



**Point Pleasant Borough Schools**  
**2100 Panther Path**  
**Point Pleasant, NJ 08742**

## **PRE-K AND KINDERGARTEN REGISTRATION REQUIREMENTS**

ONLY THE NATURAL PARENT OR LEGAL GUARDIAN MAY REGISTER A STUDENT

- I. Proof of Residency (necessary before beginning any registration);
  - A. **Please provide one (1) of the following:**
    1. Tax bill, Deed, Contract of Sale, Closing or Mortgage Statement; or Lease/Rental receipt with address of property; signed letters from landlords or other evidence of personal attachment to a particular location; and
  - B. **Please provide three (3) of the following:**
    1. Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and or other evidence of personal attachment to a particular location.
    2. Court Order, state agency agreements or other evidence of court or agency placements or directives.
    3. Receipts, bills, cancelled checks, insurance claims or payments or other evidence of expenditures demonstrating personal attachment to a particular location or where applicable, to support the student
    4. Medical reports, counselor or social worker assessments, employment documents, unemployment claims, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship or temporary residency.
    5. Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance from the parent, legal guardian, person keeping an “affidavit of domicile” student, adult student, person(s) with whom a family is living, or others, as appropriate.
    6. Documents pertaining to military status and assignment
    7. Any business record or document issued by a governmental entity
    8. Any other form of documentation relevant to demonstrating entitlement to attend school
  - C. In the event an “Affidavit of domicile” is required, you will be given the appropriate one to be notarized and returned.
- II. Health Records (Immunizations): **YOU MUST HAVE EXISTING IMMUNIZATION RECORDS (LISTING OF SHOTS) TO REGISTER.**
- III. Original Birth Certificate with raised seal (Bureau of Vital Statistics)
- IV. Divorced or separated parents must provide custody papers



# POINT PLEASANT BOROUGH PUBLIC SCHOOLS STUDENT REGISTRATION FORM

**Student Information: Please print/fill in all information for each student registering.**

Student Name (First, Middle, Last):			
Date of Birth:	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Placement:
Birth City, State & Country			
U.S. Entry Date (if born outside the United States)	Ethnicity:		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native/Other Pacific Islander			
Language Spoken at Home:		Primary Language Spoken:	
Child of a District Employee or Board of Education Member (Regardless of Town of Residence) <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Student is a</b> <input type="checkbox"/> a member of the full time, Active Duty Forces <b>dependent of:</b> <input type="checkbox"/> someone <b>NOT</b> in the full time, Active Duty Forces	

**Student Residential Address Information:**

Home Address:	Apartment/Unit #
City/Zip Code:	Third Party Residence?

<b>Student Resides With/Head of Household:</b>	<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother * <input type="checkbox"/> Father * <input type="checkbox"/> Guardian * * Do you have legal custody of the above-named child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> Sole Custody <input type="checkbox"/> Joint Custody <input type="checkbox"/> <u>Restricted Release</u> - If there are any issues relating to custody and releasing your child please be aware that the school must have a copy of the legal documents in our files.
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Parent/Guardian #1:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian	
Home Phone:	Cell Phone:	Business Phone:
<i>Email Address:</i>		
Marital Status:		

Parent/Guardian #2:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian	
Home Phone:	Cell Phone:	Business Phone:
<i>Email Address:</i>		
Marital Status:		

**If dual notification of Progress Reports and Report Cards are needed, please complete below:** (Used for joint custody only)

Name:	Relationship to student:
Mailing Address:	Contact Phone:

**Registration Office Use Only!**

School to Attend:	<input type="checkbox"/> OR <input type="checkbox"/> NB <input type="checkbox"/> MMS <input type="checkbox"/> PPBHS	Year of Graduation:		
<input type="checkbox"/> Affidavit of Guardianship attached		Grade Level:		
Home School (if different)	Entry Code:	Free/Reduced Lunch <input type="checkbox"/> Yes <input type="checkbox"/> No		
Proof of Residency	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No
Custody Papers	Tuition:	Tuition Code:	1 2 3 4 5 6 7 9	
Student ID#:	SID#:	Family Code:		
Birth Certificate <input type="checkbox"/> No <input type="checkbox"/> Yes	Transfer Card <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Records <input type="checkbox"/> Yes <input type="checkbox"/> No	Report Card <input type="checkbox"/> Yes <input type="checkbox"/> No	Locker:
Registration Date:	Enrollment Date:	Registrar:		

**Emergency Contact Information:** (Someone other than parent/guardian)

Name:		Phone:		Relationship to student:	
Name:		Phone:		Relationship to student:	
Name:		Phone:		Relationship to student:	

**Sibling Information:** Please list ALL children in the family from oldest to youngest. If additional room is needed, please list on the back of this page.

Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Does sibling attend school in Point Pleasant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which school?		

Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Does sibling attend school in Point Pleasant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which school?		

**District Curricular Information:**

Was the student previously enrolled in a Point Pleasant Borough School?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, which school?	
Last school attended:		City, State	Grade
My child was receiving the following assistance in his/her previous school:			
<input type="checkbox"/> Student seen by the CST	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Basic Skills	<input type="checkbox"/> 504 Plan
<input type="checkbox"/> Student referred to the CST	<input type="checkbox"/> ELL/Bilingual Education	<input type="checkbox"/> Math <input type="checkbox"/> Reading	
<input type="checkbox"/> Student classified by the CST	<input type="checkbox"/> Gifted & Talented	<input type="checkbox"/> Free or Reduced Lunch	<input type="checkbox"/> Student Retained

**Health Insurance Information:**

Current Health Insurance Status of your child	Coverage (YES) <input type="checkbox"/>	Coverage (NO) <input type="checkbox"/>
If "YES" Name of Health Insurance Company		
Date of your child's last medical examination		Proof of Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply on line.

**Point Pleasant Borough Schools may release my name and address to NJ Family Care Program to contact me about health insurance.**

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
**Name of Parent/Legal Guardian (Please Print)**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**



**POINT PLEASANT BOROUGH SCHOOLS**

**CONSENT TO EMERGENCY STUDENT TREATMENT**

I \_\_\_\_\_, parent/legal guardian of the student named below, do hereby CONSENT (in advance) to any emergency treatment and/or hospital care rendered to the student at a Medical Center of Ocean County facility in the event that any situation should arise during school hours or during any school activities that would require emergency treatment or care rendered to the named student.

This consent is given at the request of the Point Pleasant Board of Education and the Medical Center of Ocean County so that prompt emergency treatment of the student may be rendered. This consent extends to the Hospital and its affiliated physicians, nurses, employees and administrative officer.

I understand that this consent will be lodged with the school that is attended by the student so that it will be immediately available for delivery to a Medical Center of Ocean County facility in the event that emergency treatment of the student is required.

I further understand that in the event of the rendering of any emergency treatment to the student by the Hospital that the Hospital will promptly communicate with me at the telephone number listed below in order to advise me of the emergency situation and treatment rendered to the student.

I further understand that any costs incurred as a result of Hospital treatment will be my responsibility and not that of the Point Pleasant Borough Public School District.

AS TO THE STUDENT: \_\_\_\_\_ (NAME) \_\_\_\_\_ (AGE)

\_\_\_\_\_ (Street Address – Town – State – Zip Code) \_\_\_\_\_ (Date of Birth)

***ALLERGIES*** that the hospital and/ or emergency care provider would need to be aware of

**AS TO THE PERSON SIGNING THE CONSENT:** \_\_\_\_\_ (Name)

\_\_\_\_\_ (Relationship to Student) \_\_\_\_\_ (Street Address – Town – State – Zip Code) \_\_\_\_\_ (Phone Number)

\_\_\_\_\_ (Signature of Person Giving Consent – Parent/Legal Guardian) \_\_\_\_\_ Date

## HEALTH OFFICE/NEW ENTRANT QUESTIONNAIRE

Student's Name \_\_\_\_\_ ID# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Birthplace \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

*Please check the following questions and explain any "Yes" answer on the space provided.*

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### MEDICATIONS:

Does your child take any daily medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list daily medications and doses: \_\_\_\_\_

Will your child require medication given in school? Yes \_\_\_\_\_ No \_\_\_\_\_

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### ALLERGIES: Is your child allergic to any of the following:

Medications: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please list: \_\_\_\_\_

Seasonal Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

Bee Sting/Insect Bites: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, list medication needed for allergic reaction: \_\_\_\_\_

Food Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, which foods? \_\_\_\_\_

Type of reaction? \_\_\_\_\_

Type of medication needed for reaction? \_\_\_\_\_

Asthma: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, frequency of attacks? \_\_\_\_\_

Known triggers? \_\_\_\_\_

Current daily asthma medications? \_\_\_\_\_

Normal Peak Flow \_\_\_\_\_

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### HEART DISEASE/HEART MURMUR: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, any limitations in activity? \_\_\_\_\_

*Please note: A doctor's note is required stating there is no limitation of activity to participate in gym, sports, or recess.*

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KIDNEY DISEASE: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please list: \_\_\_\_\_

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DIABETES: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, we will discuss and formulate care plan for the school year.

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Student's Name: \_\_\_\_\_

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SEIZURES: Yes \_\_\_\_\_ No \_\_\_\_\_

Medications/Limitations: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_ Type of seizure: \_\_\_\_\_

If current seizure disorder, we will meet and formulate care plan for the school year.

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LYME DISEASE: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, date of diagnosis: \_\_\_\_\_ Current medications/limitations? \_\_\_\_\_

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GLASSES: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, when are they to be worn? \_\_\_\_\_

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HEARING DIFFICULTIES: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

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FREQUENT EAR INFECTIONS: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, approximately how many infections and what age(s)? \_\_\_\_\_

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FREQUENT STREP INFECTIONS: Yes \_\_\_\_\_ No \_\_\_\_\_

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History of any of the following:

HEAD INJURIES: Yes \_\_\_\_\_ No \_\_\_\_\_

BROKEN BONES: Yes \_\_\_\_\_ No \_\_\_\_\_

HOSPITALIZATIONS: Yes \_\_\_\_\_ No \_\_\_\_\_

SURGERIES: Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered **yes** to any of the above, please give dates and explain: \_\_\_\_\_

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Please list any other disabilities, limitations, or health concerns: \_\_\_\_\_

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Previous School Attended: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**POINT PLEASANT BOROUGH PUBLIC SCHOOLS**

Required Pre-School Physical Examination for Pupils Entering **PRE-K & KINDERGARTEN**

Child's Name: (Last, First, Middle) \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Birth Wt.: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

**CODE: 0 – No Defect**

**1 – Slight Deviation**

**2 – Requires Attention**

E.N.T. R _____ L _____	Heart _____	Spine _____	Height _____
Vision R _____ L _____	Lungs _____	Posture _____	Weight _____
Hearing R _____ L _____	Abdomen _____	Extremities _____	
Teeth _____	Hernia _____	B.P. _____	Glands _____

**ILLNESSES:**

Chicken Pox _____	Mumps _____	Pneumonia _____	Heart Disease _____
Measles _____	Seizures _____	Allergies _____	T.B. Contact _____
German Measles _____	Diabetes _____	Scarlet Fever _____	Operations _____
Rheumatic Fever _____	Ear Trouble _____	Asthma _____	

VACCINE TYPE	1 <sup>ST</sup> DOSE MO/DAY/YR	2 <sup>ND</sup> DOSE MO/DAY/YR	3 <sup>RD</sup> DOSE MO/DAY/YR	4 <sup>TH</sup> DOSE MO/DAY/YR	5 <sup>TH</sup> DOSE MO/DAY/YR	MO/DAY/YR
DIPHtheria, TETANUS, PERTUSSIS (DTP) (If Td, DtaP, or Dt*, (Indicate in corner box) <b>One dose on or after fourth birthday.</b>						
POLIO ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box) <b>One dose on or after fourth birthday.</b>						
MEASLES, MUMPS, RUBELLA (MMR) <b>On or after first birthday</b>						
MEASLES <b>(Two doses required)</b>				MEASLES SEROLOGY	DATE	TITER
RUBELLA				RUBELLA SEROLOGY	DATE	TITER
MUMPS				MUMPS SEROLOGY	DATE	TITER
HAEMOPHILUS B (HIB) **						
HEPATITIS B ***						
VARICELLA (Chicken Pox)						
INFLUENZA						
PNEUMOCOCCAL						
Mantoux Tuberculin Test – Date: Only as Required by State Law for Transfer Students						

Recommendations or restrictions concerning this student: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date of well child physical: \_\_\_\_\_

Physician's Stamp:

# Point Pleasant Borough Public Schools

- [ ] Point Pleasant Borough High School 830 Laura Herbert Drive, Point Pleasant, NJ 08742
- [ ] Memorial Middle School 808 Laura Herbert Drive, Point Pleasant, NJ 08742
- [ ] Nellie F. Bennett Elementary School 2000 Riviera Parkway, Point Pleasant, NJ 08742
- [ ] Ocean Road Elementary School 1210 Benedict Street, Point Pleasant, NJ 08742

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## AUTHORIZATION FOR RELEASE OF CUMULATIVE RECORDS

Name of Student: \_\_\_\_\_

Previous Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

The above student has enrolled in Point Pleasant Borough School District. Please forward the following student information to the school indicated above:

- **Immunization/Health Records** (originals if coming from within New Jersey required)
- **Transcript of Academic Records** (including grades to date of withdrawal)
- **Standardized Test Records** (including New Jersey HSPA if applicable)
- **Special Service Records** (may be mailed directly to our Child Study Team)
- **Discipline Records** (if the student has been involved in offenses involving weapons, alcohol or drugs, or willful affliction of injury to persons or an act of violence against persons and/or property committed on school premises, at school or school sponsored activity, please forward appropriate disciplinary documentation)
- **Confidential Records to Include:**
  - *All Special Education* components which include psychological, sociological, educational and medical/audiovisual evaluations
  - Up-to-date individualized educational program (IEP) with handicapping conditions specified

Previous School: \_\_\_\_\_

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

School Phone # \_\_\_\_\_ School Fax # \_\_\_\_\_

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I HEREBY GIVE MY PERMISSION FOR RELEASE OF THE ABOVE RECORDS.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student 18 or older: \_\_\_\_\_ Date: \_\_\_\_\_



