



# Orange Township Public Schools

Dr. Gerald Fitzhugh, II  
Superintendent of Schools



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Lisa Spottswood Brown  
District Registrar/Information Support Services Manager

## To All Persons Registering a Child:

Only **PARENTS OR LEGAL GUARDIANS** may register a student in the Orange Township Public School District. The following items must be provided to process a student's registration packet. At the time of registration, please present **ALL** of the following items:

### STUDENT'S INFORMATION

- Birth Certificate (must be copied and kept in DR file)
- New Jersey State ID (in-state transfers)
- Immunization Records
- Physical Examination dated with a year (not mandatory for enrollment)
- A Transfer Card
- Recent Report card and Test Scores
- Complete Transcript (high school students)
- Individual Educational Program (IEP) (if applicable)

### PARENT/GUARDIAN PROOF OF IDENTITY

- Current Driver's License, State ID, or Passport

### PROOF OF RESIDENCY

At the time of registration, you must present **ONE** of the following **primary** documents **PLUS TWO** of the following **secondary** documents. All documents must be **originals** dated within the last thirty (30) days:

#### Acceptable Primary Documents

- Contract of Purchase or Sale
- Tax bill
- Mortgage statement
- Current Lease
- Property Deed
- Water bill

#### Acceptable Secondary Documents

- Utility bill (must be in your legal name)
- Credit Card statement (must be current)
- Current Driver's license or Current Vehicle Insurance or Registration Card
- Current Paycheck stub
- State Benefit Statements or Public Assistance Documents
- Medical insurance bill
- Bank Statement
- Cable/Satellite bill

**ALL PARENTS NEEDING AN OWNER/LANDLORD AFFIDAVIT MUST REPORT TO THE DISTRICT REGISTRAR'S OFFICE.**

\*\*\*\*\*Please see special conditions that apply below\*\*\*\*\*

**PROOF OF RESIDENCY SPECIAL CONDITIONS:**

- If you **do not** have a lease and you and your child (ren) are residing with a friend or relative in a **private** home, the homeowner must provide proof of ownership. Additionally, the Owner/Landlord Affidavit Form must be completed by the homeowner. **Two** (2) additional proofs of residency from our secondary list of accepted documents must be provided by the parent/guardian of the child (ren) being registered.
- If you **do not** have a lease and you and your child (ren) are residing with a friend or relative in an apartment building, the Landlord or Managing Agency must complete the Owner/Landlord Affidavit Form **not the tenant renting the apartment.** **Two** (2) additional proofs of residency from our secondary list of accepted documents must be provided by the parent/guardian of the child(ren) being registered.

\*\*\*\*\* NOTE \*\*\*\*\*

For admission to kindergarten, a child must be five years of age **on or before** October 1<sup>st</sup>.

**Registration for Guardian Affidavit, DYFS and Court Placements:**

- DYFS Placement must submit court order or DYFS ID letter.
- For Guardianship and/or Legal Custody you must report to:

**Wilentz Justice Complex  
212 Washington Street 13<sup>th</sup> Floor Room 1365 Newark  
NJ 07102  
(973) 693-5560  
Hours of Operation 8AM – 4:30PM**

**Incomplete Registration Packets Will Not Be Accepted and May Delay Student's Enrollment**



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## STUDENT RESIDENCY

### THE DISTRICT RESERVES THE RIGHT TO CONDUCT RESIDENCY CHECKS

Students not legally domiciled in Orange Township are not entitled to a free education in the Orange Public School District.

Please be advised that enrollment in Orange Public Schools is permissible only for those children whose parent(s)/guardian(s) are residents of Orange. Pursuant to **N.J.A.C. 6A:22-4.1**, eligibility for admission to the Orange Public School District is subject to thorough review and evaluation and there is a potential for assessment of tuition in the event that an initially admitted student is later found ineligible for enrollment.

Furthermore, any resident who knowingly permits their name and/or address to be used in the registration of a non-resident student for the purpose of attending Orange Public Schools will be prosecuted to the fullest extent of the law and sued for the tuition for the period of ineligible attendance in the school district.

Residency checks are completed on students on a regular basis and may be conducted as early as 6:00am.

I attest to the best of my knowledge the residency information submitted is true and correct. I fully understand fraudulent statements, claims or documents will be prosecuted to the full extent of the law.

**Please sign below:**

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

# STUDENT INFORMATION FORM

**PLEASE COMPLETE ALL SECTIONS**

**(As it appears on the birth certificate)**

Last Name	First Name	Middle Name
Home Address	City, State, & Zip Code	Date Moved In
Previous Address	City, State, & Zip Code	Current Home Telephone Number
Date of Birth	City <u>and</u> State of Birth	Country of Birth
State Identification# (SID)	Gender: Female <input type="checkbox"/> Male <input type="checkbox"/>	

Ethnicity:  White  Asian  Black  Hispanic  Alaskan/Native  Amer. Indian  Pacific Islander

Entering Grade:  KF  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>  5<sup>th</sup>  6<sup>th</sup>  7<sup>th</sup>  8<sup>th</sup>  9<sup>th</sup>  10<sup>th</sup>  11<sup>th</sup>  12<sup>th</sup>

Language Spoken at home? \_\_\_\_\_

Student Is Living With:  Mother  Father  Legal Guardian  Other

School: <input type="checkbox"/> Rosa Parks Community School <input type="checkbox"/> Cleveland Street School <input type="checkbox"/> Forest Street School	<input type="checkbox"/> Heywood Avenue School <input type="checkbox"/> Lincoln Avenue School <input type="checkbox"/> Oakwood Avenue School	<input type="checkbox"/> Orange Preparatory Academy <input type="checkbox"/> Park Avenue School <input type="checkbox"/> Orange High School
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Previous School Information:

School Name	Location	Grade	From: _____ To: _____ Dates of Attendance
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**HAS THE STUDENT BEEN CLASSIFIED OR ENROLLED IN SPECIAL EDUCATION CLASSES?**  
 YES  NO

**HAS THE STUDENT BEEN RECEIVING ACCOMODATIONS THROUGH A 504 PLAN?**  
 YES  NO

**IS THE STUDENT COVERED BY HEALTH INSURANCE?**  YES  NO

**PLEASE LIST THE INSURANCE PROVIDER** \_\_\_\_\_

**I attest to the best of my knowledge the information listed above is true and correct. Fraudulent statements or claims may lead to prosecution to the fullest extent of the law.**

Signature of Person Completing this Application	Relationship to the Student	____/____/____ Date
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(FOR OFFICE USE ONLY) Entry Date ____/____/____	Student ID# _____
Staff Member Completing the Registration Packet	____/____/____ Signature Date

## MOTHER/LEGAL GUARDIAN

**PLEASE PRINT CLEARLY**

Last Name	First Name	Relationship to Student
Home Address	City, State, & Zip Code	Date Moved In
Home Telephone Number	Cell Telephone Number	Email Address
Date of Birth	City <u>and</u> State of Birth	Country of Birth
Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan/Native <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Pacific Islander		
Residency Information:		
<input type="checkbox"/> Homeowner  <input type="checkbox"/> Renter	<input type="checkbox"/> Single Family House  <input type="checkbox"/> Two Family House  <input type="checkbox"/> Apartment Building	<input type="checkbox"/> Multi-Dwelling House  <input type="checkbox"/> Apartment in a Private Home
Previous Address Information		
_____ City _____ State _____ Zip Code		
Employer	Occupation	Work Telephone Number
Work Address		
_____ City _____ State _____ Zip Code		

## FATHER/LEGAL GUARDIAN

Last Name	First Name	Relationship to Student
Home Address	City, State, & Zip Code	Date Moved In
Home Telephone Number	Cell Telephone Number	Email Address
Date of Birth	City <u>and</u> State of Birth	Country of Birth
Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan/Native <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Pacific Islander		
Residency Information:		
<input type="checkbox"/> Homeowner  <input type="checkbox"/> Renter	<input type="checkbox"/> Single Family House  <input type="checkbox"/> Two Family House  <input type="checkbox"/> Apartment Building	<input type="checkbox"/> Multi-Dwelling House  <input type="checkbox"/> Apartment in a Private Home
Previous Address Information		
_____ City _____ State _____ Zip Code		
Employer	Occupation	Work Telephone Number
Work Address		
_____ City _____ State _____ Zip Code		



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## REQUEST FOR PUPIL RECORDS

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

\_\_\_\_\_ **Name of Previous School**

\_\_\_\_\_ **Student's Name**

\_\_\_\_\_ **Date of Birth**

\_\_\_\_\_ **Grade**

Pursuant to the authority of **P.L. 2002, c63 (N.J.S.A. 18A:36-25.1)** and **section 1 of P.L. 1982, c. 79 (N.J.S.A. 2A:4A-60)**, the Orange Township Public School District request your assistance in providing any and all information and records you may have on the above named child. This request is being made pursuant to this student entering our school system.

**Please include the following:**

- \_\_\_\_\_ Official transcripts
- \_\_\_\_\_ Test results
- \_\_\_\_\_ Key to the district grading system
- \_\_\_\_\_ Health/Immunization records or medical reports
- \_\_\_\_\_ Attendance records/data
- \_\_\_\_\_ Disciplinary records including infractions imposed by your school district
- \_\_\_\_\_ Notification that the district has obtained information pursuant to N.J.S.A. 2A:4A-60 (i.e., charges of juvenile delinquency)
- \_\_\_\_\_ Special Education testing results and/or reports (IEP's, psychological reports, etc.)
- \_\_\_\_\_ Guardianship Papers if applicable

\_\_\_\_\_ **Staff Member Requesting Records**

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





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## HOME LANGUAGE SURVEY FORM

### Introduction

This survey is the first three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

### Student Information

Student's Name: \_\_\_\_\_ Student Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Entry into the U.S.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of Birth: \_\_\_\_\_

1. What was the first language used by the student? \_\_\_\_\_

2a. At home, does the student hear or use a language other than English more than half of the time?  Yes (Proceed to question 7.)  No (Proceed to question 4.)

2b. At home, does the student hear or use a language other than English more than half of the time?  
 Yes (Proceed to question 4.)  No (Proceed to question 3.)

3. Does the student understand a language other than English?  Yes (Proceed to question 4.)  No (Proceed to question 9.)

4. When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?  Yes (Proceed to question 7.)  No (Proceed to question 5.)

5. When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?  Yes  No

6. Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?  Yes  No

7. List home languages spoken below, then proceed to the records review process.

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



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## Student Health History

Female     Male

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

\_\_\_\_\_  
Student's Home Address

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Telephone #

Student Lives with:

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

Parent/Guardian (circle one)  
Address (omit if same as above)  
Phone Number

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

Parent/Guardian (circle one)  
Address (omit if same as above)  
Phone Number

\_\_\_\_\_  
Student's Physician

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Physician's City & State

Normal Pregnancy     Yes     No

Normal Infancy and Childhood     Yes     No

Place of Birth: \_\_\_\_\_

Birth Weight: \_\_\_\_\_

Length of Pregnancy: \_\_\_\_\_

- Allergies
- Food Allergies
- Asthma
- Diabetes
- Heart Murmurs
- Seizures
- Sickle Cell Disease
- Sickle Cell Trait

- Lead Poisoning
- Anemia
- Speech Impairment
- Tuberculosis
- Measles
- Mumps
- Whooping Cough
- Developmental Delays

- Urinary Tract Infections
- Kidney Problems
- Bladder Problems
- Speech Problems
- Hearing Problems
- Rheumatic Fever
- Chicken Pox
- Heart Problems

Please give more information about anything that was checked off:



**Please answer all of the following questions:**

Has your child ever been hospitalized?  Yes  No

If yes, when and why? \_\_\_\_\_

Does your child have any eye problems?  Yes  No

Does your child need/wear glasses?  Yes  No

Does your child see a dentist at least every six months?  Yes  No

Does your child have any dental problems?  Yes  No

Has your child ever had seizures?  Yes  No

Is your child taking medication regularly?  Yes  No

If so, what medication? \_\_\_\_\_  Yes  No

Does your child have frequent ear infections?  Yes  No

Is your child in good physical shape to participate in all school activities?  Yes  No

Any medical or dental concerns that may affect your child's educational experience?  Yes  No

History of concussion or serious head injury?  Yes  No

History of broken bones?  Yes  No

Has your child ever had any surgery?  Yes  No

If so, what was done? \_\_\_\_\_

Has your child ever had a hernia?  Yes  No

If so, what type? \_\_\_\_\_

Does your child have any physical impairment?  Yes  No

Please inform us of any medical, emotional, or dental concerns you would like to discuss: \_\_\_\_\_

**Family History**

Does either parent have any health problems?  Yes  No

If so, explain: \_\_\_\_\_

**Students are expected to have a physical exam completed (within the last 12 months) and given to the school nurse upon entrance to Orange Township Public Schools. Failure to comply within 30 days may result in your child being excluded by the building principal.**

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

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

**MUST BE COMPLETED BY THE SCHOOL NURSE ONLY:**

Grade: \_\_\_\_\_ Previous School: \_\_\_\_\_ State or Country: \_\_\_\_\_ Language: \_\_\_\_\_

PE Done: \_\_\_\_\_ Immunization UTD: \_\_\_\_\_ Provisional Status: \_\_\_\_\_ A45 Done: \_\_\_\_\_

PE Due: \_\_\_\_\_ Immunization Needed: \_\_\_\_\_ Medical Authorization Given: \_\_\_\_\_ VSP Given: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health

**SECTION I - TO BE COMPLETED BY PARENT(S)**

Child's Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER**

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)
	Height (must be taken within 30 days for WIC)
	Head Circumference (if <2 Years)
	Blood Pressure (if >3 Years)

<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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**MEDICAL CONDITIONS**

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

**PREVENTIVE HEALTH SCREENINGS**

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

*I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.*

Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	

# Instructions for Completing the Universal Child Health Record (CH-14)

## Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

## Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at [www.nj.gov/health/forms/ch-15.dot](http://www.nj.gov/health/forms/ch-15.dot) or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

*Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at [www.pacnj.org](http://www.pacnj.org) or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.