



# 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.

## **REGISTRATION CHECKLIST**

**All Registration Steps (1-2) online ([www.ebnet.org/register](http://www.ebnet.org/register)) MUST be completed for each student.** Registration paperwork should be dropped off at the Administration Building located at 760 Route 18. Your student is not registered for school until hard copies of registration paperwork listed below are dropped off and processed by the District Registration Department.

- \_\_\_\_\_ **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 732-613-6980 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)**
- \_\_\_\_\_ **NJ Transfer Card for students transferring from another NJ public school**
- \_\_\_\_\_ **For grades K-8 current/previous school report cards**
- \_\_\_\_\_ **For grades 9-12 a copy of unofficial transcript**
- \_\_\_\_\_ **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)
  - \_\_\_\_\_ **Record Release Letter** (returned to District Registration Office with registration paperwork.  
Parent/Guardian should NOT send to previous school.)
  - \_\_\_\_\_ **Elective Forms for grades 5, 6 & 7**
  - \_\_\_\_\_ **Athletic Form for grades 9-12**

**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 <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Remarried <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/> (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)_____			
<b>SPECIAL EDUCATION:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>IEP?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Have a 504 Plan?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b><u>Required for State/Federal Reports:</u></b> (these questions must be answered)			
<b><u>Race:</u></b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
<b><u>Ethnicity:</u></b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			

**PARENT/GUARDIAN INFORMATION**

<b>Please Circle: Parent or Legal Guardian</b>	<b>Please Circle: Parent or Legal Guardian</b>
(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

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.		Specify and Recommend
	Normal	Abnormal	
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 1 <sup>st</sup> birthday)					
Mumps (on or after 1 <sup>st</sup> birthday)					
Rubella (on or after 1 <sup>st</sup> birthday)					
Hib					
Hepatitis B (min spacing intervals)					
Varicella (on or after 1 <sup>st</sup> birthday)					
Meningococcal (Grade 6)(after 10 <sup>th</sup> 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### Previous School Contact

City, State, Zip: \_\_\_\_\_

(office use)

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# NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

## STUDENT-ATHLETE RESIDENCY AFFIDAVIT

\_\_\_\_\_  
Print Student's Full Name

\_\_\_\_\_  
School

\_\_\_\_\_  
Date

I, \_\_\_\_\_, of full age, being duly sworn to law, upon my oath  
depose and say:

1. I am the parent/legal guardian of the above listed student. (circle)
2. I currently reside at: \_\_\_\_\_  
I have resided at the above address since: \_\_\_\_\_
3. The above-named student moved with me at my new address on: \_\_\_\_\_
4. Prior to moving to the new residence address listed above, I resided at the following address:  
\_\_\_\_\_
5. Prior to moving to the new address listed in #2 above, the student resided at the following address:  
\_\_\_\_\_  
with named parent/legal guardian \_\_\_\_\_
6. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.
7. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.
8. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent/Guardian Full Name

STATE OF NEW JERSEY, COUNTY OF \_\_\_\_\_. The above-named affiant appeared before me, a  
notary public of the State of New Jersey, on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and I made known to  
him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

Notary Public: \_\_\_\_\_

***Copies of this Affidavit must be sent to the New Jersey State Interscholastic Athletic Association upon request***