Haworth Public School

Dear Parents/Guardians:

Welcome to the Haworth Public School.

In order to enroll your child(ren), please provide the School Office with the following paperwork:

1) **Four (4) forms of proof of Haworth residence:**
   a. Deed/Lease papers
   b. PSE&G or Rockland Electric bill
   c. Drivers License **OR** other utility bills
2) School Records from previous school
3) Health Records from child(ren)'s physician
4) Birth Certificate **OR** Passport

We appreciate your supplying the above information as soon as possible so that we may expedite the registration process. If you have any questions, please do not hesitate to contact the main office at 201-384-5526, ext. 35100 or 35101.

Sincerely,

Adrienne Huettenmoser

Adrienne Huettenmoser
Principal

205 Valley Road
Ph: 201-384-5526

Haworth, New Jersey 07641
Fax: 201-384-8619

Haworth Public School

REQUEST FOR SCHOOL RECORDS

Date: _____

Dear Colleague:

_____, a student formerly registered in your school, has enrolled in

Grade _____ in the Haworth Public School.

I would greatly appreciate your forwarding copies of the following to my attention:

1) _____ Standardized Achievement Test Scores
2) _____ Report Cards
3) _____ Participation in Gifted & Talented Program
4) _____ Health Records (please include original A45)
5) _____ Attendance Information
6) _____ Child Study Team Records **(including most current IEP)**
7) _____ 504 Records
8) _____ NJ SMART State ID Number ***(if coming from another NJ Public School)***

The records above are to be released to:

Mrs. Adrienne Huettenmoser
Haworth Public School
205 Valley Road
Haworth, NJ 07641

Thank you for your assistance in this important matter.

Sincerely,

Adrienne Huettenmoser

Adrienne Huettenmoser
Principal

I hereby grant permission for the release of the above records to the Haworth Public School.

Parent/Guardian Signature and Date: _____

Name, Address and Phone # of School releasing records: _____

_____

Haworth Public School

SCHOOL REGISTRATION FORM & PERMANENT RECORD INFORMATION

Today's Date: _____ Entry Date _____ GRADE ENTERING: _____

Child's Name: _____ Ethnicity: _____ Gender: F M X

Date of Birth: _____ City & Country of Birth: _____

Permanent Address/Address of Domicile: _____

Is this Student a dependent of a full-time active duty member of the Armed Forces? Yes No

Home Phone: _____ Mom Cell: _____ Dad Cell: _____

Mom Email: _____ Dad Email: _____

Guardian's Home & Cell Number: (H): _____ (C): _____

	NAME	HOME ADDRESS (if different from above)	OCCUPATION	CITIZENSHIP	BIRTHPLACE
FATHER					
MOTHER					
***GUARDIAN**					

(If legal guardian is someone other than the child's parents, please complete the appropriate Domicile Affidavit Document on file in the school's Main Office).

SIBLINGS' NAMES (if any)	DATE OF BIRTH	CURRENT GRADE

Former Residence: _____

Former School Name and Phone Number: _____

Former School Address and Grade: _____

205 Valley Road
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Haworth, New Jersey 07641
Fax: 201-384-8619

Haworth Public School

Home Language Survey

Date: _____

Student's Name: _____

Grade: _____

1. What was the first language used by your child?

2. At home does your child hear or use a language other than English more than half of the time?

3. Does the child understand a language other than English?

4. When interacting with parents or guardians, does your child use a language other than English more than half of the time?

5. When interacting with caregivers other than parents or guardians, does your child use a language other than English more than half of the time?

6. Has your child recently moved from another school district where he/she was identified as an English language learner?

7. How long has your child lived in the United States?

Parents/Guardians: Is there a parent/guardian in the home who is comfortable receiving school notices in English? ☐**Yes** ☐**No**

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Haworth, New Jersey 07641
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Haworth Public School

ALLERGY & MEDICATION SURVEY

Child's Name:_____ Grade: _____

1. Allergy Information: Does your child have any allergies?

	Please Specify	YES	NO
Medications (i.e. antibiotics)		☐	☐
Food (i.e. milk, eggs, wheat, yeast, peanuts)		☐	☐
Environmental (i.e. grass, dust, animal)		☐	☐
Insect Bites (i.e. bees, spiders, mosquito)		☐	☐
Food Dyes		☐	☐
Asthma		☐	☐
Others		☐	☐

If yes, what kind of reaction does your child experience?

_____

_____

Does your child take medication for an allergic reaction?

_____

_____

2. Medication Information: Please list below all medications, supplements, complementary therapies, etc., that your child is taking.

Medication/Therapy	Dosage	How Often	Reason

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Haworth, New Jersey 07641
Fax: 201-384-8619

APPROVED SCHOOL PHYSICAL EXAMINATION FORM
HAWORTH PUBLIC SCHOOLS
(K - 8)

UNIVERSAL CHILD HEALTH RECORD

Endorsed by:
American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐Immunization Record Attached ☐Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐None ☐Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐None ☐Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐None ☐Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐None ☐Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐None ☐Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐None ☐Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐None ☐Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐None ☐Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐Capillary ☐Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	