

# WATERFORD TOWNSHIP SCHOOL DISTRICT ENROLLMENT REQUIREMENTS

**ONLY** the parent or legal guardian may enroll a student and  
the student **MUST** reside in Waterford Township

## DOCUMENTS REQUIRED

1. **Proof of Residence – (6 points needed)** [NJSA 18A:38(a)] [NJAC 6A:22-3.4]
  - a. Current Property Tax Bill (4 points), **OR**
  - b. Current Mortgage or Lease (4 points)
    - Leases **MUST** be **CURRENT** and signed by **BOTH** parties- (tenant & landlord)
  - c. Agreement of Sale within 30 days (4 points), **AND**
  - d. Current Bill [Gas, Electric, Water, Sewer, Cable, Car Insurance] (2 points each)
    - Bill **MUST** be current.
    - Bring **ENTIRE** bill along.
  - e. Other Current document with address (1 point each)  
(Bank Statement, Medical Bill, Driver's License) [2 point maximum]
  - f. **Affidavit** – If the parent/guardian is **NOT** the homeowner or lessor, the homeowner or lessor **MUST** complete a notarized affidavit [we will provide] & prove their residency by providing the documents listed above.
2. **Proof of Parent / Guardian Identity** [NJSA 18A:36-25]
  - a. Current Photo Drivers License **OR** Photo ID.
  - b. DCP&P placement **OR** Court Documents – if applicable
  - c. If parent & child have different names due to marriage **MUST** supply marriage certificate.
3. **Proof of Custody (if divorced or separated)**
  - a. Custody Agreement showing Joint or Residential Custody **OR**
  - b. Admission Form 3 [we will provide] parent agreement of School District.
4. **Proof of Student Identity** [NJSA 18A:36-25.1]
  - a. Birth Certificate (**Original**)
5. **Health Information** [NJAC 8:57-4]
  - a. Immunization record
  - b. Physical
6. **School Records (transfers only)**
  - a. Transfer Card
  - b. Report Cards
  - b. IEP – if applicable

**FOR OFFICE USE ONLY:**  
IdentiFlo Verification (4 points):

\_\_\_ Pass

\_\_\_ Fail

**WATERFORD TOWNSHIP SCHOOL DISTRICT**  
**REGISTRATION FORM**

**STUDENT INFORMATION**

\_\_\_\_\_  
Last Name                      Generation      First Name                      Middle Name

Date of Birth \_\_\_\_\_ Nickname \_\_\_\_\_ M / F

Race/Ethnicity (please check all that apply)

\_\_\_\_\_ Hispanic or Latino

\_\_\_\_\_ Black

\_\_\_\_\_ American Indian/Alaskan

\_\_\_\_\_ Pacific Islander/Hawaiian

\_\_\_\_\_ Asian

\_\_\_\_\_ White

**NJ SMART – FEDERAL LEP INFORMATION**

Birth City \_\_\_\_\_ Birth State \_\_\_\_\_

Birth Country \_\_\_\_\_ Entry Date into US School System \_\_\_\_\_

Language used at home \_\_\_\_\_

Language most often spoken by student \_\_\_\_\_

First Language Spoken (Native) \_\_\_\_\_

Has the student attended US schools for more than 3 full years (Immigrant Status)? Y / N

**PRIOR SCHOOL INFORMATION**

Prior School Name \_\_\_\_\_

Prior School City \_\_\_\_\_ Prior School State \_\_\_\_\_

**PLEASE SELECT FROM THE FOLLOWING OPTIONS REGARDING THE STUDENT'S PARENT/GUARDIAN:**

\_\_\_\_\_ No military affiliation

\_\_\_\_\_ Active Duty

\_\_\_\_\_ National Guard or Military Reserves

\_\_\_\_\_ Unknown

**RESIDENCY INFORMATION** (please circle)

•Own my Home

•Rent/Lease

•Live with district resident

•Temporary Situation



### MEDIA RELEASE

Periodically throughout the school year, photographs may be taken of our students and staff in various academic and non-academic activities. Since these images may be used in printed and online materials such as the school district newsletter and/or brochures, local/regional publications, district website, social media, video presentations, or be displayed at various seminars and/or workshops in which the district participates, we need to obtain permission to take them.

\_\_\_\_\_ I GIVE permission for my child to be photographed for school-related publications, website and presentations.

\_\_\_\_\_ I DO NOT give permission for my child to be photographed for school-related publications, website and presentations.

### TECHNOLOGY ACCEPTABLE USE POLICY

I understand the conditions set forth in the district Technology Acceptable Use Policy (a copy of which is provided during registration). I further understand that any violation is unethical and may constitute a criminal offense. Should my child commit any violation, their access privileges may be revoked, disciplinary and/or appropriate legal action may be taken.

\_\_\_\_\_ I have reviewed and understand the AUP and WILL ALLOW my child to use the internet.

\_\_\_\_\_ I DO NOT give permission for my child to use the internet.

### I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE:

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Registration Form  
Revised: July 2017

### OFFICE USE ONLY

STUDENT ID # \_\_\_\_\_ STATE ID # \_\_\_\_\_

Date of Registration \_\_\_\_\_ Preschool \_\_\_\_\_ Kindergarten \_\_\_\_\_ Transfer \_\_\_\_\_

Teacher \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Permanent Records: Req. \_\_\_\_\_ Rec'd \_\_\_\_\_ CST Records: Req. \_\_\_\_\_ Rec'd \_\_\_\_\_



# WATERFORD TOWNSHIP PUBLIC SCHOOLS EMERGENCY FORM

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Main Phone Number: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_

**CUSTODY ISSUES: YES / NO** STUDENT LIVES WITH: \_\_\_ Mother \_\_\_ Father \_\_\_ Both Parents Other \_\_\_\_\_

## PLEASE SELECT ONE OF THE FOLLOWING:

- ☐ There are no custody issues regarding my child. If at any time this status changes, I am responsible for providing a copy of the custody papers to the Waterford Twp. Public School Office. If I do not, I understand that my child may be released to either parent or any persons listed on the emergency form.
- ☐ I have given the Waterford Twp. Public School Office a copy of the latest custody papers for my child. I am also aware that it is my responsibility to furnish any updated custody papers. If I fail to do so, the latest papers on file will be enforced.

My child is not permitted to be released to: \_\_\_\_\_ (as noted by legal documentation)

MOTHER / GUARDIAN: Primary Contact 1 <sup>st</sup> or 2 <sup>nd</sup> (circle)	FATHER / GUARDIAN: Primary Contact 1 <sup>st</sup> or 2 <sup>nd</sup> (circle)
First Name:	First Name:
Last Name:	Last Name:
Relationship to Student:	Relationship to Student:
Mailing Address:	Mailing Address:
Main Phone:	Main Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email Address:	Email Address:
<b>PLEASE SELECT ALL THAT APPLY</b>	<b>PLEASE SELECT ALL THAT APPLY</b>
Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>

## **OTHER CONTACTS within 30 minutes of the school**

OTHER CONTACTS within 30 minutes of the school		
First Name:	First Name:	First Name:
Last Name:	Last Name:	Last Name:
Relationship to Student:	Relationship to Student:	Relationship to Student:
Mailing Address:	Mailing Address:	Mailing Address:
Main Phone:	Main Phone:	Main Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
<b>Please select all that apply</b>	<b>Please select all that apply</b>	<b>Please select all that apply</b>
Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/>
Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>

**\*CONTINUE ON REVERSE\***

**STAFF USE ONLY:** Is any contact a current Staff or BOE Member? \_\_\_\_\_



MEDICAL / DENTAL / INSURANCE INFORMATION

Family Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Telephone # \_\_\_\_\_

Does your child have health insurance? Yes/No If yes, name of insurance company \_\_\_\_\_

For more information call 800-701-0710 or visit [www.nifamilycare.org](http://www.nifamilycare.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 to 20 U.S.C. & 1232 (b)(1) and 34 C.F.R. 99.30(b)

Please check if the student has any of the following conditions:

\_\_\_\_\_ diabetes \_\_\_\_\_ asthma \_\_\_\_\_ vision or hearing problems \_\_\_\_\_ heart conditions with restrictions  
\_\_\_\_\_ seizure disorder \_\_\_\_\_ wears glasses \_\_\_\_\_ on medication(s) \_\_\_\_\_ heart conditions without restrictions  
\_\_\_\_\_ severe allergies \_\_\_\_\_ wears contacts \_\_\_\_\_ G.I. issues \_\_\_\_\_ other \_\_\_\_\_

Please explain items above that are checked \_\_\_\_\_

My child is on the following medication(s):

Please list any and all allergies:

List brothers/sisters attending school in this district: Name: \_\_\_\_\_

Grade: \_\_\_\_\_ School: Atco / TR / WES

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: Atco / TR / WES

**INFORMATION ON THIS CARD MAY BE SHARED WITH OTHER STAFF MEMBERS. IN CASE OF EMERGENCY, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL ONLY WHEN YOU CANNOT BE REACHED. I GIVE MY SON/DAUGHTER PERMISSION TO RECEIVE EMERGENCY HOSPITAL TREATMENT IF NECESSARY.**

Date \_\_\_\_\_ Mother/Guardian Signature: \_\_\_\_\_ Father /Guardian Signature \_\_\_\_\_



**WATERFORD TOWNSHIP PUBLIC SCHOOLS**  
**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Sex: ☐ Male ☐ Female

School: ☐ Waterford ☐ Atco ☐ Thomas Richards

Grade: \_\_\_\_\_

Mother & Father's Complete Name: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**IS YOUR CHILD SUBJECT TO: (Please circle YES or NO)**

Frequent colds	YES	NO
Bronchitis	YES	NO
Frequent sore throats	YES	NO
Allergies	YES	NO
Speech difficulties	YES	NO

Chronic cough	YES	NO
Vision loss	YES	NO
Poor posture	YES	NO
Emotional problems	YES	NO
Earaches	YES	NO

**HAS YOUR CHILD HAD:**

Poor eating habits	YES	NO
Tonsils removed	YES	NO
Eye disease	YES	NO
Head injury	YES	NO

Difficulty sleeping	YES	NO
Eye injury	YES	NO
Convulsions	YES	NO
Epileptic seizures	YES	NO
Severe fall	YES	NO

**MISCELLANEOUS:**

Does child stumble, fall or bump into things frequently?	YES	NO
Did mother have serious illness or measles during pregnancy?	YES	NO

**FAMILY HISTORY: (Please circle)**

TB, Diabetes, Heart Disease, Allergies, Asthma, Epilepsy, Cancer, Kidney Ailments, Blindness, Deafness, Poor vision

**HAS CHILD HAD: (IF YES, INCLUDE DATES IF POSSIBLE)**

Diabetes	YES	NO
Kidney Disease	YES	NO
RH Factor	YES	NO
Bone defects	YES	NO
Pneumonia	YES	NO
Rheumatic Fever	YES	NO
Cardiac history	YES	NO

Asthma	YES	NO
High fever	YES	NO
Mumps	YES	NO
Chicken Pox	YES	NO
Measles	YES	NO
German Measles	YES	NO
Scarlet Fever	YES	NO

**MEDICAL HISTORY**

Describe any major illnesses or medical conditions (including hospitalizations, convulsions, high fevers, vision concerns, hearing concerns, allergies, persistent colds, ear infections, or other medical problems) your child may have experienced: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any specialists that have seen your child: \_\_\_\_\_

Describe any medications your child is taking (including type of medication, dosage, time): \_\_\_\_\_

\_\_\_\_\_



Name of Child: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_

**FORM TO BE COMPLETED BY PHYSICIAN**

DATE OF EXAMINATION: \_\_\_\_\_

VACCINE TYPE	Disease Date	1 <sup>st</sup> Dose Mo/Day/Yr	2 <sup>nd</sup> Dose Mo/Day/Yr	3 <sup>rd</sup> Dose Mo/Day/Yr	4 <sup>th</sup> Dose Mo/Day/Yr	5 <sup>th</sup> Dose Mo/Day/Yr	6 <sup>th</sup> Dose Mo/Day/Yr
Diphtheria, Tetanus, Pertussis-DTP *(If DT or Td, indicate in corner box)							
Tdap							
Oral Polio Vaccine (OPV) *(If Salk Vaccine, indicate IPV in corner box)							
MMR (Measles, Mumps & Rubella)							
Measles					or Measles Serology	Date	Titer
Rubella					or Rubella Serology	Date	Titer
Mumps					or Mumps Serology	Date	Titer
Haemophilus B (HIB) Required for Day/Child Care Enrollees (2 mos - 5 <sup>th</sup> birthday only)							
Hepatitis B					Hepatitis A		
Varicella					HPV		
Pneumococcal (PCV)							
Influenza							
Meningitis							
Other							

☐ Provisional admission attached-Date Granted \_\_\_\_\_ ☐ Medical exemption attached \_\_\_\_\_ ☐ Religious exemption attached \_\_\_\_\_

**CHILDHOOD DISEASES [GIVE DATES]**

Chickenpox _____	Rheumatic Fever _____
German Measles _____	Scarlet Fever _____
Measles _____	Whooping Cough _____
Mumps _____	

**OPERATIONS**

Tonsillectomy _____	Hernia _____
Appendectomy _____	Other _____

**MEDICAL HISTORY**

Convulsive Disorders _____	Fracture _____
Diabetes _____	Other Injuries _____
Kidney Disorders _____	Speech Defect _____
Cardiac Disorders _____	Asthma _____
Other Serious Illnesses _____	Allergies _____

**PHYSICAL EXAMINATION**

Height _____	Weight _____	Blood Pressure _____
Ears _____	Abdomen _____	
Nose _____	Hernia _____	
Throat _____	Genitalia _____	
Teeth _____	Feet _____	
Gums _____	Skin _____	
Thyroid _____	Nutrition _____	
Heart _____	Posture _____	
Lungs _____	Nervous Symptoms _____	
Vision R _____ L _____	Hearing R _____ L _____	

General Condition \_\_\_\_\_

Current Health Problems \_\_\_\_\_

Medications Being Taken \_\_\_\_\_

PRINT NAME OF PHYSICIAN \_\_\_\_\_

SIGNATURE OF PHYSICIAN \_\_\_\_\_

THIS INFORMATION IS VITAL TO THE WELFARE OF THE CHILD. CONFIDENTIAL INFORMATION MAY BE DISCUSSED WITH THE SCHOOL NURSE.

DENTAL SCREENING

Name of Student: \_\_\_\_\_

The above-named student has been seen by the dentist.

Results: \_\_\_\_\_  
\_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Dentist

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Date