



## Haworth Public School

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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



**Haworth Public School**

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**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

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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): \_\_\_\_\_

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

***\*(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).***

<b>SIBLINGS' NAMES (if any)</b>	<b>DATE OF BIRTH</b>	<b>CURRENT GRADE</b>

Former Residence: \_\_\_\_\_

Former School Name and Phone Number: \_\_\_\_\_

Former School Address and Grade: \_\_\_\_\_



**Haworth Public School**

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**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



**Haworth Public School**

**ALLERGY & MEDICATION SURVEY**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

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

	<u>Please Specify</u>	<u>YES</u>	<u>NO</u>
Medications (i.e. antibiotics)		<input type="checkbox"/>	<input type="checkbox"/>
Food (i.e. milk, eggs, wheat, yeast, peanuts)		<input type="checkbox"/>	<input type="checkbox"/>
Environmental (i.e. grass, dust, animal)		<input type="checkbox"/>	<input type="checkbox"/>
Insect Bites (i.e. bees, spiders, mosquito)		<input type="checkbox"/>	<input type="checkbox"/>
Food Dyes		<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>	<input type="checkbox"/>
Others		<input type="checkbox"/>	<input type="checkbox"/>

**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.

<b>Medication/Therapy</b>	<b>Dosage</b>	<b>How Often</b>	<b>Reason</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth /    /		
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)	
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
<b>MEDICAL CONDITIONS</b>					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
<b>PREVENTIVE HEALTH SCREENINGS</b>					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
Name of Health Care Provider (Print) _____			Health Care Provider Stamp:		
Signature/Date _____					