East Brunswick Public Schools

Please use the checklist below to ensure all necessary documents are submitted for student registration. **ALL of the documentation requested below is necessary to process registration**. Please understand that failure to provide requirements or complete online steps may delay registration. If you have any questions, please call 732-613-6980.

KINDERGARTEN REGISTRATION CHECKLIST

All Registration Steps (1-2) online (www.ebnet.org/register) **MUST** be completed for each student.
Your student is not registered for school until hard copies of registration paperwork listed below are dropped off at the District Registration office, which is located at 760 Route 18, East Brunswick.

_____ **Proof of Residency**
Documents must be in the name of the parent/guardian. A copy of the Deed, a currently dated mortgage statement or current lease agreement **must be provided** at time of registration. TWO additional UTILITY bills must also be provided to complete the residency requirement. Online statements and confirmation of service are acceptable. If you have just moved into your home, bills must be provided within 30 days of registration. If the home is not in the name of parent/guardian, please call 732-613-6751 for residency affidavit instructions.

_____ **Parent/Guardian Photo ID**

_____ **Student's Birth Certificate (provide a copy – no originals)**

_____ **Student's current immunization record (MUST be provided at time of registration)**

_____ **IEP/504 Plan** if applicable

_____ **Custody Documentation** if applicable

_____ **Registration Packet** printed (single sided) and all forms completed (one packet per student)

- _____**Registration Data Form**
  All fields and check boxes must be filled in completely**. Guardian boxes are for parents/legal guardians only.** Please provide all contact information.
- _____**Student Health History**
- _____**Student Physical Exam Form**
  (must be completed by physician and returned to school nurse within 30 days of registration)

EAST BRUNSWICK PUBLIC SCHOOLS

REGISTRATION DATA SHEET

SCHOOL _____ **DATE** _____ **STUDENT ID** _____

PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETED

_____ _____ _____ _____

Student Last Name | Student First Name (Legal) | M. I. | Nickname

Date of Birth: (M)/_____(D)/_____(Y)_____ Age: _____ Gender: _____ Grade: _____

_____

Student Street Address | Town | Zip Code

Student resides with (Relationship): _____Parent Status: Married ☐Divorced ☐Separated ☐Single ☐Remarried ☐

If divorced or separated, who has legal custody? _____Who has residential custody? _____

Student's previous Address & Telephone #:_____

If you have a residence elsewhere, what is the address and when do you live there?_____

Student's previous School & Address: _____

Do you have other children attending East Brunswick Public Schools? Yes ☐ No☐ (List Full Names Below)

(1)_____(2)_____(3)_____(4)_____

First U.S. School Entry Date: (M)_____(D)_____(Y)_____ Original U.S. Entry Date: (M)_____(D)_____(Y)_____

SPECIAL EDUCATION: Yes ☐ No ☐ **IEP**? Yes ☐ No ☐ **Have a 504 Plan**? Yes ☐ No☐

Required for State/Federal Reports: (these questions must be answered)

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

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

PARENT/GUARDIAN INFORMATION

Please Circle: Parent or Legal Guardian	**Please Circle: Parent or Legal Guardian**
(Ms.) (Mrs.) (Mr.) (Dr.)	**(Ms.) (Mrs.) (Mr.) (Dr.)**
Last Name: _____	**Last Name:** _____
First Name: _____	**First Name:** _____
Address: _____	**Address:** _____
City:_____ **State:**_____ **Zip:**_____	**City:** _____**State:**_____ **Zip:**_____
Parent E-mail : _____	**Parent E-mail:** _____
Home Phone #: ( ) _____	**Home Phone #: ( ) _____**
Cell Phone #: ( ) _____	**Cell Phone #: ( ) _____**
Business #: ( ) _____	**Business #: ( ) _____**
Occupation: _____	**Occupation:** _____
Employer's Name: _____	**Employer's Name:** _____
Employer's Address: _____	**Employer's Address:** _____

I certify that the foregoing statements made by me are true. I am aware that if any of them are willfully false, I will be subject to legal action. As per State Law and Board Policy, if it is discovered that my child (children) is (are) illegally attending the East Brunswick Schools and not living in East Brunswick, I will be responsible for the payment of all accrued tuition fees. In addition, I acknowledge that I will be responsible for any legal expenses incurred by the East Brunswick Board of Education in relation to the situation.

Print Name _____**Signature** _____**Date** _____

Revised 11/2023

East Brunswick Public Schools

Student Services Department
Student Health History Form

It is necessary that the following confidential information concerning the health history, growth and development of your child be completed. This information is essential for a total understanding of each child as an individual. It also assists in planning the child's individual education plan.

Student Name :_____ Date of Birth: _____

Preschool experience: Yes ☐ No ☐ Preschool attended:_____ How Long?_____

Primary language spoken at home:_____ Language(s) spoken by child:_____

Physician Name and Phone:_____

List siblings (name, age, general health):

_____

Does your child have vision problems? Yes ☐ No ☐ If yes, please indicate:_____
Does your child wear glasses? Yes ☐ No ☐ Does your child wear contact lenses? Yes ☐ No ☐
Does your child have hearing problems? Yes ☐ No ☐ If yes, please indicate:_____
Does your child have any allergies? Yes ☐ No ☐ If Yes, please indicate: _____
Does your child require Epinephrine? Yes ☐ No ☐ If Yes, please indicate reason:_____
Does your child have any skin conditions (eczema, etc.)? Yes ☐ No ☐ If yes, please indicate:_____
Does your child have difficulty concentrating and/or a short attention span? Yes ☐ No ☐
If yes, list any medication given if applicable :_____
Has your child been treated for a medical condition/mental illness? Yes ☐ No ☐ List illness, duration, medications given: _____

List any serious accidents (i.e. head injury, etc), operations, hospitalizations, emergency room visits:

_____

Infections/Illness	Circle One		Infections/Illness	Circle One	
Chicken Pox	Yes/ Age:_____	No	Strep	Yes/ Age:_____	No
Measles	Yes/ Age:_____	No	Lyme Disease	Yes/ Age:_____	No
Mumps	Yes/ Age:_____	No	Arthritis	Yes/ Age:_____	No
Seizures/Convulsions	Yes/ Age:_____	No	Pneumonia	Yes/ Age:_____	No
Tuberculosis	Yes/ Age:_____	No	Migraines	Yes/ Age:_____	No
Asthma	Yes/ Age:_____	No	Hepatitis	Yes/ Age:_____	No

List any information you wish to share with the school which might be beneficial to your child and helpful to the school:

_____

Screening procedures are conducted on students in the East Brunswick Public Schools according to the following regulations and Board of Education policies. PLEASE READ AND SIGN this form to indicate your approval of these procedures for your child. This form will become part of the student's permanent health record. The school nurse will answer any questions you may have concerning these procedures.

HEIGHTS, WEIGHTS AND BLOOD PRESSURE will be done annually on all students in grades K-12. **AUDIOMETRIC SCREENING: NJAC 6A:16-2.2, NJSA 18A:40-4** - Audiometric screening for hearing acuity is done annually for all students in preschool programs, grades K-3, 7 and 11, students new to the district with no available record of audiometric screening, students referred to the Child Study Team for evaluation, students at risk of hearing impairment and those referred by teacher, parent or self. **VISION SCREENING: NJAC 6A:16-2.2** - Vision screening is done annually on students in preschool programs, grade K-1, 3, 5-8 and 10, students referred to the Child Study Team for evaluation or review, students entering the district with no available record of vision screening and those referred by teacher, parent or self.

Parent/Guardian Signature:_____ Date:_____

East Brunswick Public Schools
East Brunswick, New Jersey 08816
Student Services

Student Physical Examination Form

Student Name: _____ Date of Birth: _____

School: _____ Date: _____

School Address: _____

Dear Parent:

Please present this form to your physician at the time of your child's examination. Upon completion, please return this form within 30 days of student's registration. Thank you.

Height: _____ Weight: _____ B.P.: _____ Pulse: _____

Vision-Right: _____ Left: _____ Both: _____

Glasses-Right: _____ Left: _____ Both: _____

Physical Findings	Please indicate with a √ (check) in the appropriate column. Normal	Abnormal	Specify and Recommend
EYES			
VISION			
COLOR PERCEPTION			
EARS - OTOSCOPIC			
HEARING			
Left			
Right			
TEETH/MOUTH			
NOSE			
THROAT			
LYMPH GLANDS			
THYROID			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
GENITO-URINARY			
ORTHOPEDIC (STRUCTURAL)			
SCOLIOSIS SCREENING			
SKIN			
NUTRITION			
NERVOUS SYSTEM			
SPEECH			
OTHER			
GENERAL APPEARANCE			

Student Physical Examination Form

Student Name: _____

DATE OF MOST RECENT MANTOUX TUBERCULIN:

TEST: _____ RESULT: _____ FOLLOW-UP: _____

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

DPT/DTaP					
Tdap (Grade 6)					
Polio					
MMR					
Measles (on or after 1st birthday)					
Mumps (on or after 1st birthday)					
Rubella (on or after 1st birthday)					
Hib					
Hepatitis B (min spacing intervals)					
Varicella (on or after 1st birthday)					
Meningococcal (Grade 6)(after 10th birthday)					
Pneumococcal (Pre-School)					
Influenza (Pre-School)					

PLEASE LIST ANY HEALTH PROBLEMS WHICH MIGHT INTERFERE WITH THE STUDENT'S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR PHYSICAL EDUCATION PROGRAM:

INDICATE ANY RESTRICTIONS:

COMMENTS:

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____

PRINTED NAME, ADDRESS AND TELEPHONE: _____

_____

_____

_____