

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

NJSLEDS - FEDERAL ML INFORMATION

Birth City _____ Birth State _____

Birth Country _____ Entry Date into US School System _____

Language used at home _____

Language most often spoken by student _____

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

NJSLEDS - PRIOR SCHOOL INFORMATION

Prior School Name _____

Prior School City _____ Prior School State _____

Has the student been registered in a school district but not attend? Y / N

Has the student ever been referred for Early Intervention? Y / N

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: September 2026

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: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐	Resides: ☐ Send Mail: ☐ Allow Pick Up: ☐ Medical Contact: ☐

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: ☐ Send Mail: ☐	Resides: ☐ Send Mail: ☐	Resides: ☐ Send Mail: ☐
Allow Pick Up: ☐ Medical Contact: ☐	Allow Pick Up: ☐ Medical Contact: ☐	Allow Pick Up: ☐ Medical Contact: ☐

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.njfamilycare.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): _____

Name of Child: _____ Birth date: _____
 School: _____ Grade: _____

FORM TO BE COMPLETED BY PHYSICIAN

DATE OF EXAMINATION: _____

VACCINE TYPE	Disease Date	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	6 th Dose Mo/Day/Yr
Diphtheria, Tetanus, Pertussis-DTP *(If DT or Td, indicate in corner box)							
Tdap							
Oral Polio Vaccine (OPV) *(If Salk Vaccine, indicate IPV in corner box)							
MMR (Measles Mumps & Rubella)							
Measles					or Measles Serology	Date	Titer
Rubella					or Rubella Serology	Date	Titer
Mumps					or Mumps Serology	Date	Titer
Haemophilus B (HIB) Required for Day/Child Care Enrollees (2 mos - 5 th birthday only)							
Hepatitis B					Hepatitis A		
Varicella					HPV		
Pneumococcal (PCV)							
Influenza							
Meningitis							
Other:							

☐ Provisional admission attached Date Granted _____ ☐ Medical exemption attached _____ ☐ Religious exemption attached _____

CHILDHOOD DISEASES [GIVE DATES]

Chickenpox _____
 German Measles _____
 Measles _____
 Mumps _____

Rheumatic Fever _____
 Scarlet Fever _____
 Whooping Cough _____

OPERATIONS

Tonsillectomy _____
 Appendectomy _____

Hernia _____
 Other _____

MEDICAL HISTORY

Convulsive Disorders _____
 Diabetes _____
 Kidney Disorders _____
 Cardiac Disorders _____
 Other Serious Illnesses _____

Fracture _____
 Other Injuries _____
 Speech Defect _____
 Asthma _____
 Allergies _____

PHYSICAL EXAMINATION

Ears _____
 Nose _____
 Throat _____
 Teeth _____
 Gums _____
 Thyroid _____
 Heart _____
 Lungs _____
 Vision R _____ L _____

Height _____ Weight _____ Blood Pressure _____
 Abdomen _____
 Hernia _____
 Genitalia _____
 Feet _____
 Skin _____
 Nutrition _____
 Posture _____
 Nervous Symptoms _____
 Hearing R _____ L _____

General Condition _____

Current Health Problems _____

Medications Being Taken _____

PRINT NAME OF PHYSICIAN _____

SIGNATURE OF PHYSICIAN _____

THIS INFORMATION IS VITAL TO THE WELFARE OF THE CHILD. CONFIDENTIAL INFORMATION MAY BE DISCUSSED WITH THE SCHOOL NURSE.



Waterford Township
School District

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: _____ Date of Birth (mm/dd/yyyy): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

2.) Was the first language used by the student a language other than English?

_____ No _____ Yes

3.) Does the student speak or understand a language other than English?

_____ No _____ Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Waterford Township Public School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR 99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR 300.622 require a one time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian: _____

Date: _____

I give consent to bill for SEMI: Yes ☐
 No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school in writing.