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

Elementary School

Registration Packet

1. School Registration Form – Student / Family / Emergency Information
2. Physical Examination & Immunization Requirements
3. Immunization Record
4. 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 or passport 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: _____

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

US School Entry Date:_____

1st Language Spoken:_____Primary Language Spoken at Home: _____

Proficient in English: Yes ☐ No ☐ All Languages Spoken: _____

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):_____

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

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FAMILY INFORMATION (CONTINUED) FOR:

 # 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: _____

SIBLING INFORMATION

Name	Birthdate	Grade	Gender	Relationship	School	Resides w/Student

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.

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**, 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: _____ Date: _____

School Official Signature: _____ Date: _____

* If checked, guardianship papers must be produced for examination

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

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.

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	

VERONA PUBLIC SCHOOLS
Verona, New Jersey

State of New Jersey
IMMUNIZATION RECORD
Kindergarten – Grades 12

Name of Child (Last, First, M.I.)		Immunization Registry Number	
		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:
Flu Vaccine For Preschool	Date: By December 31st	

☐ Provisional Admission Attached-Date Granted: _____

☐ Medical Exemption Attached

☐ Religious Exemption Attached

VERONA PUBLIC SCHOOLS
Verona, New Jersey

OFFICIAL RECORDS REQUEST FORM
TRANSFER CARD

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 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