VERONA PUBLIC SCHOOL

121 FAIRVIEW AVENUE, VERONA, NEW JERSEY 07044
973-571-2029

Kindergarten Round Up

Please bring completed School Registration form, along with the following documentation to your home school during round up week (January 10-14, 2022) between the hours of 7:45 am – 3:45 pm. or scan to your home school during round up week.
Your child must be 5 years of age on or before 10/1/2022 to enroll in kindergarten for the 2022-23 school year.

1) An **original** birth certificate (copy will be made)

2) Primary Proof of Residency in Verona:
   - Renting: signed, non- expired lease
   - Homeowner: current mortgage statement, property tax bill, deed or HUD settlement statement

3) Secondary Proof of Residency
   - Current utility bill, insurance bill

4) Parent/Guardian Proof of identity
   - Driver's license or passport

PLEASE DO NOT SUBMIT REGISTRATION PACKET UNTIL ALL ITEMS ARE COMPLETE.

Verona Public Schools, Office of the Superintendent

121 Fairview Avenue
PHONE 973-571-2029
Dr. Lydia E. Furnari lfurnari@veronaschools.org
Superintendent of Schools
www.veronaschools.org

Verona, New Jersey 07044
FAX 973-571-6779
Jorge Cruz
Business Administrator/Board Secretary

KINDERGARTEN ROUND-UP FOR SEPTEMBER 2022

Dear Incoming Kindergarten Parents:

The Verona Public Schools offer a kindergarten program for all youngsters who are five years of age on or before October 1, 2022. This program is designed as a child's first introduction to public school. A full academic curriculum—including media skills, formal art, music, and physical education is offered during the school day. Kindergarten is also a time for students to form new friendships, to work cooperatively in groups, and to learn fundamental academic skills.

The kindergarten session runs from 8:30 am to 2:45 pm. The Montclair YMCA offers an aftercare program between 2:45 and 6:00 pm. Information about this program is available from Rob Casale at 973-415-6117 or rcasale@montclairymca.org.

We will be conducting Kindergarten Round-Up January 10th through the 14th. The purpose of Round-Up is to identify students eligible for September's class and to begin the formal registration process. Please download this enrollment packet along with the information on documents required to register. Please complete the enrollment form during Round-Up week and scan to or drop off at your home school along with **all required registration materials**, by Friday January 14th. School offices are open from 7:45 am- 3:45 pm Monday -Friday. Submit all materials (excluding medical) at the same time. A list of the fax numbers and email addresses for scanning are listed below.

A physical exam is required for all students entering Verona Public Schools for the first time (Preschool, Kindergarten and students who transfer into the district). The **Universal Child Health Record** (included in the downloaded forms) along with a copy of the most recent **Immunizations** must be submitted to the school nurse. Physical exams that were performed by a healthcare provider between Sept. 2, 2021 and Sept. 2, 2022 will be acceptable. All current immunization records must be received by 6/2/2022. Copies of immunizations from your child's patient portal are acceptable.

Please note that parents of children attending the Verona Preschool Program should register their child in the child's neighborhood school and complete the screening process in that school. If your child receives special education services their information will be subsequently forwarded to the appropriate school, as per his or her IEP.

The importance of completing early registration cannot be stressed enough. The formation of kindergarten classes and orientation meetings require an accurate forecast of student numbers. In the interest of balancing class sizes across the district, parents may request to send their child to one of the three other elementary schools. Should this be the case, parents should send a written request to the Office of the Superintendent as soon as possible. Requests of this nature will be decided in April or May of 2022. If the enrollment of the requested school becomes too high, the decision may be reversed. If you know of someone whose child is eligible for kindergarten, please pass on this information.

Please mark your calendars for the following important events:

Kindergarten Parent Orientation Dates

Brookdale	FN Brown	Forest	Laning
5/12/22-6:30 PM	**3/24/22-7:00 pm**	**3/24/22—7:00 PM**	**3/23/22- 7:00 PM**

Principals, teachers and other staff will offer you an overview of the kindergarten program. This orientation may be virtual depending on current restrictions.

We have traditionally offered monthly Saturday morning Pre-Kindergarten experiences beginning in February. This is organized by the SCA in each school. Due to COVID restrictions we are unable to confirm if these will be held. We will keep you informed as decisions are made.

Thank you for your timely attention to these requests. Our principals and teachers look forward to meeting and working with you to help prepare your child for a positive school experience.

Very truly yours,

Dr. Lydia E Furnari
Interim Superintendent of Schools

Brookdale Ave. School
email: ddenotaris@veronaschools.org
fax: 973-571-6768

FN Brown School
email: tbarrett@veronaschools.org
fax: 973-571-6769

Forest Ave. School
email: dlawrence@veronaschools.org
fax: 973-571-6770

Laning Ave. School
email: swilliamson@veronaschools.org
fax: 973-571-6764

Acceptable documents for proof of residency:
ONE FROM EACH LIST

Proof of domicile
Current lease
Deed
Property Tax Bill

Proof of attachment to address
utility bill
telephone bill
cable bill
driver's license

VERONA PUBLIC SCHOOLS

SCHOOL REGISTRATION

School_____ Grade_____ Entry Date _____ Student ID #_____

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Nickname: _____ Student Email (Grades 6-12):_____ Gender: M ☐ F ☐

Home Address: _____

If Renting, Date Lease Expires: _____ Home Telephone: ( )_____

Ethnicity(***must check one***): Hispanic ☐ Non-Hispanic ☐

Race (***must check at least one, or all that apply***): White ☐ Black/African American ☐ Asian ☐

Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐

Date of Birth: _____ City, State, Country of Birth: _____

Home Language Information

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

   _____

2. Was the first language used by the student a language other than English: Yes ☐ No ☐
3. Does the student speak or understand a language other than English: Yes ☐ No ☐

If student was born outside of the US, please provide the following information:

US School Entry Date _____

Names, Dates and Grades of Previous Schools of Attendance (including Pre-K):

School and Address	Grades Attended	First Date of Enrollment	Last Date of Enrollment	Public or Private

NJ State ID# (if transferring from another NJ Public School: _____

Is the student's legal parent/guardian name(s) on the deed, mortgage, or lease: __ Yes __ No

Move in date? _____ How long do you plan on living at this residence? _____

Previous address: _____

How long did you reside at the previous address? _____

Last school attended: _____ City: _____ State:_____

FAMILY INFORMATION

#1 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parents ☐ Guardian* ☐ Affidavit ☐ Other ☐

Last Name: _____ First Name: _____ Middle Name: _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: ( )_____ Business Phone: ( )_____ Occupation:_____

Employer Name/Address: _____

#2 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parents ☐ Guardian* ☐ Affidavit ☐ Other ☐

Last Name: _____ First Name: _____ Middle Name: _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: ( )_____ Business Phone: ( )_____ Occupation:_____

Employer Name/Address: _____

#3 - Non-Custodial Parent **No Contact Allowed:** ☐ **Receives Extra Mailings** ☐

Relationship to Student: Mother ☐ Father ☐ Parents ☐ Guardian * ☐ Affidavit ☐ Other ☐

Last Name: _____ First Name: _____ Middle Name: _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: ( )_____ Business Phone: ( )_____ Occupation:_____

Employer Name/Address: _____

#4 - Student Resides at More than One Address:

Relationship to Student: Mother ☐ Father ☐ Parents ☐ Guardian * ☐ Affidavit ☐ Other ☐

Last Name: _____ First Name: _____ Middle Name: _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: ( )_____ Business Phone: ( )_____ Occupation:_____

Employer Name/Address: _____

*If checked, guardianship papers must be produced for examination

Please answer ALL of the following questions:

Is the student's home address a temporary living arrangement? ____Yes ____No

Is this a temporary living arrangement due to loss of housing or economic hardship? ___Yes ___No

Is this student in temporary or emergency foster care placement? ___Yes ___No

Is this student not living with a parent or legal guardian? ___Yes ___No

FAMILY INFORMATION (continued)

Where is the student currently living?

- ☐ With more than one family in a house or apartment
- ☐ Temporary/emergency foster home
- ☐ In a motel/hotel - Name of motel/hotel: _____
- ☐ Transitional Housing - Name of transitional housing: _____
- ☐ Group Home - Name of group home: _____
- ☐ Moving from place to place or a location not designed for sleeping accommodations (example: car, park, or campsite

SIBLING INFORMATION

Name	Birthdate	Grade	Gender	Relationship	School	Resides w/ Student

EMERGENCY INFORMATION

In case of an emergency or early dismissal the parent/guardians will be contacted. Please list the individuals to whom the school may entrust your child if parent/guardians aqr unreachable. **DO NOT** list a parent or guardian as Emergency Contact. **No student shall be released from school unless accompanied by an adult designated by the parent.**

Please check if your child may ONLY be released to parent: ☐

Contact Name (Not parent/guardian)	Relationship	Address	Home Phone	Work Phone	Cell Phone
1					
2					
3					

PHYSICIAN/INSURANCE INFORMATION

My child's medical care is provided by: _____ _____

(name of Doctor, Clinic, or HMO) (Telephone)

My child has Health Insurance: Yes ☐ No ☐

If **Yes**, *pleased provide name of Insurance Company*: _____

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

Parent/Guardian Signature: _____ Date: _____

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	

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 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 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 heath 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.