

DATE: _____

School Year 2024-2025

STUDENT REGISTRATION FORM

Pascack Valley Regional High School District - PASCACK HILLS HIGH SCHOOL

PLEASE PRINT CLEARLY – COMPLETE BOTH SIDES

Student Last Name _____

Student First Name _____

Middle Name/Initial _____

Grade Level 9 10 11 12

Gender Male Female

Student's Date of Birth _____ / _____ / _____
Month Day Year

Siblings Attending PVRHSD

Name(s) _____ Grade(s) _____

Student Resides With	Ethnic Category	Sending School
<input type="checkbox"/> Mother & Father	<input type="checkbox"/> White, Not of Hispanic Origin	<input type="checkbox"/> Fieldstone M.S.
<input type="checkbox"/> Mother Only	<input type="checkbox"/> Black, Not of Hispanic Origin	<input type="checkbox"/> George White M.S.
<input type="checkbox"/> Father Only	<input type="checkbox"/> Hispanic/Black	<input type="checkbox"/> Holdrum M.S.
<input type="checkbox"/> Mother & Stepfather	<input type="checkbox"/> Hispanic/White	<input type="checkbox"/> Woodcliff M.S.
<input type="checkbox"/> Father & Stepmother	<input type="checkbox"/> Hispanic/Amer.Indian/Alask.Native	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Guardian(s)	<input type="checkbox"/> Amer. Indian/Alaskan Native	_____
	<input type="checkbox"/> Asian	
	<input type="checkbox"/> Pacific Islander	

Birthplace _____
City State

If not U.S., First Date of Entry into U.S. School: Month _____ Year _____
First Date of Entry in U.S. : Month _____ Year _____

Language Spoken at Home _____ Country of Birth if not U.S. _____

Parent Information

Father's Name Mr./Dr. _____
First Last

Father's Address _____

Home Telephone Number _____ Cell Number _____ Work Number _____

Father's Email Address _____

Mother's Name Ms./Mrs./Dr. _____
First Last

Mother's Address _____

Home Telephone Number _____ Cell Number _____ Work Number _____

Mother's Email Address _____

OR

Guardian Information

Name _____

Address _____

Home Telephone Number _____ Cell Number _____ Work Number _____

Email Address _____

PLEASE CHECK HERE IF PARENTS/GUARDIANS LIVE AT DIFFERENT ADDRESSES AND REQUEST SEPARATE MAILINGS/COMMUNICATIONS

EMERGENCY INFORMATION VERIFICATION

Emergency numbers will only be used in the event that we cannot reach the parent/guardian at the other numbers provided.

CONTACT TYPE	NAME/RELATION	TELEPHONE NUMBER
Emergency Contact		
Student's Doctor		

Court Orders/Legal Restrictions

Does your child have health insurance coverage?

Yes _____ No _____

If yes, what is the name of the Insurance Company?

Please sign here to indicate that we have your permission to call the physician listed or to have your child taken to the hospital when you are not available or in an emergency.

Signature _____ Date _____

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Signature _____ **Printed Name** _____ **Date** _____