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

Middle School/High School

Registration Packet

1. School Registration Form – Student / Family / Emergency Information
2. Physical Examination & Immunization Requirements
3. NJ DOE Annual Athletic Pre-Participation Physical
4. Immunization Record
5. 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** birth certificate must be presented at the time of registration

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

☐ Current school transcript/school report card

☐ Custodial documentation, if applicable

PLEASE 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:_____Student Email (Grades 6-12):_____Gender: M ☐ F ☐

Home Address [Street] _____

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 ☐ _____

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 ☐ Parent ☐ ☐
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 ☐ Parent ☐ ☐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

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

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

Last Name:_____First Name:_____Middle Name:_____
Home Address [Street]:_____[City, State, Zip] _____
Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____
Home Phone: ( )_____Cell Phone: ( )_____Business Phone:( )_____
Employer/Address:_____Occupation: _____

4 – Student Resides at More than One Address: ☐ **Receives Extra Mailing:** ☐

Relationship to Student: Mother☐ Father ☐Parent ☐ Guardian *☐ Affidavit ☐ Other☐
_____ Last Name:_____First Name:_____
Middle Name: _____
Home Address [Street]:_____[City, State, Zip] _____
Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____
Home Phone: (____)_____Cell Phone: (____)_____Business Phone:(____)_____
Employer/Address:_____Occupation: _____

Please answer ALL of the following questions:

Is this 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 the 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 INFOR MATION

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.

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 /IN S URA NCE INFOR M A TIO N

My child's medical care is provided by: _____ _____
(name of Doctor, Clinic, or HMO) (Telephone)

My child has Health Insurance: Yes ☐ No ☐
*If **Yes**, please 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:

must be produced for examination

_____

School Official Signature:

_____

* If checked, guardianship papers

Date:_____ Date: ___

VERONA PUBLIC SCHOOLS

VERONA, New Jersey

PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

Kindergarten – Grades 12

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 health history 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.

All students entering Kindergarten in the State of New Jersey must have documentation of a completed physical examination by their personal physician before entering the school district. 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:

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

HPV (Human Papillomavirus Vaccine) - Optional

Administer to females, minimum age 9 years, and ages 13 to 18 if not previously vaccinated
1st dose – Age 11 or 12 years
2nd dose - 2 months after first dose
3rd dose - 6 months after first dose (at least 24 weeks after 1st dose)

HIB (Haemophilus Influenza Type B)

One (1) dose annually - Ages 12 months to 59 Months

■ 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 keep a 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.

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?		

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?		

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 _____

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

_____

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

■ 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_____

Address _____ Phone _____

Signature of physician, APN, PA _____

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

■ 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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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
_____

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

VERONA PUBLIC SCHOOLS

Verona, New Jersey

State of New Jersey

IMMUNIZATION RECORD

Kindergarten – Grades 12

		Immunization Registry Number
Name of Child (Last, First, M.I.)	**Date of Birth (Mo/Day/Yr)**	**Sex** ☐ Male ☐ Female
Parent/Guardian	**Name**	
	Address	**Telephone No.**

TO BE COMPLETED BY HEALTH CARE PROVIDER

DISEASE	**1st Dose Mo/Day/Yr**	**2nd Dose Mo/Day/Yr**	**3rd Dose Mo/Day/Yr**	**4th Dose Mo/Day/Yr**	**5th Dose Mo/Day/Yr**			
DTaP (DIPHTHERIA, TETANUS, PERTUSSIS) or any combination **If Td or DT, indicate in box*	/_____/	/_____/	/_____/	/_____/	/_____/			
Tdap (TETANUS, DIPHTHERIA TOXOIDS, ACELLULAR PERTUSSIS)								
IPV (INACTIVATED POLIOVIRUS) OR OPV (ORAL POLIOVIRUS) *If IPV or OPV, indicate in box*	/_____/	/_____/	/_____/	/_____/	/_____/			
MMR (MEASLES, MUMPS, RUBELLA)								
HEPATITIS B								
VARICELLA								
PCV (PNEUMOCOCCAL CONJUGATE)								
MENINGOCOCCAL								
HPV (HUMAN PAPILLOMAVIRUS)								
HIB (HAEMOPHILUS INFLUENZA TYPE B)								

Lead Screening	
Test Date	**Result**

Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Hepatitis B	**Date:**	**Titer:**
Varicella	**Date:**	**Titer:**
Measles	**Date:**	**Titer:**
Mumps	**Date:**	**Titer:**
Rubella	**Date:**	**Titer**
Flue Vaccine For Preschool	**Date: By December 31st.**	

☐ **Provisional Admission Attached-Date Granted:** _____

☐ **Medical Exemption Attached**

☐ **Religious Exemption Attached**

VERONA PUBLIC SCHOOLS

Verona, New Jersey

Please Print

OFFICIAL RECORDS REQUEST FORM
TRANSFER CARD

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 student in an ESL or Bilingual Program? Yes No
State Assessments	Has student ever been referred for a 504? Yes No Has student ever received intervention or supplemental services? Yes No
Special Education Records	Has 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