NEW STUDENT REGISTRATION

Welcome to Atlantic Highlands Elementary School. We are excited to welcome your child into our school community. Please complete all forms included in this packet to register your child.

INCLUDED FORMS

- ⬜ New Student Registration Demographic Information
- ⬜ Home Language Survey
- ⬜ Universal Health Record and Health History Form

ADDITIONAL DOCUMENTS REQUIRED

- ⬜ Copy of child's original birth certificate
- ⬜ Proof of residency

(mortgage statement, tax statement, current rental agreement,affidavit of residency)

- ⬜ Immunization record

When all forms and documents are completed, please return them to:

Atlantic Highlands Elementary School
140 First Avenue
Atlantic Highlands, NJ
07716
Phone: (732) 291-2020

If you have questions regarding the registration process, please contact the main office at (732) 291-2020 or email Amy Elia (aelia@ahes.k12.nj.us) and Kathleen Gallagher (kgallagher@ahes.k12.nj.us).

New Student Registration Demographic Information

Date: _____ (Please print)

Child's First Name: _____ Child's Middle Name: _____

Child's Last Name: _____ Gender: MALE or FEMALE

Child's Birthdate (MM/DD/YYYY): _____ City/State of Birth:

_____

Child's Age: _____ Grade entering: _____ Are you a military family? YES or NO

Ethnicity: ⬜White ⬜Black ⬜Hispanic/Latino ⬜Asian ⬜Pacific Islander

⬜Other:_____

Primary Language Spoken at home: _____

Secondary Language: _____

Home address:

_____

_____

Does your child have Medical Insurance?

⬜YES, Insurance Provider:

_____

⬜NO. Would you like your name and address released to the NJ Family Care Program?_____

CONTACT INFORMATION

Parent/Guardian #1 (First & Last Name): _____
Relationship to student: _____
Mobile Phone #: _____
Home Phone #: _____
Email address: _____

***Do you want this parent/contact to receive message broadcasts from the school?**
YES or NO

Parent/Guardian #2 (First & Last Name):

_____
Relationship to student: _____
Mobile Phone #: _____
Home Phone #: _____
Email address: _____

***Do you want this parent/contact to receive message broadcasts from the school? YES or NO**

Emergency Contact #1 (First & Last Name): _____
Relationship to student: _____
Mobile Phone #: _____
Home Phone #: _____
Email address: _____
***Does this contact have permission to pick up your child from school? YES or NO**

NOTE: Additional emergency contacts can be added in the Genesis Parent Portal at a later time.

New Student Registration Demographic Information

(Please print)

(For new Kindergarten students)
Did your child attend a preschool program? YES or NO
***If yes, for how many months/years?**

_____

Name/address of preschool:

_____

Did your child receive services through the NJ Early Intervention Program? YES or NO

(For other new students: Gr. 1 - 6)
Previous school's name, address & phone number:

_____

_____

_____

What grade levels did you child complete at this school:

_____

Was your child evaluated by the Child Study Team?

_____

Please check off any programs/services that your child had in their previous school:

- ⬜ **Special Education programs through an Individual Education Plan (IEP)**
- ⬜ **Speech Therapy** ⬜ **Occupational Therapy** ⬜ **Physical Therapy**
- ⬜ **Behavioral Support** ⬜ **Support from the School Counselor**
- ⬜ **504 Plan (medically based)** ⬜ **Nursing Support**
- ⬜ **Basic Skills Support Programming for ELA**
- ⬜ **Basic Skills Support Programming for Mathematics**
- ⬜ **Gifted & Talented (Enrichment) Programming**
- ⬜ **English as a Second Language support (ESL)**
- ⬜ **Free and Reduced Lunch Program**
- ⬜ **Band - Instrument? _____**

***Is the child's home equipped with the internet? YES or NO**

Additional comments:

_____

_____

_____

Parent/Guardian Signature: _____

Date: _____

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 (YYYYMMDD): _____

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**

Health Requirements for School

Physical Examination:

Each student entering school **must** have documentation of a physical exam done within one year prior to the date of entrance to school. This must be on a form provided for this purpose. The doctor must note what, if any, modifications are required for full participation in the school program.

Immunizations:

The following are the required immunizations for school attendance (N.J.A.C. 6A:16-2.2 and 8:57-4) **A copy of your child's most recent immunization record OR a copy of a Religious Exemption signed and dated must be submitted BEFORE AUGUST 30, 2023 in order for your child to be admitted into school.**

Preschool:

-DPT: a minimum of 4 doses
-POLIO: a minimum of 3 doses
-MMR: One dose given on or after 1st birthday
-VARICELLA: One dose given on or after the 1st birthday OR written documentation of having had chicken pox from physician or lab evidence of immunity is acceptable
-HEPATITIS B: 3 doses
-PNEUMOCOCCAL (PCV): One dose given on or after 1st birthday
-HIB: One dose given on or after 1st birthday
-INFLUENZA (FLU): One dose between September 1-December 31 of each year for ages 6-59 months. **Students who do not receive the flu vaccine, or have documentation for non-vaccination, by December 31 will be excluded from school until proof of vaccination is received.**

Kindergarten Immunization Requirements are:

-DPT: a minimum of 4 doses, one dose **must** be after the 4th birthday**,** or any 5 doses
-POLIO: a minimum of 3 doses, one dose **must be** after the 4th birthday, or any 4 doses
-MMR: 2 doses with first dose on or after 1st birthday, lab evidence of immunity is acceptable
-VARICELLA: One dose on or after 1st birthday or written documentation of having chicken pox from physician or lab evidence of immunity is acceptable
-HEPATITIS B: 3 doses

**** Please contact Nurse Daria Del Prete with any questions related to health requirements for school at 732-291-2020 ext. 1106 or ddelprete@ahes.k12.nj.us****

Atlantic Highlands Elementary School

HEALTH HISTORY FORM

Student's Name_____Birth Date:_____Sex:_____
Address_____ Telephone_____

Doctor's Name_____ Telephone_____
Address_____

Guardian 1 Name & Phone#_____
Guardian 2 Name & Phone #_____

IMMUNIZATIONS: Please attach a copy of your child's updated immunization record from their primary care physician.

Health History Questionnaire:
Does your child have any ongoing or chronic illness?_____
_____
_____
Does your child wear glasses or use a hearing aid?_____
Has your child had any recent injuries?_____
Has your child had surgery?_____
Does your child take any prescribed medications?_____
_____
_____
Does your child have any allergies or asthma?
_____
_____
Does your child have a life threatening allergy that may require the administration of an epinephrine auto-injector?_____

*****If your child carries an epinephrine auto-injector (such as EPIPEN), please contact the school nurse as soon as possible to discuss the care of your child during the school year.*****

Has your child had:

Anxiety/nervousness	_____	Frequent headaches	_____
Bleeding issues	_____	Diabetes	_____
Frequent ear infections	_____	Seizures	_____
Frequent sore throats	_____	Gastrointestinal issues	_____

Are there any other health conditions that we should be aware of?_____
_____

Parent signature:_____Date:_____

732-291-2020 732-872-9117 (fax)
140 FIRST AVENUE ATLANTIC HIGHLANDS, NJ 07716 www.ahes.k12.nj.us

APPENDIX H

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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐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 give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		This form may be released to WIC. ☐Yes ☐No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER		
Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐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)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

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

CH-14 OCT 17 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

732-291-2020 732-872-9117 (fax)
140 FIRST AVENUE ATLANTIC HIGHLANDS, NJ 07716 www.ahes.k12.nj.us