Central Registration Office

331 Levis Drive
Mount Holly, NJ 08060

Mrs. Charisse Jones

Central Registrar

NEW STUDENT REGISTRATION
JOHN BRAINERD ELEMENTARY SCHOOL

PRESCHOOL PACKET

Please complete and bring with you the attached forms along with the listed documents below

- You will bring completed packet forms with you to your scheduled appointment

Documents to bring in with your registration packet:

1. Original Birth Certificate
2. Proof of residency (Deed or mortgage statement, tax bill, lease (if you rent)
   Please provide 2 documents from the list below:
   - utility bills, cable, phone, electric etc.
   - Voter registration, licenses, permits, bank statement etc.
   - Documents issues by a governmental entity
3. Up to Date Immunization Records
4. Physical Examination Record (Universal or Physical provided in the packet)
5. Transfer Card from last school attended (if student attended public school in NJ)
6. Last Report Card (if applies)
7. Achievement Test Scores (if applies)
8. Child Study Team Documents (if applies)

PLEASE NOTE: YOUR CHILD WILL NOT BE FULLY REGISTERED UNTIL YOU COMPLETE ALL STEPS AS INDICATED ABOVE.

Phone: 609-267-7108 Fax: 609-702-9082 Email: cjones@mtholly.k12.nj.us

Student Registration Questionnaire

School Year _____

Date: _____

Student Name: _____

Please answer the following questions relating to prior/present schooling:

1. Please list the name and address of the most recent school your child attended.

   _____

   _____

2. Does your child have an IEP for Special Education? _____ Or a 504 Plan? _____
3. Has your child ever been retained in school? _____ If so, what grade level(s)? _____
4. Has your child previously attended Mount Holly Township School District? _____
5. If applicable, please list any siblings that are enrolled in Mount Holly Township Schools:

   _____

   _____

For children born in another country outside of the United States, please answer the following:

IF your child was born outside of the United States, what was his/her first date of entry into the US? _____
AND what was your child's first date he/she was enrolled in school in the US? _____

Please answer the following questions relating to residency:

1. Who has primary custody of your child? (check one) Both Mom and Dad _____ Mom_____ Dad_____

   Other (please list relationship) _____
   If other, you must provide custody documents
2. Do you own your home? _____
3. Do you rent? _____
4. Are you living temporarily with family or friends? _____ If yes, you will need to complete a residency affidavit.

_____ _____

Printed name of Parent or Guardian **Signature of Parent or Guardian**

Mount Holly Township School District
331 Levis Drive, Mount Holly, NJ 08060
STUDENT REGISTRATION PACKET

Date

Name of Person Enrolling Student

Relationship to Student

Primary Language(s) you Speak

STUDENT RESIDENCE INFORMATION

Student Name (First, Middle, Last)

Street Address/Apt #

City, State, Zip

How long has student lived at this address? Years Months

Does the student reside in any other residence? Yes ☐ No ☐

If yes, please list other address.

When does the student reside there?

Do you have any present intention of moving from this/these address(es)? Yes ☐ No ☐

If yes, when do you plan to move?

Where do you plan to move?

Domicile is the place where a person lives in his or her fixed, permanent home. This home must be the place to which he or she intends to return when he or she goes away, and from which he or she has no intention of moving. A person can have only one "domicile" at a time, even if he or she may have more than one residence.

I hereby swear that the student is domiciled within the Mt. Holly Township School District, and I will assume all personal obligations for the student relative to school requirements.

I further understand that falsifying residence information will result in my financial responsibility for district expenses up to and including tuition calculated for each day of the student's ineligible attendance within the district based on an annual tuition rate determined by the district.

Printed Name Date

_____

Signature

STUDENT REGISTRATION PACKET

STUDENT PERSONAL INFORMATION

Date of Birth

Current Age of Student

Gender

Birth City

Birth State

Birth Country

Primary Language Spoken in Student's Home

Ethnicity Select If other, please specify

Is this Student in Need of Child Study Team Services? Yes ☐ No ☐

Yes If yes, please explain

Has this student attended school outside of the U.S.? Yes ☐ No ☐

If yes, when did the student first attend a school in the U.S.

Has this student ever previously attended school in the Mount Holly Twp. School District? Yes ☐ No ☐

If yes, what school? Select One

Grades Attended

Years Attended

Has this student ever attended school in any other school District? Yes ☐ No ☐

If yes, what school?

Grades Attended

Years Attended

STUDENT REGISTRATION PACKET

STUDENT SIBLING(S) Please list all Name

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

STUDENT REGISTRATION PACKET

MOTHER OF STUDENT

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

FATHER OF STUDENT

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

STUDENT REGISTRATION PACKET

LEGAL GUARDIAN OF STUDENT, (if applicable)

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

PARENTS/LEGAL GUARDIANS/OTHER PERSON HAVING CUSTODY AND CONTROL OF STUDENT INFORMATION

Who has legal custody of the student? Select One

If other, please explain

Does the student reside with an adult other than the parent? Yes ☐ No ☐

If yes, please explain

Does that person have legal control of the student, either through a custody order or legal guardianship?

Yes ☐ No ☐

(All legal guardians are required to provide original court credentials from a United States Court with the original court seal and signature of a Judge.)

STUDENT REGISTRATION PACKET

EMERGENCY CONTACT #1 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #2 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #3 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #4 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

NEW JERSEY DATA COLLECTION INFORMATION

Do you have health insurance Yes ☐ No ☐

If yes, please list insurance provider:

If no, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, visit www.njfamilycare.org to apply online or call 1-800-701-0710.

You may release my name and address to the NJFamilyCare Program to contact me about health insurance Yes ☐ No ☐

All information I provided on these pages is tru and correct to the best of my knowledge. There is no deliberate omission, concealment, or falsification of relevant facts.

Printed Name Date

_____

Signature

Sworn and subscribed to me on

this _____ day of _____, 20____

_____

Signature of Notary Public

Affix Stamp Here

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS

Central Registration Office
331 Levis Drive, Mount Holly, NJ 08060

Mrs. Charisse Jones, Central Registrar

Tel: (609) 267-7108

Date:

To:

Fax:

Phone:

The following student has registered into the Mount Holly Township Public School District.

STUDENT'S NAME	GRADE	DATE OF BIRTH

Please forward all academic and health records, standardized test scores as soon as possible to:

John Bralnerd School
100 Wollner Drive Mount Holly, NJ 08060 Phone: (609) 267-3600
Fax: (609) 702-0569
cjones@mtholly.k12.nj.us

Gertrude C. Folwell School
455 Jacksonville Road
Mount Holly, NJ 08060
Phone: (609) 267-0071
Fax: (609) 267-0062
cjones@mtholly.k12.nj.us

F. W. Holbein Middle School 333 Levis Drive
Mount Holly, NJ 08060
Phone: (609) 267-7200
Fax: (609) 702-9775
cjones@mtholly.k12.nj.us

All Special Education Records Mailed to:
CST Office
331 Levis Drive
Mount Holly, NJ 08060
Phone: (609) 267-7108
Fax: (609) 702-9082
tlasala@mtholly.k12.nj.us

I,_____, do hereby request the release of all school records to Mount Holly Township Public Schools. I hereby attest that I have legal authority to request the release of these records.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Printed Name of Parent / Guardian Relationship to Student

MOUNT HOLLY TOWNSHIP SCHOOLS
MOUNT HOLLY, NEW JERSEY

CENTRAL REGISTRATION AFFIDAVIT

Re: _____
Student's Name

I _____, have been informed by the Mount Holly Township School District Central Registration Office that I can only register students in this district if I am the parent and/or legal guardian of the above student.

Signing this form implies that I have stated to Registration Officials that I am the current parent and/or legal guardian of _____ and that I am aware that I am being allowed to register under that assumption, and that this registration can and will be terminated if this fact is found to be untrue at any time, and that if there is a change of guardianship, I must report it to this office immediately.

I am aware that any person who makes a false statement or permits false statements to be made concerning residence for the purpose of allowing non-resident students to attend Mount Holly Township Schools, commits a disorderly persons offense pursuant to N.J. 18A:38-1.

I hereby authorize the Mount Holly Township School District to investigate and confirm any and all statements by me in this affidavit.

_____ _____
Signature of Adult Registering Student) *Date*

Sworn to and subscribed Before me this _____ day of _____, 20__,

_____
(Signature of Notary)

Medicaid Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?
- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS

Special Services Office

331 Levis Drive, Mount Holly, NJ 08060

Tel: (609) 267-7108
ext. 7105, 7115
Fax: (609) 267-6480

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____/_____/_____

Parent/Guardian: _____

Date: ____/_____/_____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Preschool Home Language Survey
Parent/Guardian Questionnaire

PLEASE PRINT

Child's name: _____ Date of birth: _____
(first) (middle) (last)

Date of school entrance: _____ First Date of School in the United States _____

Person completing the survey: [ ]Mother [ ]Father [ ]Grandparent [ ]Guardian [ ]Other

Please tell us about your child:

1. What language did the child learn when he/she first began to talk? _____
2. What language does the family speak at home most of the time? _____
3. What language (s) does the primary caregiver (s) speak to the child most of the time? _____
4. What language (s) does the child speak to his/her primary caregiver (s) most of the time? _____
5. What language (s) does the child speak to his/her brothers and sisters most of the time? _____
6. What language does the child speak to his/her friends most of the time? _____
7. Please list any preschool program(s) your child attended before coming to our program:
   _____
8. In which language do you wish to receive information from the school? _____
9. What name do you use for your child (if different from above)? _____

Sources:
Questions 1 – 8 are based on the *NJ DOE Home Language Survey* that was adapted from the sample survey in *A Manual for Community Representatives of the Title VI Steering Committee*, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

Question 9 was adapted from the Parent Questionnaire in *One Child, Two Languages 2nd Edition published 2/2008* by Patton O. Tabors, Paul H. Brookes Publishing

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS-MOUNT HOLLY, NJ
HEALTH OFFICE INFORMATION FORM

Student's Name _____ DOB: _____ Grade: _____

Home Address: _____

Parent/Guardian's Name: _____

Student's Dentist: _____ Dentist's Phone: _____

Date of last Dental Exam: _____ Date of last Vision Exam: _____

Student's Physician: _____ Physician's Phone: _____

Date of last physical: _____ Purpose: ☐ Routine ☐ Illness

If illness, please explain: _____

Is student currently under a physician's care? Yes ☐ No ☐

In the past, has your child had any health problems in the following areas?

Asthma: _____

Allergies (Specify): _____ Epi-Pen: ☐ YES ☐ NO

Hives/Bee sting reactions: _____ Epi-Pen: ☐ YES ☐ NO

___Arthritis	___Headaches, frequent	___Skin Problems
___Asthma	___Hearing Aid/other device	___Sleep Problems
___Cancer	___Hearing Problem	___Sore Throat Frequent
___Concussion/Head Injury	___Heart Disease	___Speech Issues
___Constipation/Diarrhea	___Hemophilia	___Stomachaches, Frequent
___Cystic Fibrosis	___Hepatitis	___Surgery/Hospitalization
___Diabetes	___Kidney Disorders	___Tonsillectomy
___Ear Tubes Inserted	___Meningitis	___Vision Problem
___Eczema/Dermatitis	___Mononucleosis	___Glasses Contacts
___Epilepsy/Seizures	___Neurological Disorders	___Color Blindness
___Fainting	___Orthopedic Problems	
___Fractures	___Sickle Cell	

Please list details as needed if checking any of the above: _____

_____

Please list any illnesses within the last 12 months: _____

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____
Written consent required pursuant to 20 U.S.C. § 1232 g(b)(1) and 34 C.F.R. 99.30(b).

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS
MEDICAL PERMISSION FOR HEALTH SERVICES

HEALTH OFFICE INFORMATION FORM (Page 2)

Student's Last Name _____ First Name _____

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

☐ No: My child does not have health insurance. You may release my name and address to the NJ Family Care 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 800-701-0710 or visit WWW.njfamilycare.org to apply online.

☐ Yes: My child has health insurance (Please indicate insurance company below)

Name of child's health insurance company: _____

I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers necessary.

In case of emergency, illness or accident the school is authorized to proceed as indicated on the District's Enrollment/Emergency Procedure Form

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. Height, weight, and blood pressure screening annually.
2. Vision/hearing screening every other year.
3. I understand that each student must have a physical examination upon entry into the Mount Holly Township 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. If a physical has not been done 365 days prior to entry to school, one must be done within 90 days of registration.
4. I understand the importance of obtaining subsequent examinations at least once during each of the student's development stages through my home physician:
   - Early childhood (pre-school through grade 3)
   - Pre-adolescence (grades 4 through 6)
   - Adolescence (grades 7 through 12)
5. I understand that scoliosis screening will be done by the school nurse on all students ages 10 to 18 bi-annually. Scoliosis is a lateral curve of the spine, most commonly found during the adolescent-growth period.
6. I have received information regarding the NJ Family Care Program for students who are knowingly without medical coverage.

If your child will need to take medication in school (i.e. Tylenol, Adderall, inhalers, etc.) please contact the nurse's office for the medication permission form. Students are not permitted to carry medication with them.

In most cases of extreme emergency the student will be taken to Virtua Hospital/Mount Holly via the emergency squad.

I understand that the relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary.

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS
MOUNT HOLLY, NEW JERSEY 08060

CONFIDENTIAL

Student History Form

Child's Name:_____

Address:_____ Phone #:_____

MEDICAL HISTORY: MOTHER'S PREGNANCY

1. Any complications (difficulties, sick or hospitalized during pregnancy) Yes _____ No ____

_____

Full-term pregnancy? Yes _____ No _____

BIRTH: Breech _____ C/S _____ Natural _____ Infant's Birth Weight: _____

Any problems as an infant? _____

Any Surgery _____ **Any hospitalization?** _____

Bed Wetting: Trouble with urination, kidneys, or bladder infections:_____
Does he/she still wet the bed? Yes_____ No_____
How would you describe your child as a baby or young child?
1. Activity: Hyper_____ High_____ Average_____ Low_____
2. Easy going/happy_____
3. Quiet/slow to warm up_____
4. Problems sleeping at night_____

SOCIAL: Child plays with: Brother_____ Sister_____ Friend(s)_____ by Self_____

PRESCHOOL HISTORY:

Preschool Name/Address: _____

_____

Days per week: _____ Years of Attendance: _____

OTHER: Anything you think we should know about your child. (Any experience that seemed upsetting to him/her?)

_____
_____

_____ _____
Parent/Guardian Signature Date

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	