ABSECON PUBLIC SCHOOLS
ABSECON, NEW JERSEY
ENROLLMENT PROCESS

Absecon Public Schools conducts registration by appointment only. You may pick up the enrollment forms in the Board Office or download them from our website at www.abseconschools.org.
Once you have completed the forms and have collected all your documentation contact the board office to schedule an appointment 609-641-5375x1011.

To register your child in the Absecon Public School District, you will need to present the following:

1. _____ Original Birth Certificate
2. _____ Immunization Records
3. _____ Transfer Card (if applicable, Not required for Kindergarten)
4. _____ Most recent Report card
5. _____ Verification of Parent/Guardianship (including custody agreement if applicable)

As proof of your residency in Absecon you will need to provide:
At least one (1) of the following:

1. _____ Mortgage statement
2. _____ Current lease or rental agreement (fully executed)
3. _____ Property deed
4. _____ Property Tax Statement (current Year)

**5. _____ Notarized Residency Affidavit Form (with resident's documentation, forms available in the Board Office)

And two (2) of the following (Current or within the last 60 days)

1. _____ Utility Bill
2. _____ Cell Phone, Cable Bill
3. _____ Voter Registration
4. _____ Current Vehicle NJ Registration or Proof of Insurance
5. _____ Official Federal, State or Local Government Correspondence
6. _____ Court orders, State Agency Agreements or placement directives
7. _____ Paystub
8. _____ Other (describe)_____

** If you are currently residing with a resident of the district who is not the parent or guardian, please contact the district for a copy of the District's Residency Affidavit Form.

ABSECON PUBLIC SCHOOLS

ENROLLMENT FORM - ABSECON PUBLIC SCHOOLS Date

Student's Information

Child's Legal Name _____ _____ **Grade** _____
First Middle Last

Gender ☐ M ☐ F Child's date of Birth____/___/_____ City of birth _____

State of Birth _____ Country of Birth_____ Date Entered US ____/____/_____*

*If country of birth is not USA, provide entry date into USA school:

Race: ☐ Asian ☐ White ☐ Black or African American ☐ American Indian ☐ Native Hawaiian or Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language spoken in Home _____ Native Language _____

Previous School Attended

Last School Attended _____ Phone _____

Address _____ City _____ State _____

Child resides with (check one)
☐ Mother & Father | ☐ Mother | ☐ Father
☐ Mother & Step Father | ☐ Father & Stepmother
☐ Grandparents | ☐ Other Relative
☐ Guardian | ☐ Other _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Address: _____

City _____ State _____ Zip _____

Primary Phone _____ Type: ☐ Mom Cell | ☐ Dad Cell | ☐ Mom Work | ☐ Dad Work | ☐ Landline

Phone 2 _____ Type: ☐ Mom Cell | ☐ Dad Cell | ☐ Mom Work | ☐ Dad Work | ☐ Landline

Phone 3 _____ Type: ☐ Mom Cell | ☐ Dad Cell | ☐ Mom Work | ☐ Dad Work | ☐ Landline

Email1: _____ Email2: _____

Mother's employer:_____ Phone:_____

Father's Employer:_____ Phone:_____

Military: ☐ Active Duty ☐ National Guard or Reserve ☐ No Military Affiliation

REGISTRATION FORM ABSECON PUBLIC SCHOOLS

Additional Contact Information (Please provide at least two additional contacts)

Name: _____ **Relationship:** _____ □ **Can Pick up**

Address: _____ □ **Mail to**

City _____ State _____ Zip _____ □ **Medical**

Primary Phone _____ Type: □ Cell | □ Work | □ Landline

Phone 2 _____ Type: □ Cell | □ Work | □ Landline

Phone 3 _____ Type: □ Cell | □ Work | □ Landline

Email1: _____ Email2: _____

Name: _____ **Relationship:** _____ □ **Can Pick up**

Address: _____ □ **Mail to**

City _____ State _____ Zip _____ □ **Medical**

Primary Phone _____ Type: □ Cell | □ Work | □ Landline

Phone 2 _____ Type: □ Cell | □ Work | □ Landline

Phone 3 _____ Type: □ Cell | □ Work | □ Landline

Email1: _____ Email2: _____

Special Education

Has your Student received any Special Education Support? □ Yes □ No
If Yes check the box and describe on the line below the services received.

□ IEP □ Speech □ Occupational/Physical Therapy □ 504 □ Basic Skills □ ESL

_____

_____

Household

Siblings Name _____ Age ____ School attending _____ Grade ____
Siblings Name _____ Age ____ School attending _____ Grade ____
Siblings Name _____ Age ____ School attending _____ Grade ____

Others Living in Household _____

REGISTRATION FORM ABSECON PUBLIC SCHOOLS

NJ Smart Health Care Information

NJ FamilyCare 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 online.

Does your child have health insurance? (Check one) ☐ Yes ☐ No If yes List Provider _____

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

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

Free and Reduced Lunch Program

Absecon offers a Free and Reduced Lunch Program to qualifying students. If your student qualified at a previous school their qualification may automatically carry over to the Absecon Schools

Was your student receiving Free or Reduced lunch at their previous school? (Check one) ☐ Free ☐ Reduced ☐ No
If Free or Reduced check the appropriate box ☐ Direct Certification: ☐ Application
If Direct Certification NJSnap or NJ TANF case number _____

Certification of Information

I certify that all the information provided on this form is accurate and correct, and I understand that falsifying information or presenting false documentation is a violation of New Jersey State Law, and Department of Education Administrative Code, and may result in revocation of enrollment, criminal fines, and payment of back tuition to the Absecon Public Schools.

Signature of Parent _____Date_____

ABSECON PUBLIC SCHOOLS
MEDICAL HISTORY QUESTIONAIRE

Student's name _____ Birthdate _____ Grade _____

Please circle a response

Yes No 1. Has the student been advised by a physician not to participate in any sport?
If yes, explain: _____

Yes No 2. Is the student presently under a physician's care?
If yes, explain: _____

Yes No 3. Has the student ever experienced a loss of consciousness after an injury?
If yes, explain: _____

Yes No 4. Has the student ever had a dislocation or fractured bone?
If yes, explain: _____

Yes No 5. Has the student ever been hospitalized?
If yes, explain: _____

Yes No 6. Does the student take medication on a regular basis?
If yes, name of medication _____

Yes No 7. Does the student have allergies?
If yes, list allergies _____

Yes No 8. Does the student have asthma?
If yes, explain: _____

Yes No 9. Does the student have a reaction to bee stings?
If yes, explain: _____

Yes No 10. Has the student ever experienced frequent chest pains or palpitations?
If yes, explain: _____

Yes No 11. Has the student recently suffered fatigue or undue tiredness?
If yes, explain: _____

Yes No 12. Does the student have a history of fainting with exercise?
If yes, explain: _____

Yes No 13. Has any family member suffered sudden death?
If yes, explain: _____

Yes No 14. Has the student had any ear infections in the past?
If yes, explain: _____

ABSECON PUBLIC SCHOOLS
MEDICAL HISTORY QUESTIONAIRE

Yes No 15. Does the student wear eyeglasses?
If yes, explain: _____

Yes No 16. Does the student wear an orthodontic appliance?
If yes, explain: _____

Yes No 17. Does your child have any other medical problems that the school should be aware of?
If yes, explain: _____

I understand that this information will be shared with the appropriate staff members having contact with my child.

_____ _____
Parent/guardian signature Date

Form A

ABSECON PUBLIC COMMUNITY SCHOOLS
ASTHMA QUESTIONNAIRE

_____Not Applicable

This form must be completed and signed by the parent or legal guardian of each student prior to the first full week of school.

You have informed the school nurse that your child has asthma. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the 2022-2023 school year.**

Student's Name_____Grade_____Date of Birth_____
MEDICAL HISTORY: (To be completed by parent/guardian and physician)

Briefly describe what causes the child's asthma:
_____
_____
_____

What are his/her signs of onset of an asthmatic episode?
_____
_____
_____

Does exercise induce episodes of asthma? _____ If so, list types of exercise: _____
_____
_____
_____

Do certain weather conditions affect your child's asthma? _____ if so, list them: _____
_____
_____
_____

Please list medications that are taken routinely?
Name: Dosage: Time:
_____
_____

Does this child suffer any side effects from the medication? _____ if so, list them:
_____
_____

Is the child capable of self-administration of his/her medication? _____ Yes _____no

Form B (page 2)

ASTHMA QUESTSIONNAIRE

EMERGENCY PROCEDURES: (To be completed by physician)

Steps for an acute asthma episode:

1. _____
2. _____
3. _____

_____ _____
Physician's/Health Care Provider's Signature Date

EMERGENCY PHONE NUMBERS:

Mother: Home_____ Work _____

Father: Home_____ Work _____

Other: Name _____ Relationship _____

Home _____ Work _____

_____ _____
Physician's/Health Care Provider's Signature Date

Preferred hospital: _____

I understand that this information may be shared with appropriate staff members having contact with my child.

_____ _____
Parent's/Guardian's Signature Date

Form C

ABSECON COMMUNITY SCHOOLS
DIABETES QUESTIONNAIRE

_____ NOT APPLICABLE

You have informed the school nurse that your child has diabetes. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the 2022-2023 school year.**

Student's Name _____ Date of Birth_____ Grade _____

MEDICAL HISTORY: (To be completed by parent/guardian and physician)

Blood Glucose
Target range for blood glucose: _____ mg/dl to_____mg/dl

Glcohemoglobulin A1C result: _____ Date: _____

Usual times to test blood glucose (check all that apply):
_____ before breakfast _____ before lunch _____before dinner
_____ before exercise _____ after exercise _____ PRN

Can child perform their own blood glucose tests? Yes No
Type of meter: _____
Ketones: Urine_____ Blood _____
Circumstances for testing: _____

Date of last eye examination: _____ Physician: _____

Insulin
Times, type and dosages of insulin injections taken:

Time:	Type:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Medications: _____

ABSECON PUBLIC SCHOOLS
MEDICAL HISTORY QUESTIONAIRE

Form D (page 2)

DIABETES QUESTIONNAIRE

Meals and Snacks

Meals and Snacks**:**	Time:	Food Content/Amount:
Breakfast	_____	_____
Midmorning Snack	_____	_____
Lunch	_____	_____
Midafternoon Snack	_____	_____
Other times to give snack	_____	_____

Preferred snack foods: _____
Foods to avoid, if any: _____

Exercise and Sports

A snack such as _____ should be readily available at the site of exercise and sports.
Restrictions on activity, if any: _____
Child should not exercise if blood sugar is: _____

Hypoglycemia

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

If glucagons is to be given please list the dose, route and side effects (If glucagons is given, 911 will be activated and parents/guardians notified immediately):

_____

Hyperglycemia

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

Physician's/Health Care Provider's Signature Date

Emergency Phone Numbers

Mother: Home _____ Work _____
Father: Home _____ Work _____
Other: Name _____ Relationship _____
Home _____ Work _____
Doctor/Health Care Provider _____ Phone _____
Preferred Hospital: _____

_____ _____
Parent's/Guardian's Signature Date

Form E

ABSECON COMMUNITY SCHOOLS
PHYSICAL EDUCATION AND RECESS EXCUSE FORM

____Not Applicable

Dear Parent/Guardian:

New Jersey Statue 18A:35-7 requires that every student participate in health, safety and physical education. Physical education is an important part of a child's development. Though the student may not be able to do all of the activities, any activity that he or she is capable of doing will help to improve physical and social development.

A student may only be excused from physical education class by a licensed physician/health care provider stating a specific time period, activities and reason for exclusion. Please have your doctor complete the information below and return it to the school nurse.
This form is valid for the 2022-2023 school year only.

TO BE COMPLETED BY PHYSICIAN

Student's Name _____ Grade _____

Please excuse my patient, _____ from regular physical education and recess activities from _____ to _____

Reason: _____

_____

He/she may continue to participate in the following activities: (please check)

_____ exercise _____ kicking _____throwing _____ dance _____ aerobics

_____ running _____ walking _____stationary bike ____ upper body strengthening

other_____

_____ _____
Physician's/Health Care Provider's Signature Date

Form F

ABSECON COMMUNITY SCHOOLS
PERMISSION TO ADMINISTER MEDICATION

Dear Parent/Guardian and Doctor:

The state requires a written doctor's order, written permission by the parent/guardian, and the original container that the medication came in order for the nurse to administer medication in school. This includes over-the-counter and prescription medications. It is preferred that any medication, whether prescription or non-prescription, be given before or after school hours whenever possible. However, if it is essential that the student receive the medication during school hours, we will need you to provide the following information. **This form is valid for the 2022-2023 school year only.**

I give my permission for the school nurse to give my child,

_____ medication as prescribed by his/her doctor.

_____ **_____**

Date **Parent/Guardian signature**

TO BE COMPLETED BY THE DOCTOR

Name _____ DOB _____

Medication _____

Dosage and route
Time and Frequency _____

Side Effects _____

For school trips/after hour sports events:

____ May self medicate

____ They do not need medication on the trip

Physician's Signature _____ Date _____

ABSECON PUBLIC SCHOOLS
MEDICAL HISTORY QUESTIONAIRE

PHYSICAL EXAMINATION REPORT

School year ____2022-2023_____

Name _____Exam Date _____ Age _____ Date of Birth _____

Address _____ City/State/Zip _____ Phone _____

School _____ Grade _____ Gender_____

Physician _____ Phone _____ Fax _____

Address _____ City/State/Zip_____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

Height _____ Weight _____ Blood Pressure _____/_____ Pulse
Vision R 20/___ L 20/___ Corrected Y/N Contacts Y/N Glasses Y/N
Hearing R _____ L _____

	NORMAL	**ABNORMAL FINDINGS**	**COMMENTS**
Ears			
Eyes/Sclera/Pupils			
Lymph Glands			
Thyroid			
Nose/Mouth Teeth/Throat			
Heart Murmurs/Rhythm/*rate			
Lungs			
Abdomen			
Hernia	**No**	**Yes/Possible**	
Genito-Urinary			
Orthopedic – Structural Posture Feet			
Scoliosis			
Skin			
Nutrition			
Neurological			
Speech			
Other			
GENERAL APPEARANCE			
VACCINES: PLEASE ATTACH A COPY OF IMMUNIZATIONS			

ABSECON PUBLIC SCHOOLS
MEDICAL HISTORY QUESTIONAIRE

MEDICAL HISTORY

1. **Have you ever had a seizure?** **YES** **NO** **Date _____**
2. **Have you ever fainted or passed out?** **YES** **NO** **Date _____**
3. **Have you ever experienced chest pain?** **YES** **NO** **Date _____**
4. **Have you ever experienced shortness of breath?** **YES** **NO** **Date _____**
5. **Do you have asthma?** **YES** **NO** **Describe _____**
6. **Do you have diabetes?** **YES** **NO** **Date _____**
7. **Are you allergic to anything?** **YES** **NO** **Date _____**

School year _____

Have you ever had any of the following diseases:

Chickenpox	**YES**	**NO**	**Lyme Disease**	**YES**	**NO**
Mononucleosis	**YES**	**NO**	**Scarlet Fever**	**YES**	**NO**

Medications currently in use:

Recent:

1. Surgeries _____

_____

2.Injuries _____

_____

Additional Observations:

Signature of Physician **Physician's Stamp**

_____

Date of Exam_____

☐ **Is able to participate in sports for the _____ school year.**

Special Education Medicaid Initiative (SEMI) Parental Consent form

_____ School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____/_____/_____

Parent/Guardian: _____

Date: _____/_____/_____

I give consent to bill for SEMI: Yes ☐
No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

OCTOBER 2017

Appendix A: Home Language Survey Forms

In addition to this static form, an online version of the HLS is available for school districts/charter schools to copy and utilize. In addition, HLS translations will be made available on the NJDOE's Bilingual/ESL Education.

Home Language Survey Form

Introduction

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 Information

Student name: Student birth date:

Street Address:

City: State: Zip Code:

Phone number:

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 7.

No. Proceed to question 4.

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 4.

No. Proceed to question 3.

Question 3

Does the student understand a language other than English?

Yes. Proceed to question 4.

No. Proceed to 9.

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 7.

No. Proceed to question 5.

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

7. List home languages spoken and proceed to 8

8. Proceed to Step 2: Records Review Process.

Home Language Survey is complete.

9. Do not proceed to Step 2: Records Review Process.

Home Language Survey is complete. Student is not an English-Language Learner (ELL)