _____

The above student has enrolled in the Brick Township School District. Please send the following student information to the school indicated above as soon as possible:

- **Health Records** (originals if coming from within New Jersey required).
- **Transcript of Academic Records** (including grades to date of withdrawal).
- **Standardized Test Records** (including New Jersey HSPA if applicable).
- **Special Service Records** (may be mailed directly to our Child Study Team).
- **Discipline Records** (if the student has been involved in offenses involving weapons, alcohol or drugs, or willful affliction of injury to persons or an act of violence against persons and/or property committed on school premises, at school or school sponsored activity, please forward appropriate disciplinary documentation.)

Previous School: _____

Address: _____

I HEREBY GIVE MY PERMISSION FOR RELEASE OF THE ABOVE RECORDS.

Signature of Parent/Guardian: _____

Signature of Student 18 or older: _____