Public Schools of Edison Township

ENROLLMENT CENTER
312 PIERSON AVENUE * EDISON, NEW JERSEY 08837
TELEPHONE (732) 452-4570 FAX (732) 452-4576
Monday through Friday 9:00 am – 3:00 pm

Bernard F. Bragen, Jr., Ed.D.
Superintendent of Schools

Richard Benedict
Manager of Enrollment/ Data Systems/
District Homeless Liaison/Stability Liaison

ENROLLMENT REQUIREMENTS

* PARENT OR GUARDIAN MUST ENROLL A STUDENT (UNLESS STUDENT IS AN ADULT)
* STUDENT MUST LIVE IN EDISON
* STUDENT MUST BE PRESENT IN ORDER TO ENROLL OR RE-ENROLL

THE FOLLOWING DOCUMENTS SHOULD BE PRESENTED AT THE TIME OF ENROLLMENT:

PREFERRED PROOFS OF RESIDENCY:
FOUR (4) OF THE FOLLOWING PROOFS OF RESIDENCY MAY BE SUBMITTED:

Current property tax bill, deed, lease, lease renewal or signed letter from landlord, indicating residency
Current utility bill with name and address
Photo ID of parent/guardian with current address (Driver's License, Permanent Resident Card, etc.)
Paid rent receipts or cancelled rent checks
Current automobile registration or insurance card
Bank or credit card statement
Documents pertaining to military status and assignment
Court orders, State agency agreements and other evidence of court or agency placements or directives

(Note: Alternate documentation of residency will be considered.)

PROOF OF STUDENT'S DATE OF BIRTH
Birth Certificate / Passport / Other Official Document Indicating Age

UPDATED IMMUNIZATION RECORD
Document in English, with student's name, doctor or clinic name, and month, date & year of shots

SCHOOL RECORDS (if available) – Transfer Card / Withdrawal or Leaving Certificate / Report Card / Letter from previous school, confirming attendance and grade level / Test Scores / IEP

PROOF OF CUSTODY, if applicable, may be requested.

FOR MORE INFORMATION, VISIT US ON THE WEB AT: http://www.edison.k12.nj.us/enrollment

2/14
RB/kk

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PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

REGISTRATION HEALTH HISTORY

Student's Name:_____ **Date of Birth:**_____

School:_____ **Grade:**_____

IMMUNIZATION RECORD

Immunization Document Received Date _____

Requested from parents/guardian Date _____

CHILDHOOD ILLNESSES, INJURIES, OPERATIONS, ORTHOPEDIC CONDITIONS:
Please give age of child when illness, injury, occurred explain:

Asthma _____ Measles_____
Chicken Pox _____ Mononucleosis_____
Diabetes _____ Ear Infections_____
Heart Condition _____ Pneumonia/Bronchitis_____
Kidney/Bladder Condition _____ Rheumatic Fever_____
Strep Infection _____ Seizure(s) _____

Other

Any known speech/hearing problem: _____
Any known Visual Problem: _____
Allergies or Eczema: _____
Behavioral Difficulties: _____
Gastrointestinal Problem: _____
Toileting Difficulties: _____
Neurological Disorders: _____
Muscle or Bone Problems: _____
Other Medical Conditions: _____
Previous Injuries/Accident: _____
Sleeping Problems: _____
Significant or Frequent Illness: _____
Surgery: _____
Breathing Difficulties: _____
Nutritional/Eating Problems: _____
Other difficulties: _____

Has the child ever had prolonged use of medication, or is any medication or therapy being given at this time? If so, please explain:_____

_____

(over)

Physical Limitations:

_____

_____

Has your child ever been confined to a hospital? If so, please explain:

_____

_____

Has your child ever been advised not to participate in a sport or to reduce activity? If so, please explain:

_____

_____

Has your child had a loss of, or serious impairment of a paired organ such as a kidney, eye, lung, etc. If so, please explain:

_____

_____

List additional health information.

_____

_____

I/we give permission for the nurse to share any health-related information with principal, guidance counselors & teachers on a "need to know" basis for as long as my child is a student in Edison Public Schools.

My child is covered by health insurance ___ yes ___ no

My child receives his/her health care at: _____
Name of health care provider or clinic

_____ _____
Signature of Parent/Guardian Date

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PARENT/GUARDIAN CONSENT FOR RELEASE OF RECORDS

NAME OF PREVIOUS SCHOOL _____

ADDRESS _____

_____

NAME OF STUDENT _____

GRADE _____ DATE OF BIRTH _____

The above student has enrolled in the Edison Township Public School System. Please send a transcript of his/her past and current grades (report card), health records, standardized test scores, special services records and any other pertinent information concerning this student.

Thank you.

_____ _____
Signature of Parent/Guardian Date

Please send records to: (name and address of new Edison school)

_____

_____

_____

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FRAUDULENT STATEMENTS

_____ Any false statements, answers, or declarations provided during the enrollment process may be subject to criminal prosecution for the crime of false swearing in violation N.J.S.A. 2C:28-2. If convicted of such crime, you may be punished by a fine of up to $10,000.00 and/or be imprisoned for up to eighteen (18) months.

_____ Pursuant to N.J.S.A. 18:A:38-1 if you fraudulently allow a student to use your residence and you are not the primary financial supporter of the student, you will have committed a disorderly persons offense. If you are convicted of such offense, you may be fined up to $1,000.00 and/or be imprisoned for up to six (6) months.

The Edison Township Board of Education will prosecute to the fullest extent of the law.

_____ _____

Signature of Parent/Guardian **Date**

RB/ml
12/9/19

OFFICE USE ONLY:
GE: ___ SE: ___

Public Schools of Edison Township

312 Pierson Avenue * Edison, New Jersey 08837
Telephone (732) 452-4948 Fax (732) 452-4992

ID#:

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI)
PARENTAL CONSENT FORM

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: _____ (please print)

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.

Nothing Less Than Excellence

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

August 25, 2014

Dear Parent/Caregiver:

The purpose of this letter is to let you know about the **Special Education Medicaid Initiative (SEMI)** program. Your child may be receiving special education services in school such as speech therapy, occupational therapy or physical therapy under SEMI.

Here are three things you should know about SEMI:

1. Your school district may be eligible to receive federal money through the SEMI program which helps to pay for special education services.
2. A school district may receive SEMI money only if a consent form is signed by the parent.
3. Signing the consent form will have no effect on your child's Medicaid health coverage for services outside of school.

If you do not sign the consent form, it will not affect the services your child receives in school since the district is required to provide a free and appropriate public education, including all services listed in your child's Individualized Education Plan (IEP).

The SEMI program is an important source of funding for the school districts. We appreciate your assistance in this program and hope that you will consider the importance of signing the parent consent form and submitting it to your district.

Please feel free to contact your district's special education department if you have any questions.

Sincerely,

Valerie Harr
Director

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NEW STUDENT PHYSICAL EXAMINATION

School: _____ **Enrollment Date:** _____

Grade: _____

Dear Parent / Guardian of _____:

Your child has been enrolled as a new student in the Edison Public Schools. State regulations N.J.A.C. 6A:16-2.2 and district policy 5141.3 require you to submit documentation of a physical examination for your child. The physical examination documentation must be submitted to the school nurse by _____.

Your child will be excluded from school if this requirement is not met.

The physical exam must be signed by a U.S. licensed physician, Advanced Practice Nurse or Physician's Assistant, and must include the physician's address and telephone number. The physical exam must have been conducted within 365 days of your child's Edison school entry date.

If you do not have health insurance, you may call the Edison Health Department to make an appointment for a physical exam. Please call 732-248-7285 for location, directions, cost and further information. This service is available **ONLY** to families who do not have health insurance.

Please be sure to take the attached physical form to be completed by the health department staff or your child's physician, and return it to the nurse at your child's school by the date noted above.

Thank you for your prompt attention to this important matter. If you have questions about this physical examination requirement or the due date, please contact your child's school nurse.

RB/ka
3/11

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HEALTH CARE PROVIDER EXAMINATION (Grades Pre K-12, excluding Sports or Intramurals)
RETURN TO THE SCHOOL NURSE

N.J.A.C. 6A:16-2.2 requires all medical examinations must be done by the student's family physician or clinic where the student receives his/her healthcare.
If you do not have a family physician or clinic who provides medical care for your child, please contact the school nurse for a school physician exam request form.

Student: _____ Grade: _____ School: _____

Male/Female (circle one) Date of Birth: _____

IMMUNIZATIONS ADMINISTERED

_____

LABORATORY TESTS DONE

_____

_____ T.B. Mantoux Test: (date)_____Result _____mm.

RECORD OF PHYSICAL EXAMINATION:

Hearing R: _____ L _____

Height: _____ Weight: _____ BMI Percentile: _____ Blood Pressure: _____ Pulse: _____

Vision R: _____ L _____ Vision correction (glasses/contacts):_____
Hearing/Ears (tubes/hearing aides):_____
Skin and scalp:_____ Abdomen: _____
Rashes _____ Jaundice _____Infection _____ Hepatomegaly _____ Splenomegaly _____ Mass _____
Head and neck:_____ Lymph nodes:_____
Nose and throat:_____ Teeth:_____
Extremities:_____ Inguinal area (hernia):_____
Mobility _____ Deformity _____ Joint Instability _____
Lungs: _____ Spine (scoliosis etc.):_____
Neurological: _____ Reflexes _____ Balance _____ Coordination _____
Females: Normal Menstruation: _____ Males: _____ Hernia: _____Testes Descended
Heart (any irregularity? If yes, please explain): Murmurs _____ Rhythm/Rate _____
Injuries, operations? Explain: _____
Chronic Illness Condition or Disease:

_____
Orthopedic defects: Yes ____ No ____. Accommodations necessary? _____
Mobility _____ Instability _____ Deformity _____
Medications being taken by the student? No _____ Yes _____ If yes, please list: _____

****

Assessment of Physiologic Maturation:

_____

General condition of student:

_____

Are there any health findings which might have an effect on the educational management of the student? If yes, please explain:

_____

In your opinion, is the student capable of carrying a full program in physical education, and field trips?

Yes ____ No ____. Explain:

_____

Restrictions of Activity Recommended:_____

_____ _____ _____
Name of Healthcare Provider (please print) Signature of Healthcare Provider Telephone Number

_____ _____
Address Date of Exam

Revised:12/03, 4/04, 8/08, 9/10
file:NHSM Form 16

(over)

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837

HEALTH HISTORY
(TO BE COMPLETED BY PARENT OR GUARDIAN)

Student's Name: _____ **Grade/Section:** _____ **School:** _____

1.	Has student ever been hospitalized or had surgery?	Y	N
1a.	Significant illness or injury in past year or less? (sprain, mononucleosis,etc.)	Y	N
2.	Is student presently taking any medication? (daily or occasionally)	Y	N
3.	Does student have any **severe allergies** to (medicines, foods, or insects)?	Y	N
3a.	Does student have an Epi-Pen for severe allergic reaction?	Y	N
4.	Has student ever passed out during or after exercise ?	Y	N
	Has student ever been dizzy during exercise?	Y	N
	Has student ever had chest pain during or after exercise?	Y	N
	Has student ever had high blood pressure?	Y	N
	Has student ever been told you had a heart murmur?	Y	N
	Has student ever had racing of your heart or skipped beats?	Y	N
	Has anyone in your family died of heart problems or sudden death before the age of 50?	Y	N
		Y	N
5.	Does student have any skin problems under treatment (itching, rashes, acne)?	Y	N
6.	Has student ever had a head injury or concussion?	Y	N
7.	Has student ever been dizzy or passed out in the heat?	Y	N
8.	Does student have any problems with hearing loss?	Y	N
9.	Does student have trouble breathing during or after exercise?	Y	N
9a.	Does student have asthma?	Y	N
9b.	Does student use asthma inhaler(s)?	Y	N
10.	Has student had any problems with eyes or vision?	Y	N
10a.	Does student wear contact lenses or glasses during sports?	Y	N
11.	Does student have any medical conditions (diabetes, seizure disorder, severe headaches, etc.)	Y	N
12.	Has student ever fractured or dislocated any of the following? Skull Neck Shoulder Arm Elbow Wrist Hand Thigh Leg Knee Ankle Foot	Y	N
13.	Does student wear orthodontic braces or retainer?	Y	N

14. Explain any YES answers (include dates): _____

_____

_____

_____

_____

Signature of Parent/Guardian: _____ DATE: _____

Revised:12/03,4/04, 8/08
file: NHSM Form 16

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

DENTAL HEALTH FORM

Dear Parent/Guardian:

An important part of your child's total well-being is the care of the teeth and prevention of decay. In order to promote positive dental health maintenance at an early age, we are asking you to have your family dentist complete the dental form below and return it to the school. This dental form then becomes an essential part of your child's school and health records.

The condition of a child's teeth often affects not only attendance at school but also performance including speech development, in school. Statistics demonstrate that many children have not achieved as well as their capabilities indicate because of discomfort and pain due to cavities and discomfort, pain and illness from teeth that are abscessed.

All parents are interested in the scholastic achievement, health and welfare of their children. In order to improve the dental health of the children of our township, especially those who will be entering kindergarten in September, you are urged to arrange for dental examination of your child's teeth by your family dentist without appreciable delay. The preventive measure of determining tooth defects and decay and obtaining early corrective treatment will help protect permanent teeth and assist in their proper development.

Following the dental examination, please ask your dentist to complete the attached form and return it to school as soon as possible.

Respectfully,

_____	_____	_____
School Nurse	School	Phone

==========

TO BE COMPLETED BY FAMILY DENTIST

I have examined _____ D.O.B. _____

Please check one:
_____ Patient under treatment.
_____ Dental treatment completed.
_____ No treatment necessary.

Remarks: _____

_____

_____
Signature of Dentist

_____
Date