VERONA PUBLIC SCHOOLS

121 FAIRVIEW AVENUE, VERONA, NEW JERSEY 07044

973-571-2029

Middle School and High School
Registration Packet

1. School Registration Form – Student / Family / Emergency Information
2. New Jersey Department of Education Annual Athletic Pre-participation Physical Examination Form/ Immunization Record
3. Official Records Request Form – Transfer Card

In addition to the Registration Packet please provide the following documentation:

☐ Primary Proof of Residency in Verona

- Renting: Signed non-expired lease
- Homeowner: Current mortgage statement, property tax bill, deed, or HUD settlement statement

☐ Secondary Proof of Residency

- Current utility bill, insurance bill

☐ Proof of Age: An **original** certified copy of the child's birth certificate or other proof of the child's identity such as a passport must be presented at the time of registration or within 30 days of registration (pursuant to 18A:36-25.1)

☐ Parent/Guardian ID as Proof of Identity (driver's license or passport)

☐ Current school transcript/school report card

☐ Custodial documentation, if applicable

DO NOT SUBMIT REGISTRATION PACKET UNTIL ALL ITEMS ARE COMPLETE.

VERONA PUBLIC SCHOOLS

SCHOOL REGISTRATION

School______________________________________Grade_________Entry Date___________Student ID # ___________________

STUDENT INFORMATION

Last Name:___________________________________First Name:___________________________Middle Name: _______________

Nickname:____________________________________ Gender: ☐ Female ☐ Male ☐ Non/Binary/Undesignated

Home Address: ____

Date of Birth:____________________City, State, Country of Birth: _________________

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

☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Race (***must check at least one, or all that apply***):

☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native

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
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? ☐ Yes ☐ No
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? ☐ Yes ☐ No
6. If the student was born outside of the US, when did they begin attending a US school? ______________________

Names, Dates and Grades of Previous Schools of Attendance (including Pre-K): Please list most recent school first			
School and Address	Grades attended	First Date of Enrollment	Last Date of Enrollment
☐ Public ☐ Private			
☐ Public ☐ Private			
☐ Public ☐ Private			
☐ Public ☐ Private			
☐ Public ☐ Private			
☐ Public ☐ Private			

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

FAMILY INFORMATION

1 - Home Where the Student Lives

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

Last Name:____________________First Name:____________________Middle Name:____________

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

Cell Phone: (   )__________ Business Phone: (   )__________ Occupation:__________

Home Address: ____________________

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

Last Name:____________________First Name:____________________Middle Name:____________

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

Cell Phone: (   )__________ Business Phone: (   )__________ Occupation:__________

***If checked, guardianship papers or affidavit must be produced for examination**

2 - Non-custodial Parent ☐ No Contact Allowed** ☐ Receives Extra Mailings

Relationship to Student: ☐ Mother ☐ Father ☐ Other

Last Name:____________________First Name:____________________Middle Name:____________

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

Cell Phone: (   )__________ Business Phone: (   )__________ Occupation:__________

Home Address: ____________________

****If no contact is checked, legal paperwork must be produced for examination**

3 - Student resides at more than one address ☐ Yes ☐ No ☐ Receives Extra Mailings

Relationship to Student: ☐ Mother ☐ Father ☐ Other

Last Name:____________________First Name:____________________Middle Name:____________

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

Cell Phone: (   )__________ Business Phone: (   )__________ Occupation: __________

Home Address: ____________________

Sibling Information

Name	Birthdate	Grade	Gender	School	Residing with Student? (Y/ N)

ADDITIONAL INFORMATION

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

Is the student's home address a temporary living arrangement? ☐ Yes ☐ No

If this is a temporary living arrangement, is it due to loss of housing/economic hardship? ☐ Yes ☐ No

Is the student in a temporary or emergency foster care placement? ☐ Yes ☐ No

Is the student living with someone other than a parent or legal guardian? ☐ Yes ☐ No

Is the student currently living

- ☐ with more than one family in a house or apartment?
- ☐ in a temporary/emergency foster home?
- ☐ in a motel/hotel? Name of motel/hotel: ____________________
- ☐ in transitional housing? Name of transitional housing: ____________________
- ☐ in a group home? Name of group home: ____________________
- ☐ moving from place to place or location not designed for sleeping accommodations (car, office, park, etc.)

Emergency Information

In the 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 are 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.

☐ ***This student may ONLY be released to parent/guardian.***

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

VERONA PUBLIC SCHOOLS
Verona, New Jersey

OFFICIAL RECORDS REQUEST FORM FOR STUDENTS TRANSFERRING INTO VERONA PUBLIC SCHOOLS

Please Print

Student Information

Last Name	First Name	Middle Name
Street City State Zip		Date of Birth
Place of Birth [City, State, Country]	Languages Spoken at Home	

Previous School

Name of School ☐ Public ☐ Private

Address [Street, City, State, Zip]

Telephone Fax

Last Date of Attendance Last Grade Attended

NJ State ID# (if transferring from a Public School in NJ)

Entering School – Send Info to:

☐ **Brookdale Avenue School**, 14 Brookdale Crt., Verona, NJ 07044

☐ **FN Brown School**, 125 Grove Ave., Verona, NJ 07044

☐ **Forest Avenue School**, 118 Forest Ave., Verona, NJ 07044

☐ **Laning Avenue School**, 18 Lanning Ave., Verona, NJ 07044

☐ **HB Whitehorne Middle School**, 600 Bloomfield Ave., Verona, NJ 07044

☐ **Verona High School**, 151 Fairview Ave., Verona, NJ 07044

Records to Be Released

District Assessments	Is the student in an ESL or Bilingual Program? ☐ Yes ☐ No
State Assessments	Has the student ever been referred for a 504? ☐ Yes ☐ No Has the student ever received intervention or supplemental services? ☐ Yes ☐ No
Special Education Records	Has the student ever been referred for Special Education? ☐ Yes ☐ No If yes, please indicate the specific classification, if any:

Comments

Office Use Only

Requested By	Requested Date	Received By	Received Date

I hereby give my permission for release of the above records and for the school district to contact my child's former district for further information.*

Signature of Parent/Legal Guardian(circle one) Signature of Student (18 or above) Date

*Parental permission is no longer required when records are requested by authorized school personnel. (Family Education Rights and Privacy Act, Final Rule on Educational Records. Federal Register, June 17, 1976, Vol.41, No. 118, page 24673). The prior District may also release the following mandated records: transcript of grades, health records, attendance records, child study team records and disciplinary records pursuant to N.J.A.C. 6:3-6.5

***Please submit a current copy of your child's immunizations along with the New Jersey Department of Education Annual Athletic Pre-participation Physical Examination Form which should be completed by your healthcare provider.**

IMMUNIZATION RECORD INFORMATION

All of the required information must be submitted prior to the first day of school (or starting date). A student can be refused entry until all requirements are met. If registering in the spring for the next school year, the forms are due June 15. If registering during the summer for September entrance, the forms are due prior to September 1. If registering for the current school year, the immunization record and New Jersey Department of Education Annual Athletic Pre-participation Physical Examination Form are due before entrance. The physical exam form is due within 30 days of entrance. Exceptions may be granted only for religious beliefs or medical recommendations.

We have provided you with the form. This exam must have been performed within 365 days prior to the first day of school (or starting date) and must state what, if any, modifications are required for full participation in the school program. Dental, hearing and eye examinations are also recommended, but not mandatory. A record of the student's medical history, physical and emotional make-up may be very helpful in handling and teaching the student should problems subsequently develop. Families who do not have a personal physician or access to medical care should discuss this with the school nurse.

In addition to the requirements noted above, TB (Mantoux Testing) may be required for a select group of foreign born students and/or students transferring from a high TB incidence country into the Verona Public Schools. Please consult your school nurse for details.

Immunization Requirements for Children Entering Kindergarten & Higher Grades:
Please view the immunization requirements at:
https://nj.gov/health/cd/documents/imm_requirements/k12_parents.pdf

DTaP (Diphtheria and Tetanus Toxoids and Pertussis Vaccine)
Age 5-6 years: A minimum of four (4) doses of DTaP are required. One dose must have been administered on or after the fourth birthday or any five (5) doses.
Age 7-9 years: A minimum of three (3) doses of Td or any previously administered combination of DTP, DTaP and DT to equal three (3) doses.

Tdap (Tetanus and Diphtheria Toxoids and Acellular Pertussis Vaccine)
One (1) dose for students entering Grade 6, or comparable age level for special education programs.

OPV (Oral Poliovirus Vaccine) or IPV (Inactivated Polio Vaccine)
Age 5-6 years: A minimum of three (3) doses of poliovirus vaccine is required, providing one dose is given on or after the fourth birthday, or any four (4) doses.
Age 7 and older: Any three (3) doses

MMR (Measles, Mumps, Rubella)
Administered after the first birthday:
Two (2) doses of a live Measles-containing vaccine One (1) dose of live Mumps-containing vaccine One (1) dose of live Rubella-containing vaccine

Hepatitis B Vaccine
Three (3) doses are required.

Varicella Vaccine
One (1) dose administered on or after the first birthday for children born after 1/1/1998

PCV (Pneumococcal Conjugate)
Two (2) doses - Ages 2–11 months One (1) dose - Ages 12-59 months

Meningococcal
One (1) dose for students entering Grade 6, or comparable age level for special education programs

HIB (Haemophilus Influenza Type B)
One (1) dose annually - Ages 12 months to 59 Months

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keepa copy of this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ________ Grade __________ School ____________________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

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____

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____

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____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________ Signature of parent/guardian ______________ Date ______

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HE0503

9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ________ Grade __________ School ____________________ Sport(s) ____________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) ______________ Date of exam ________

Address ______________________________ Phone ____________

Signature of physician, APN, PA ______________________________

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

  Reason ______________________________

Recommendations ______________________________

____

____

____

____

____

EMERGENCY INFORMATION

Allergies ______________________________

____

____

____

____

____

Other information ______________________________

____

____

____

____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ______________________________
(Date)

Approved ______ Not Approved ______

Signature: ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ______________________________ Date __________

Address ______________________________ Phone __________

Signature of physician, APN, PA ______________________________

Completed Cardiac Assessment Professional Development Module

Date ______________ Signature ______________________________

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