

WATERFORD TOWNSHIP SCHOOL DISTRICT
REGISTRATION FORM

STUDENT INFORMATION

_____ **Last Name** _____ **Generation** _____ **First Name** _____ **Middle Name**

Date of Birth _____ **Nickname** _____ **M / F**

Race/Ethnicity (please check all that apply)

_____ **Hispanic or Latino** _____ **Black**
_____ **American Indian/Alaskan** _____ **Pacific Islander/Hawaiian**
_____ **Asian** _____ **White**

NJ SMART – FEDERAL LEP INFORMATION

Birth City _____ **Birth State** _____

Birth Country _____ **Entry Date into US School System** _____

Language used at home _____

Language most often spoken by student _____

First Language Spoken (Native) _____

Has the student attended US schools for more than 3 full years (Immigrant Status)? **Y / N**

PRIOR SCHOOL INFORMATION

Prior School Name _____

Prior School City _____ **Prior School State** _____

PLEASE SELECT FROM THE FOLLOWING OPTIONS REGARDING THE STUDENT'S PARENT/GUARDIAN:

_____ **No military affiliation** _____ **Active Duty**
_____ **National Guard or Military Reserves** _____ **Unknown**

RESIDENCY INFORMATION (please circle)

•Own my Home •Rent/Lease •Live with district resident •Temporary Situation

MEDIA RELEASE

Periodically throughout the school year, photographs may be taken of our students and staff in various academic and non-academic activities. Since these images may be used in printed and online materials such as the school district newsletter and/or brochures, local/regional publications, district website, social media, video presentations, or be displayed at various seminars and/or workshops in which the district participates, we need to obtain permission to take them.

_____ I GIVE permission for my child to be photographed for school-related publications, website and presentations.

_____ I DO NOT give permission for my child to be photographed for school-related publications, website and presentations.

TECHNOLOGY ACCEPTABLE USE POLICY

I understand the conditions set forth in the district Technology Acceptable Use Policy (a copy of which is provided during registration). I further understand that any violation is unethical and may constitute a criminal offense. Should my child commit any violation, their access privileges may be revoked, disciplinary and/or appropriate legal action may be taken.

_____ I have reviewed and understand the AUP and WILL ALLOW my child to use the internet.

_____ I DO NOT give permission for my child to use the internet.

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE:

Signature: _____ Relationship: _____

Registration Form
Revised: July 2017

OFFICE USE ONLY

STUDENT ID # _____ STATE ID # _____

Date of Registration _____ Preschool _____ Kindergarten _____ Transfer _____

Teacher _____ Grade _____ School _____

Permanent Records: Req. _____ Rec'd _____ CST Records: Req. _____ Rec'd _____

WATERFORD TOWNSHIP PUBLIC SCHOOLS EMERGENCY FORM

Student Name: _____ Date of Birth: _____

Address: _____ Main Phone Number: _____

Grade: _____ Teacher: _____ School Year: _____

CUSTODY ISSUES: YES / NO **STUDENT LIVES WITH:** Mother Father Both Parents Other _____

PLEASE SELECT ONE OF THE FOLLOWING:

- There are no custody issues regarding my child. If at any time this status changes, I am responsible for providing a copy of the custody papers to the Waterford Twp. Public School Office. If I do not, I understand that my child may be released to either parent or any persons listed on the emergency form.
- I have given the Waterford Twp. Public School Office a copy of the latest custody papers for my child. I am also aware that it is my responsibility to furnish any updated custody papers. If I fail to do so, the latest papers on file will be enforced.

My child is not permitted to be released to: _____ (as noted by legal documentation)

MOTHER / GUARDIAN: Primary Contact 1st or 2nd (circle)	FATHER / GUARDIAN: Primary Contact 1st or 2nd (circle)
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Relationship to Student: _____	Relationship to Student: _____
Mailing Address: _____	Mailing Address: _____
Main Phone: _____	Main Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____
PLEASE SELECT ALL THAT APPLY	PLEASE SELECT ALL THAT APPLY
Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>

OTHER CONTACTS within 30 minutes of the school

First Name: _____	First Name: _____	First Name: _____
Last Name: _____	Last Name: _____	Last Name: _____
Relationship to Student: _____	Relationship to Student: _____	Relationship to Student: _____
Mailing Address: _____	Mailing Address: _____	Mailing Address: _____
Main Phone: _____	Main Phone: _____	Main Phone: _____
Cell Phone: _____	Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____	Work Phone: _____
Please select all that apply	Please select all that apply	Please select all that apply
Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>	Resides: <input type="checkbox"/> Send Mail: <input type="checkbox"/> Allow Pick Up: <input type="checkbox"/> Medical Contact: <input type="checkbox"/>

CONTINUE ON REVERSE

STAFF USE ONLY: Is any contact a current Staff or BOE Member? _____

MEDICAL / DENTAL / INSURANCE INFORMATION

Family Physician _____ Telephone # _____

Family Dentist _____ Telephone # _____

Does your child have health insurance? Yes/No If yes, name of insurance company _____

For more information call 800-701-0710 or visit www.nifamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance. Signature: _____ Printed Name: _____

Date: _____ Written consent required to 20 U.S.C. & 1232 (b)(1) and 34 C.F.R. 99.30(b)

Please check if the student has any of the following conditions:

- _____ diabetes _____ asthma _____ vision or hearing problems _____ heart conditions with restrictions
- _____ seizure disorder _____ wears glasses _____ on medication(s) _____ heart conditions without restrictions
- _____ severe allergies _____ wears contacts _____ G.I. issues _____ other

Please explain items above that are checked _____

My child is on the following medication(s):

Please list any and all allergies:

List brothers/sisters attending school in this district: Name: _____ Grade: _____ School: Atco / TR / WES

Name: _____ Grade: _____ School: Atco / TR / WES Name: _____ Grade: _____ School: Atco / TR / WES

INFORMATION ON THIS CARD MAY BE SHARED WITH OTHER STAFF MEMBERS. IN CASE OF EMERGENCY, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL ONLY WHEN YOU CANNOT BE REACHED. I GIVE MY SON/DAUGHTER PERMISSION TO RECEIVE EMERGENCY HOSPITAL TREATMENT IF NECESSARY.

Date _____ Mother/Guardian Signature: _____ Father /Guardian Signature _____

WATERFORD TOWNSHIP PUBLIC SCHOOLS
MEDICAL HISTORY FORM

Name: _____ Date: _____
(Last) (First) (Middle)

Address: _____

Birth Date: _____

Sex: Male Female

School: Waterford Atco Thomas Richards

Grade: _____

Mother & Father's Complete Name: _____

Family Physician: _____ Phone: _____

IS YOUR CHILD SUBJECT TO: (Please circle YES or NO)

Frequent colds	YES	NO	Chronic cough	YES	NO
Bronchitis	YES	NO	Vision loss	YES	NO
Frequent sore throats	YES	NO	Poor posture	YES	NO
Allergies	YES	NO	Emotional problems	YES	NO
Speech difficulties	YES	NO	Earaches	YES	NO

HAS YOUR CHILD HAD:

Poor eating habits	YES	NO	Difficulty sleeping	YES	NO
Tonsils removed	YES	NO	Eye injury	YES	NO
Eye disease	YES	NO	Convulsions	YES	NO
Head injury	YES	NO	Epileptic seizures	YES	NO
			Severe fall	YES	NO

MISCELLANEOUS:

Does child stumble, fall or bump into things frequently? YES NO
Did mother have serious illness or measles during pregnancy? YES NO

FAMILY HISTORY: (Please circle)

TB, Diabetes, Heart Disease, Allergies, Asthma, Epilepsy, Cancer, Kidney Ailments, Blindness, Deafness, Poor vision

HAS CHILD HAD: (IF YES, INCLUDE DATES IF POSSIBLE)

Diabetes	YES	NO	Asthma	YES	NO
Kidney Disease	YES	NO	High fever	YES	NO
RH Factor	YES	NO	Mumps	YES	NO
Bone defects	YES	NO	Chicken Pox	YES	NO
Pneumonia	YES	NO	Measles	YES	NO
Rheumatic Fever	YES	NO	German Measles	YES	NO
Cardiac history	YES	NO	Scarlet Fever	YES	NO

MEDICAL HISTORY

Describe any major illnesses or medical conditions (including hospitalizations, convulsions, high fevers, vision concerns, hearing concerns, allergies, persistent colds, ear infections, or other medical problems) your child may have experienced: _____

List any specialists that have seen your child: _____

Describe any medications your child is taking (including type of medication, dosage, time): _____
