Pequannock Township School District
Office of the Superintendent
538 Newark Pompton Turnpike
Pompton Plains, New Jersey 07444
Phone (973) 616-6040 • Fax (973) 616-6043
Twitter: @PantherTownNJ

Dr. Michael Portas, Superintendent of Schools michael.portas@pequannock.org

Preschool Registration
General Information
www.pequannock.org

- All students must be at least 3 years old, but less than 5 years old, on or before October 1st.

- All students must be fully potty trained.

- Classes run Monday to Friday
  - Full day hours 8:15 A.M. - 2:00 P.M.
  - Half day A.M. hours 8:15 A.M. - 10:43 A.M.
  - Half day P.M. hours are 11:33 A.M. - 2:00 P.M.

- Once accepted to the program a contract will be mailed to you and you will need to submit the signed contract as well as the nonrefundable deposit to hold your child's spot. Deposits and contracts are due no later than June 5th. If not received, your child's spot will be offered to a student on the waiting list.

- Once your child is accepted to the preschool program, online preregistration must be completed. Once online preregistration is complete, an automated email will be sent with instructions on how to upload the required documents. Online preregistration is found on the website under *Menu* then *Registration*. If you need assistance, please call 973-616-6040 ext. 1008.

- Tuition must be paid in full by August 31st or in two installments by August 31st and January 31st. Tuition may be made by check payable to "Pequannock Township Board of Education" or on the website under *Menu*, *Registratio*n then *Tuition* located on the left hand sidebar.

PEQUANNOCK TOWNSHIP SCHOOL DISTRICT

REGISTRATION CHECKLIST

____ Original birth certificate ***REQUIRED PRIOR TO ATTENDING SCHOOL***

____ Most recent physical and immunizations (completed by physician)
REQUIRED PRIOR TO ATTENDING SCHOOL

____ Must provide three (3) original proofs of residency within 60 days.
Documents can include driver's license, deed/lease, tax bill, mortgage statement, bank statement, voter registration, utility bill, etc.

____ Home Language Survey

____ Records Release Form, if applicable

____ IEP/504, if applicable

____ Most recent report card or transcript, if applicable

____ Custody papers, if applicable

____ Oral Health Assessment Form, completed by dental professional
(***Preschool & Kindergarten only***)

____ Parent Questionnaire and Preschool Release Form (***Kindergarten only***)

____ 1:1 Chromebook Program Signature Page (***Grades 6-12 only***)

____ NJSIAA Transfer form for sports athletes (***Grades 9-12 only***)

____ NJSIAA Student Athlete Residency Affidavit for sports athletes
(***Grades 9-12 only***)

Home Language Survey

Purpose

This survey is the first of three steps to identify whether a student is eligible to be identified as an English language learner (ELL).

Directions

Start with 'Question 1' and continue until the HLS is complete. Select the answer for each question and follow the directions. When you arrive at a decision, the HLS is complete. Proceed to *Step 2: Records Review Process* if the Home Language Survey indicates additional information is needed.

Student Information	
Student Name:	Date of Birth (MM/DD/YYYY):
Street Address:	
City, State, Zip:	
Phone Number:	

Step 1: Survey Questions:

Question 1: List all languages used in the student's home and go to #2:

____

Question 2: Was the first language used by the student a language other than English?

☐ No (Go to #3)

☐ Yes (Go to #3)

Question 3: Does the student speak or understand a language other than English?

☐ No (Go to *Result C*)

☐ Yes (Go to #4)

Question 4: When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English most of the time?

☐ No (Go to #5)

☐ Yes (Go to #5)

Question 5: When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English most of the time?

- ☐ No (Go to *Result C*)
- ☐ Yes (Go to *Result B*)

Results [For Internal Use Only]:

Did they answer “Yes” to either Question #4 or Question #5?

- ☐ No (Go to *Result C*)
- ☐ Yes (Go to *Result B*)

Result B:

The student is a *possible* ELL. Reviewers should proceed to Step 2 of Identification Process: Conduct Records Review Process.

Result C:

The student is ***not*** an ELL.

Step 2: Conduct Records Review Process - This *step is to be completed by NJ Certified Staff only – reference ESSA ELL entry and Exit Guidance.*

Purpose

This process is the second of three steps to identify whether a student is eligible to be identified as an ELL. This review process is mandatory for all school districts/charters starting in July of 2019 and cannot be altered according to *ESSA* §3111(b)(2)(A).

Step 3: Testing for Identification - *This process ensures multiple steps for identification are used to make the final decision regarding whether a student is an ELL.*

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Dear Parents and Guardians of Preschool and Kindergarten Students:

It is our intent to promote oral health care which can affect student learning. We are requesting that the oral health assessment form be completed and returned with the medical registration packet. Tooth decay (or cavities) is the number one chronic childhood disease in America. Tooth decay is preventable with good oral hygiene and dental visits. One alarming statistic is that 51 million school hours are lost each year to untreated cavities. Young children who suffer from oral disease can have decreased appetite, inattentiveness, and distractibility caused by pain or infection.

Please have your child visit a dentist to ensure preventable disease. The NJ Dental Association offers an online find-a-dentist resource at www.njda.org.

Thank you for your support in keeping our students healthy to optimize learning.

Sincerely,

Pequannock Township Elementary School Nurses

ORAL HEALTH ASSESSMENT FORM

The New Jersey Children's Oral Health Education Program is administered by the New Jersey Department of Health. Program activities take place throughout the State with emphasis in areas of high need/high risk.

SECTION 1: Child's Information (completed by parent/guardian)

Child's Last Name:	First Name:	Child's Date of Birth:
Address: City/Zip Code:		
Child's Sex: ☐ Male ☐ Female	Parent/Guardian Name:	

SECTION 2: Oral Health Data Collection (completed by a licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box:

Dental Examination Date:	Caries Experience - Restorations Present: ☐ Yes ☐ No	Visible Decay Present: ☐ Yes ☐ No	Treatment Urgency: ☐ No obvious problem found ☐ Dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) ☐ Urgent care needed (pain, infection, swelling or soft tissue lesions)
Oral Hygiene:	___ **Unsatisfactory**	___ **Satisfactory**	___ **Above Average**

_________________________________ _______________ ____________
Licensed Dental Professional Signature ***NJ License Number*** ***Date***

SECTION 3: Waiver of Oral Health Assessment Requirement
To be filled out by parent/guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason.)

☐ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is: ____

☐ I cannot afford a dental check-up for my child.

☐ I do not want my child to receive a dental check-up.

Optional: Other reasons my child could not get a dental check-up: ______________________________

If asking to be excused from this requirement: ____
Signature of Parent/Guardian ***Date***

Revised 9/2022

Pequannock Township School District
Parent/Guardian Questionnaire

Child's Name____

Please answer the following questions to help us provide your child with a great learning experience.

Did your child attend Preschool? ____ YES ____ NO
Name of Preschool ____

What are your child's strengths?____
____
____

What are your child's weaknesses?____
____
____

Has your child ever received Early Intervention Services? __________________________

If so, what and for how long? (Occupational Therapy, Speech and Language, Physical Therapy, Educational Services) ____
____

	YES	NO	SOMETIMES
Does your child have a diagnosed disability?			
Is your child's speech understandable to most people?			
Does your child participate in cooperative play with peers?			
Does your child prefer to play alone?			
Does your child follow single step directions?			
Does your child write his/her name?			
Does your child have an interest in books?			
Can your child sit still and listen for a 3-5 minute period of time?			
Can your child concentrate on a task for at least 10 minutes?			
Does your child show a sense of confidence when away from parent for 2-3 hours?			
Does your child recall past events/rhymes/songs?			
Does your child enjoy being read to?			

Is there anything else you think we should know about your child as we plan for the upcoming school year? ____
____

Revised 9/2022

PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS
Health Office
PHYSICAL EXAMINATION

Name: ______________________ Date of Birth: ______________ Grade: ________
School: ____
Medical History: ______________________________________
____

Each student must have a physical on file in the health office.

1. Urine Sugar ________ Albumin ________
2. Pulse ______________________
3. Blood Pressure ______________________
4. Height ______________________
   Weight ______________________
5. Vision Right ________ Left ________
6. Hearing Right ________ Left ________
7. Scoliosis ______________________
   Extremities ______________________
8. Neurological ______________________
9. Heart ______________________
   Murmur ______________________
   Rhythm ______________________
10. Lungs ______________________
11. Immunization given ______________________
12. TB Test ______________________
13. Skin ______________________
    Head ______________________
    Eyes ______________________
    Ears ______________________
    Nose ______________________
    Mouth ______________________
    Teeth ______________________
    Neck ______________________
14. Abdomen ______________________
    Hernia ______________________
    Genitalia ______________________
15. Physical Maturation ______________________
16. Hgb/Hct ______________________

Other ____

Remarks ____
____

Date of Physical ______________ Physician's Signature ______________________

Date of Signature ______________

Please print/type/stamp your name, address and telephone number
____
____
____