



# East Brunswick Public Schools

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## Welcome Class of 2039



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](http://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 732-613-6980 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)**

\_\_\_\_\_ **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 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

**OFFICE USE ONLY**

HOME SCHOOL \_\_\_\_\_ STUDENT ID \_\_\_\_\_ DATE \_\_\_\_\_

Start Date in Genesis: \_\_\_\_\_

**PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETED**

Student's Full Name *(As appears on the Birth Certificate)*

\_\_\_\_\_

First Name

Middle Name

Last Name

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 Public Islander

**Ethnicity:** Hispanic Yes  No

**PARENT/GUARDIAN INFORMATION**

Please Circle: Parent or Legal Guardian

(Ms.) (Mrs.) (Mr.) (Dr.)

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Parent E-mail: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_

Business #: ( ) \_\_\_\_\_

Please Circle: Parent or Legal Guardian

(Ms.) (Mrs.) (Mr.) (Dr.)

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Parent E-mail: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_

Business #: ( ) \_\_\_\_\_

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 \_\_\_\_\_

**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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_