Alpha Public School
Student Registration Form

Date: _____/_____/_____ Grade/Teacher: _____

STUDENT INFORMATION:

_____
Full Legal Name: (Last, First, Middle)

_____
Current Address: (Number/Street, City, State, Zip)

_____ _____ _____
Gender (M/F) Home Telephone Cell Telephone

_____/_____/_____ _____
Date of Birth Place of Birth (City, State, County, Country)

_____
Name of Previous School Address (City, State, Zip) Phone

Ethnic Data: (Please check the category that best describes your child.)
/_____/ White /_____/ Hispanic/Latino /_____/ Black/African American
/_____/ Asian /_____/ American Indian/Alaska Native /_____/ Native Hawaiian/Pacific Islander

Is English the primary language spoken at home? _____ Yes _____ No

If no, please print the language(s) spoken: _____

_____ _____
Student Resides With - Name(s) of Parent/Guardian Relationship to Student

All Other Members of Household	Relationship to Student	Birthdate	Grade in School

PARENT INFORMATION:

Mother: Contact: 1st _____ 2nd _____ (Choose one)

_____ _____
Mother (Last Name, First Name) Home Phone

_____ _____
Mother's Address: (Number/Street, City, State, Zip) Cell Phone

_____
Email Address

_____ _____ _____

Employer's Name Occupation Work Phone

Father: Contact: 1st _____ 2nd _____ (Choose one)

_____ _____
Father (Last Name, First Name) Home Phone

_____ _____
Father's Address: (Number/Street, City, State, Zip) Cell Phone

_____
Email Address

_____ _____ _____
Employer's Name Occupation Work Phone

Please answer the following questions. If you answer Yes to any of these questions, please provide documentation.

1) Is student in Foster Care or in a court placement?

_____No _____Yes (If yes, please provide further information/documentation.)

2) Parents status: ____ Never Married ____Married ____ Separated ____ Divorced

- Is there a Court Custody Agreement or any Legal Documents regarding this student?

_____No _____Yes (If yes, please provide further information/documentation.)

3) Is there a guardianship agreement?

_____No _____Yes (If yes, please provide further information/documentation.)

4) Is the student currently receiving or received Special Education Services or been eligible under Section 504?

_____No _____Yes (_____ 504 / _____ SE - Classification, description of handicap currently or previously)

_____

_____

5) Does the child have any chronic medical problems, special needs or handicapping conditions?

_____No _____Yes (Please explain) _____

_____

6) What kind of health insurance does the child have? (Please check one.)

_____ Private or employment based health insurance
_____ Medicaid
_____ NJ FamilyCare
_____ Other health insurance: _____ _____ Uninsured

RESIDENCY:

Please be advised that I, the parent(s)/guardian(s) of _____,
(Print Student's Name)
entering grade _____, would like to register my child with the Alpha Public School District. I certify that I am domiciled in the Town of Alpha, New Jersey, and that the requested information and/or documentation provided herein is true and accurate. I further certify that to determine a student's eligibility for enrollment in the District, the Alpha Board of Education has the right to request documentation of domicile, residency, or affidavit of student status.

I further certify that if information/documentation of residency is falsely represented to the Alpha School District, legal action may be taken against me for payment of full tuition (back to the start date of the student's attendance in our district) together with Attorney's fees that may be incurred by the District.

I understand that I am responsible for full tuition payment to the Alpha Public School District if I am not domiciled in the Borough of Alpha, New Jersey. I affirm that all the information provided on this registration form is true and accurate. I also understand that if my residency status changes during my child's enrollment in the Alpha School District, it is my responsibility to notify the district immediately.

Name (printed): _____

Signature: _____ Date: _____

If you are residing with someone in Alpha please answer the following questions. A separate form will need to be completed by resident.

1) Is the student's home address a ___ temporary or ___ permanent living arrangement?
2) Is this a living arrangement due to loss of housing or economic hardship? ___ Yes ___ No

To finalize any new Student Registration, Alpha Public School requires **three** proofs of residency. **We will also need a copy of your child's Birth Certificate.**

We require one document from each category below:

Category A-

- Driver's License or Non- driver Photo Identification Card from NJ Division of Motor Vehicles with your current address

Category B-

- The most recent real estate tax bill for your residence showing you as the taxpayer
- A signed lease or deed for your residence
- A closing statement for the purchase of residence
- A Notarized affidavit from you and the owner of the residence stating that you reside at the residence on a full-time basis. Affidavits are available in the school office

Category C-

- Gas, electric or water bill dated within 3 months
- Home/apartment Insurance Certificate
- First class mail/letter from state or federal agency dated within the past 3 months
- Bank statement dated within the past 60 days

If you have any questions or concerns, please contact the main office at 908-454-5000 ext. 200, or bascolese@apsedu.org. Forms may be dropped off to the office, mailed to the school with the attention to Bethany Ascolese or emailed to bascolese@apsedu.org.

Residency within Alpha Public School

Please indicate if any of the following apply:

_____ The student is currently receiving special education services. **A copy of the current IEP must be provided.**

_____

Classification **Case Manager** **Telephone**

_____ The student has qualified under section 504 of the Rehabilitation Act.

_____ The student is sharing the housing of others due to the loss of housing or economic hardship.

_____ The student as been placed in the home of a district resident other than the parent or guardian by court order. **(You will be required to provide a copy of the order.)**

_____ The student as been placed in the district by the Department of Children and Families acting as the student's guardian.

_____

Name of Agency **Caseworker** **Telephone** **Date of Placement**

_____ The student is a child of a parent or guardian who is a member of the New Jersey National Guard or the United States Reserves ordered to active service in time of war or national emergency.

_____

Branch **Base Assigned** **State**

Residency:

Please indicate the section on the following pages that you will be completing according to the situation that best describes student's residency circumstances.

_____ Complete Section A (Domicile) if your permanent home is in Alpha.

_____ Complete Section B (Temporary Resident) if the parents/guardian is staying with a resident of Alpha.

_____ Complete Section C (Affidavit Student) if the student is living with someone other than parent/guardian.

In the case of divorce, separation, or one parent:

Does the student reside with one parent for the entire year? If so, with which parent and what address? _____

_____

Is there a court order or written agreement between the parents designating the district for the school attendance, and if so, where does it require the student to attend school? **(You must provide a copy of the order.)**

If not, for what portion of the time does the student reside with each parent and at what addresses? _____

_____

If the student lives with both parents on an equal-time, alternating week/month or other similar basis, with which parent did the student reside on the last school day prior to October 16th preceding the date of this application?

_____

******** PLEASE SEE REVERSE SIDE ********

ALPHA PUBLIC SCHOOL

817 North Boulevard
Alpha, New Jersey 08865
Telephone: (908) 454-5000 Fax: (908) 454-4347
www.apsedu.org

Mr. Seth Cohen
Chief School Administrator

August 2025

To: Parents/Guardians

From: Laura Griffiths, MSN, RN,CSN-NJ School Nurse

Dear Parent/Guardian,

Welcome to another school year! Attached is a Health History & Emergency Treatment Form. **Please legibly fill it out and return it to my attention as soon as possible.**

I would like to share some information with you regarding our school health services program. This is a summary of some of the contacts your child will have with the school nurse this year:

- Screening for height, weight and blood pressure shall be conducted annually for each pupil in kindergarten through grade 8.
- Screening for visual acuity shall be conducted biennially for pupils in kindergarten through grade 8.
- Screening for auditory acuity shall be conducted annually for pupils in kindergarten through grade 3 and in grade 7 pursuant to NJSA 18A:404.
- Students in grades 5 and 7 will receive a spinal screening for scoliosis. Any student will be exempt from the scoliosis screening **upon written request from a parent or guardian** (NJSA 18A:4-4,3).
- All new students must be examined upon entry into the school district. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program. The "Universal Child Health Record" form is available through the school website.
- The nurse may administer prescribed medication. However, authorization is required from both the physician and the parent. The medication must be in its original container and must be brought to school by the parent/guardian. This policy also applies to over the-counter or non-prescription medications. Please contact the school nurse for these forms.
- The REQUIRED district form(s) are available from the school nurse or at the school website www.apsedu.org.

Please feel free to contact the school nurse at 908-454-5000 x205 with any questions you may have.

SCOLIOSIS SCREENINGS ARE REQUIRED OF ALL 5TH AND 7TH GRADE STUDENTS.

- I do wish to have my child included in the scoliosis screening program.

Yes _____ No _____

- I will have my 5th or 7th grade child examined by our family physician AND SUBMIT THE REPORT TO THE SCHOOL NURSE.

Yes _____ No _____

PERMISSION FOR RELEASE OF HEALTH INFORMATION

This release authorizes the school nurse to send or receive pertinent medical information necessary for my child's health, well-being and safety. This authorization is valid for one year.

Student's Name: _____

Date of Birth: _____

Grade/Teacher: _____

Parent/Guardian's Name (MUST PRINT): _____

Parent/Guardian's Signature: _____

Date: _____

Student Health History & Emergency Medical Treatment Consent Form

Student:	School: Alpha	Grade/Teacher:
Address:	Birth Date:	Gender:

Parent/Guardian Emergency Contacts:	Relationship:	Phone:
Call 1st:		Home: Cell:
Call 2nd:		Home: Cell: Work:
Call 3rd:		Home: Cell: Work:

Student's doctor/healthcare provider:_____ Phone:_____

Insurance Information:_____ (Include Group's Name, ID #, Group # & Subscriber)

Indicate if student has been diagnosed by a licensed Healthcare Provider with any of the following:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies			List:
Allergies (other)			List:
Food Allergies			Food(s): Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Allergy to Bee Stings			Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Asthma			Rate the Severity : Mild Moderate Life-Threatening Asthma medication taken at home: Medication required at school:
Diabetes			Type 1 (Insulin Dependent) Type 2 Medication Required at School:
Seizure Disorder			Type of Seizure: Medications:
Neurological Disorder			Specify:
Heart Condition			Specify:
Blood Disorder			Specify: Treatment:
Cancer			Specify: Treatment:
Bowel/Bladder Issues			Specify:
Migraine Headaches			Triggers: Treatment:
Bone/Muscle Problems			Specify: Activity Restrictions:
ADD/ADHD			Medication for ADD/ADHD:
Mental Health /Behavioral Issues			Specify: Treatment/Medication:
Wears Glasses/Contacts			Glasses Contacts For Distance For Reading
Hearing Loss			Hearing Loss Right Ear Hearing Loss Left Ear Hearing Aides
Other Serious Illness			Specify: Dates of Onset:
Serious Injury			Specify: Date(s):
Surgery			Specify: Date(s):
Medication Taken at home (if not already listed)			List:

The information on this form may be shared confidentiality with school staff and emergency responders as needed. In the event of medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury, and/or unforeseen circumstance.

_____

Parent/Guardian Signature Printed Name Date

Reviewed by School Nurse:_____

ALPHA PUBLIC SCHOOL
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Mr. Seth Cohen
Chief School Administrator

Mrs. Lori Walker
Supervisor of Instruction

Dear Parents/Guardians of students starting Alpha Public School,

As required by NJ law, N.J.A.C. 8:57-4.2, all students entering Alpha Public School must have documentation of their current immunizations and current health physical to begin the school year. Please complete the enclosed Student Health History/Emergency Medical Treatment Consent form and Universal Child Health Record form completed by your doctor. The health form must also note any allergies, vision or hearing difficulties, or any significant medical conditions.

The following immunizations are required for admittance:

- DTaP - a total of 4 doses with one of these doses on or after your child's 4th birthday or any 5 doses.
- Polio (IPV) a total of 3 doses with one of these doses given on or after your child's 4th birthday or any 4 doses.
- HIB series at least one dose given after 1st birthday
- Pneumococcal conjugate (PCV 13) at least one dose given after on or after 1st birthday
- MMR - 2 doses
- Varicella - 1 dose
- Hepatitis B -3 doses
- Influenza (Pre-K) one dose each year between 9/1-12/31 (*documentation must be received by 12/31 in order for the student to remain in the Pre-school program*)

All new families must complete and submit all required forms and documents for each child entering the district. Registration will be considered pending until all required documentation has been verified.

If the student has a religious exemption, please forward a signed document by a parent or guardian stating this. If there is a medical exemption, please show the necessary documentation from your physician.

Any documentation may be sent to Alpha School District addressed to the school nurse. If you have any questions, please call me at (908) 454-5000 ext 205.

Thank you for your time and cooperation. Stay safe and healthy!

Laura Griffiths, RN, BSN

School Nurse, Alpha Public School

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	