

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

2026-2027 Student Emergency Form

(This form needs to be completed **EVERY** school year)

****NOTIFY SCHOOL OFFICE OF ANY CHANGES DURING THE YEAR****

Date: ____/____/____

Date of Birth: ____/____/____

Student Name: _____

Last

First

Middle

Address: _____

Street Address

Alpha

08865

City

Zip Code

Child Resides with: _____

Are there any legal documents affecting your child? Yes No If Yes, please attach documents.

Mother's/Guardian's Name: _____ Mother/Guardian will be contacted: 1st 2nd

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Father's/Guardian's Name: _____ Father/Guardian will be contacted: 1st 2nd

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contacts: In case the child listed above becomes ill or is injured at the school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following. These contacts will also be contacted if your child is absent from school without notification. They will be contacted in numerical order in case of emergency.

1.	_____	Name	_____	Relationship	_____	Phone
2.	_____	Name	_____	Relationship	_____	Phone
3.	_____	Name	_____	Relationship	_____	Phone

Health Insurance

Does your child have health insurance? Yes _____ No _____
Provider: _____

My child does not have health insurance. You may release my name and address to NJ FamilyCare Program to contact me about health insurance. NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

Date: _____

Printed Name: _____

Signature: _____

Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b)

In an emergency when parents cannot be reached, I authorize the school to call:
(Name, Address & Phone Number)

Physician / Clinical Facility: _____

Dentist: _____

Hospital: _____

Update Health Records: (List any medical/surgical care your child has received during the past year)

Recent Serious Illness

Recent Serious Hospitalization

Recent Immunizations

Restrictions

Recent Dental Exam (Date/Braces?)

Recent Eye Exam (Date/Contact/Glasses?)

Current Medications:

Yes _____ (Describe Below) No _____

Medication/Dosage

For What Condition

Allergies: _____

Additional Medical Notes:

I, the undersigned, do hereby authorize officials of Alpha Public School to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent's / Guardian's Signature: _____ Date: _____

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
<input type="checkbox"/> The student has qualified under section 504 of the Rehabilitation Act.		
<input type="checkbox"/> The student is sharing the housing of others due to the loss of housing or economic hardship.		
<input type="checkbox"/> The student has 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.)		
<input type="checkbox"/> The student has 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
<input type="checkbox"/> 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
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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 *****

SECTION A (DOMICILE): Complete this section if your permanent home is in the Alpha Public School District.

How long have you lived in this home? _____

Do you own or rent this home? _____ If Rent, Lease Start date _____ End date _____

Do you have any present intention of moving from this home? If so, when and to where? _____

Do you have residences(s) elsewhere, and if so, where are they and when do you live there? _____

Please list ~~three~~ forms of proof (see attached list) you will provide to demonstrate that the address given on page 1 of this application is your permanent home.

1. _____
2. _____
3. _____
4. _____

SECTION B (TEMPORARY RESIDENT): Complete this section if parent is staying with a resident of Alpha.

How long have you lived in this residence? _____

Please explain why you are temporarily living with the resident _____

How long do you expect to stay at this residence? _____

Do you have a domicile or residences(s) elsewhere, and, if so, where are they and when do you live there? _____

Please list ~~three~~ forms of proof (see attached list) you will provide to demonstrate that you are residing at the address given on previous page of this application, and that such residence is not solely for the purpose of the student attending school in the district.

1. _____
2. _____
3. _____
4. _____

SECTION C ("AFFIDAVITT" STUDENT): Complete this section if the student is living with a person other than the parent or guardian.

Is the person domiciled in the district, supporting the student without remuneration as if the student were his or her own child, keeping the student for a longer time than the school term and assuming all personal obligations for the student relative to school requirements? **Please explain.** (You will be asked to file a sworn statement, along with a copy of the person's lease if a tenant, or a sworn landlord's statement if a tenant without written lease.)

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

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.

Physical Examination

New Jersey State Board of Education and the New Jersey Department of Health and Senior Services require that each student: is not diminished by a remediable physical disability, that the student is able to participate in the school program, and that the school community is protected from the spread of communicable disease.

The physical examination must be done no more than 365 days prior to the entry of school. If any modifications are required for full participation, please provide the school with proper documentation.

A healthcare provider chosen by the student's parent/guardian, also referred to, as the students' MEDICAL HOME, must conduct the medical examination. A full report must be presented to the school on approved school district form. Please be sure that your physician signs and dates the form.

If the student does not have a "medical home" please contact the school nurse or school secretary for more information.

Rev. 11/02 Physical Examination

**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:
Call 1st:		Home: _____ Cell: _____
Call 2nd:		Home: _____ Work: _____ Cell: _____
Call 3rd:		Home: _____ Work: _____ Cell: _____

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
			Does your child have an EpiPen? Yes		Life-Threatening 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
Hearing Loss	.		Hearing Loss Right Ear		Hearing Loss Left Ear
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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Telephone: (908) 454-5000 Fax: (908) 454-4347 www.apsedu.org

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:	Weight (must be taken within 30 days for WIC) <input type="checkbox"/> Height (must be taken within 30 days for WIC) <input type="checkbox"/> Head Circumference (if <2 Years) <input type="checkbox"/> Blood Pressure (if ≥3 Years) <input type="checkbox"/>	
IMMUNIZATIONS	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____	
MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the signs/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> 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					