



IRVINGTON PUBLIC SCHOOLS

DISTRICT REGISTRATION REQUIREMENTS AND FORMS

Residency Identification - Information Accepted (1 Form Required):

(Documents 1-4 must be dated within the last three (3) months)

1. PSE&G Bill
2. Cable Bill
3. Homeowner's Tax Bill
4. Mortgage Statement
5. Current Signed Lease or Completed Verification of Residency document accompanied by the necessary documents. This document is found in the back of this registration packet

***Please note: Residency checks will be initiated for any notarized letter from a family member. A family member who signs a notarized letter will be held liable for tuition if it is found that the child does not reside at the address listed on the notarized form. Proof of residency is needed for any person who writes a letter that is notarized.**

****Student athletes entering the district must complete the Residency Affidavit on last page.**

Information Not Accepted

1. Credit Cards Bills
2. Income Tax Statement
3. Pay Stubs
4. Home Phone and Cell Phone Bills

Student Records: *(You must have these items along with the residency information noted above)*

1. Original Birth Certificate
2. Immunization/Medical Records
3. Report Cards or Test Scores from Previous School
4. Transfer from Previous School
5. Proof of Guardianship (if applicable)
6. Proof of Legal Guardianship (if applicable)

District/School Forms:

(All forms must be completed before registration is accepted)

1. District Registration Requirements and Forms Sheet (Page 1)
2. District / School Registration Forms (Pages 2-5)
3. Emergency Medical Information (Pages 6-9)
4. District / School Physician(s) Physical Examination Consent Form (Page 10)
5. Request for Student's Records from Previous School (Page 11)
6. Home Language Survey (Pages 12-13)

Special Services Department Forms:

1. Authorization to Obtain Information
2. Authorization to Release Information
3. Special Class Pupil's Emergency Information
4. Transfer Permission Form
5. Medicaid Annual Notification Regarding Parental Consent
6. Special Education Medicaid Initiative (SEMI) Parent Consent Form



IRVINGTON PUBLIC SCHOOLS
DISTRICT / SCHOOL REGISTRATION FORM –PLEASE PRINT

OFFICE USE ONLY

COMMENTS

STATE ID # _____
REGISTRATION DATE /ENTRY DATE _____
Families immigrating to the US have 30 days in order to provide a birth certificate without the delay of enrollment. Students aged 5 through 20 should be enrolled.
GRADE-SECTION _____
HOMEROOM TEACHER _____
HOME SCHOOL _____

SECRETARY'S SIGNATURE _____

NURSE'S SIGNATURE _____

GUIDANCE COUNSELOR'S SIGNATURE _____

- ☐ Proof of Residency _____
☐ Birth Certificate/Passport _____

☐ Proof of Guardianship _____
☐ Transfer Card _____
☐ Report Card/Transcript _____
☐ Immunizations _____
☐ Test Scores _____
☐ IEP _____

I. STUDENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
HOME ADDRESS: _____ APT. # _____
RENT: _____ OWN: _____ SHARE: _____ SHELTER: _____
Parent/Guardian PHONE#: _____ Parent/Guardian CELL#: _____
D.O.B: _____
BIRTHPLACE CITY: _____ AGE: _____ GENDER: _____
DATE OF ENTRY TO US (if applicable) _____

ETHNICITY: (Is the student Hispanic or Latino) _____ YES _____ NO

HOME LANGUAGE

OTHER LANGUAGE(S) SPOKEN AT HOME (by any member of the family): _____

RACE: What is the student's race? (Check each that applies)

- _____ (1) American Indian or Alaska Native
_____ (A) Asian
_____ (B) Black or African American
_____ (P) Native Hawaiian / Other Pac Islander
_____ (W) White

NAME AND ADDRESS OF PREVIOUS SCHOOL:

PREVIOUS GRADE COMPLETED: _____ GRADE (S) RETAINED: _____



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We have a "Parent Portal" to provide you with online access to grades and assignments, PLEASE be sure to indicate working email addresses, as they are needed for access for this valuable resource.

PARENT/GUARDIAN INFORMATION

Father: _____

Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student _____ Yes / No

Mother _____

Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student _____ Yes / No

Guardian _____

Address _____ Apt. _____

Home # _____ Cell # _____ Work # _____

Email _____ Resides with student _____ Yes / No

PROOF OF GUARDIANSHIP: (Check one)

___ DCPP PLACEMENT

___ FOSTER PLACEMENT

___ COURT PLACEMENT

___ GROUP HOME

___ OTHER (DCCP)

IF YOUR FAMILY IS LIVING IN ANY OF THE FOLLOWING SITUATIONS (CHECK ALL THAT APPLY):

Shelter _____

Transitional Housing _____

Awaiting foster Care Placement _____

Doubled-Up__ (ex. Living with friends/relatives)

Unsheltered__ (ex. Cars, Parks, Campgrounds Temporary Trailers, Abandoned Building)

Hotel/Motel _____



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II. EMERGENCY CONTACTS

Name _____	Relationship _____	Address _____
Home # _____	Cell # _____	Work # _____

Name _____	Relationship _____	Address _____
Home # _____	Cell # _____	Work # _____

Name _____	Relationship _____	Address _____
Home # _____	Cell # _____	Work # _____

III. OTHER MEMBERS OF HOUSEHOLD (Siblings)

NAME	DATE OF BIRTH	GENDER	SCHOOL/GRADE
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

IV. EDUCATIONAL HISTORY

GRADE	SCHOOL	DATE OF ATTENDANCE	ADDRESS	TELEPHONE
Elementary School/ Pre-K – 5	_____	_____	_____	_____
Middle School/ 6 – 8	_____	_____	_____	_____
High School 9 – 12	_____	_____	_____	_____

Previous Retention: <input type="checkbox"/>Yes <input type="checkbox"/>No	
If yes, indicate grade/school. _____	
Previous Services:	
<input type="checkbox"/> IEP	<input type="checkbox"/> Speech
<input type="checkbox"/> Bilingual/ESL	<input type="checkbox"/> Intellectually Gifted <input type="checkbox"/> Basic Skills



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V. MEDICAL INFORMATION

Indicate below: Physical handicaps, surgery, seizure, elevated lead level, food allergies, hearing/vision/speech problems

Health Care Insurance Provider

Family Physician _____ Address _____ Phone _____

School Nurse's Signature _____ Date _____

Does this child have any health insurance including NJ FamilyCare/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.

Signature: _____ **Print Name:** _____ **Date:** _____

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

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.

☐ **YES** my child has health insurance.

List any medical/surgical care your child has received during the past year:

Dental Exam _____
Date _____

Braces _____

Eye Exam _____
Date _____

Glasses/Contacts _____

Allergy _____
Kind _____

Medications _____

Allergic Reaction _____
Date _____

Medications _____

Immunizations/Tetanus _____
Date _____

Type _____



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Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Phone _____

Hospital Name/Address _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card 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 physicians named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, 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.

Signature of Parent(s)/Guardian

Date

VI. MEDICAID INFORMATION

Irvington Public Schools (IPS) may give my child's Medicaid number to IPS health care providers so that the providers can bill Medicaid for services they provide my child.

Medicaid No. _____

_____ **I do not wish to share my child's Medicaid number with the school.**

_____ **Does not apply – my child is covered by other insurance.**

_____ **My child is currently not covered by insurance.**

I hereby attest that all of the information on this registration form is correct, and I agree to pay all of the necessary reimbursements to the Board of Education for false documentation in any of the categories.

VII. MILITARY CONNECTED STUDENT INDICATOR

Please check one of the following items:

- ☐ 1. Not Military Connected – Student is not military connected.
- ☐ 2. Active Duty – Student is a dependent of a member of the Active Duty Forces (full-time) Army, Navy, Air Force, Marines Corps, or Coast Guard.



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- ☐ 3. National Guard or Reserve – Student is a dependent of a member of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard).
- ☐ 4. Unknown – It is unknown whether the student is military-connected.

Father's Signature _____ **Date** _____

Mother's Signature _____ **Date** _____

Guardian's Signature _____ **Date** _____



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EMERGENCY MEDICAL INFORMATION

School _____ School Year _____

Last Name _____ First Name _____

HR _____ Grade _____

Address of Student _____ Tel. _____

Mother's Name _____ Place of Business _____

Business Address _____ Business Tel. _____

Cell _____

Address (if different from student) _____

Father's Name _____ Place of Business _____

Business Address _____ Business Tel. _____

Cell _____

Address (if different from student) _____

Legal Guardian Name (if applicable) _____ Place of Business _____

Business Address _____ Business Tel. _____

Cell _____

Address (if different from student) _____



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In my / or our absence, the following (relative, neighbor, or friend) is authorized to act for me / us on behalf of my / our child. Please be sure the following people have consented to act on your behalf.

1. Name _____ Phone # _____

Street _____ Town _____

Relationship _____

2. Name _____ Phone # _____

Street _____ Town _____

Relationship _____

3. Name _____ Phone # _____

Street _____ Town _____

Relationship _____

Signature of Parent/Guardian _____

Date _____



IRVINGTON PUBLIC SCHOOLS
1 UNIVERSITY PLACE
IRVINGTON, NEW JERSEY 07111

PARENT NOTIFICATION OF STATE MANDATED HEALTH SCREENINGS

The following screenings will be scheduled during the school year

Physical Examination – New Jersey law requires that routine physical examinations are given to students in grades K, 3, 6 and 9, students new to the district without a record of an examination, students in Special Education (every three years), and students who wish to participate in athletics on a school athletic squad. There is no charge for this examination. If parents wish to be present, please contact the school nurse. Parents are notified if a child needs further evaluation.

The school medical director may accept the report of a private doctor in lieu of the school physical examination. If a parent wishes to have his or her child examined privately at the parent's own expense, the school will make available the Board approved forms to be completed by the private examining physician. These forms are available in each school health office.

IMPORTANT: Private medical examinations for this school year must be done after August 1st. The medical form should be returned to the school nurse by the end of September in that same year.

Tuberculosis Skin Testing – State law requires testing for tuberculosis infection. A Mantoux Intradermal Tuberculin test shall be given to all Kindergarten and 8th grade students, all transfer students in any grade from another state or country who do not have a valid record of a Mantoux Tuberculin Test within the past six months, and all new students from another New Jersey public school required to test eighth grade pupils who do not have a history of having received a Mantoux Tuberculin test since entering school.

Scoliosis Screening – (to detect abnormalities of the spine) for students in grades 5 – 12 and Special Education students 10 – 18 years of age will be conducted each year.

Vision Screening – is conducted each year for all students in grades K – 8

Audiometric Screening – (for hearing) shall be conducted for pupils enrolled in pre-school programs, students in grade K – 4, 6, 8, and 10th, and students entering the district with no record of recent hearing screening. Students at risk for hearing impairments, students referred to the Child Study Team for evaluation, and special requests from a teacher, a parents or a pupil will also be receive audiometric screenings.

If a parent prefers to take his/her child to a private doctor/clinic, **at the parent's own expense**, a signed letter must be sent to the school nurse. If the school does not receive a report from a private doctor by September 30th, the student will be screened in school.



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Child's Last Name **First Name** **D.O.B.** **School**

Address (number, street, city, zip code) **Tel. phone #** (____) _____

Father's Name **Mother's Name** **Guardian**

Did your child ever attend an Irvington Public School? Yes _____ No _____

Last school attended: _____

When did your child last have a physical examination? Date _____

Name of Physician/Clinic _____ **Telephone #** _____

☐ Routine Check-Up ☐ Illness/Injury Specify reason _____

Is your child subject to (please circle yes or no)?

Frequent Colds	Yes – No	Running Ears	Yes – No
Bronchitis	Yes – No	Chronic Cough	Yes – No
Frequent Sore Throats	Yes – No	Vision Loss	Yes – No
Speech Difficulties	Yes – No	Poor Posture	Yes – No
Earaches	Yes – No	Emotional Problems	Yes – No
Allergies	Yes – No	Weight Problems	Yes – No

List Allergies: _____

Does your child have, or has he/she been treated for, any of the following health problems?

Anemia	Yes – No	Heart Condition	Yes – No
Asthma	Yes – No	Kidney Disease	Yes – No
Diabetes	Yes – No	Rheumatic Fever	Yes – No
Elevated Lead Level	Yes – No	Seizures	Yes – No
Food Allergies	Yes – No	Sickle Cell Anemia	Yes – No
Fracture	Yes – No	Vision Deficiencies	Yes – No
Head Injury	Yes – No		
Hearing	Yes – No		

Other _____

Does your child take medication? Name of medication(s) _____ Epipen Yes/No Inhaler Yes/No

Has your child had:

Poor eating habits	Yes – No	Difficulty Sleeping	Yes – No
Eye Disease	Yes – No	Eye Injury	Yes – No
Head Injury	Yes – No	Eye Glasses Prescribed	Yes – No
A Severe Fall	Yes – No	Hearing Loss	Yes – No



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Development: Age began walking _____ Age began talking _____

Family History: (please circle)

Tuberculosis
Diabetes
Cancer

Kidney Condition
Heart Disease
Allergies

Asthma
Deafness
High Blood Pressure

Does your child have a history of: (please circle – give dates if possible)

Allergy
Asthma
Chickenpox
Diabetes
Enuresis (bed wetting)
Heart Disease
Hepatitis
Fractures

High Fever
Mononucleosis
Pneumonia
Rheumatic Fever
Scarlet Fever
Seizures
Tonsillitis

Tuberculosis
Operations:
Appendectomy _____
Hernia _____
Tonsils Removed _____
Ear Operation _____
Other _____

Has your child been hospital for any reason since birth? Yes or No

Explain _____

Please list other childhood diseases, accidents, problems or medical tests

Are there any problems in the home which might affect your child's learning?

Explain _____

Is there anything more about your child's health that you believe is important for us to know?

Explain _____

Siblings' Name (s): _____ **Age:** _____ **School:** _____

Parents/Legal Guardian's Signature

Date



IRVINGTON PUBLIC SCHOOLS
District / School Physician(s) Physical Examination Consent Form

To Parents/Guardians:

While your child attends the Irvington Public Schools, he/she will be examined at specified intervals by one of our school physicians, as well as such time when the building principal requests a physical examination because it is suspected that a physical defect may be interfering with your child's academic progress.

As it is your choice to be present at your child's district physical examination(s), we would like to know whether or not you wish to be present when the examinations are given. If you do not want to be present, the school physician will report results upon request or if a medical condition is identified. Please fill out the form below, and forward it to your child's school nurse within ten days of receipt. A permanent notation of your choice will be made on your child's medical record.

Be reminded that the notice below must be returned to your child's school nurse within ten days of receipt.

(Tear off – Complete and return within 10 days of receipt)

To the School Nurse:

_____ I do not wish to be present _____ I do wish to be present when my child, _____ is examined by the school doctor. Any future change to this decision will be submitted to the nurse's office in writing.

Parents/Legal Guardian's Signature

Date

Child's Name

Grade/Homeroom



IRVINGTON PUBLIC SCHOOLS REQUEST FOR STUDENT RECORDS

School: _____

Principal: _____

Phone No.: _____ Fax No.: _____

Due to the registration of the following student, please forward his/her records as soon as possible:

Name: _____ Homeroom/Grade: _____ DOB: _____

✓ CUMULATIVE ACADEMIC AND BEHAVIOR RECORDS

✓ ATTENDANCE RECORDS

✓ STANDARDIZED TEST SCORES

✓ CHILD STUDY TEAM EVALUATIONS

✓ INDIVIDUALIZED EDUCATION PROGRAM

✓ MEDICAL RECORDS

✓ DISCIPLINE RECORDS

OTHER _____
OTROS - LÒT

I give permission to release my child's records to _____

Parent/Guardian's Signature _____ Date _____

NOTE: Federal Law 99.2: No parent signature is required for educational records sent to another educational agency.

First Request _____ Date _____

Second Request _____ Date _____

Third Request _____ Date _____

Date Received _____

Please send requested information via:

☐ **Fax (973)** _____

☐ **Mail** _____, Irvington, New Jersey 07111

☐ **Phone (973)** _____ ext. _____

☐ **E-mail** _____@irvington.k12.nj.us



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HOME LANGUAGE SURVEY (HSL)

Date of registration _____
Name of student _____
Date of birth _____
City & country of birth of the child _____
Address of residence _____, Irvington, NJ 0711
Name(s) of parent(s)/guardian(s)
Mother / Guardian _____
Father / Guardian _____
Phone number(s) _____
Emergency phone number(s) _____

STEP 1

Question 1

What was the first language used by the student? _____

A language other than English. (Proceed to question **2a.**) Or English. (Proceed to question **2b.**)

Question 2a

At home, does the student hear or use a language other than English more than half of the time?

____ **Yes.** (Proceed to question **7.**) ____ **No.** (Proceed to question **4.**)

Question 2b

At home, does the student hear or use a language other than English more than half of the time?

____ **Yes.** (Proceed to question **4.**) ____ **No.** (Proceed to question **3.**)

Question 3

Does the student understand a language other than English?

____ **Yes.** (Proceed to question **4.**) ____ **No.** (Proceed to question **9.**)



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Question 4

When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

_____ Yes. (Proceed to question 7.) _____ No. (Proceed to question 5.)

Question 5

When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

_____ Yes. (Proceed to question 8.) _____ No. (Proceed to question 6.)

Question 6

Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

_____ Yes. (Proceed to question 8.) _____ No. (Proceed to question 9.)

Question 7

What are the home languages spoken? List below. (Proceed to question 8.)

Question 8

Student is an English Language Learner (ELL). **Go to Step 2.**

Question 9

Student is not an English Language Learner (ELL). **Survey Completed.**



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STEP 2

Records Review Process (To be completed by NJ ESL Certified Staff only)
(Reference [ESSA ELL Entry and Exit Guidance](#), p. 4).

Copy of HLS provided to English as a Second Language (ESL) Teacher on _____ (Date)

ESL Teachers Name

ESL Teachers Signature

Date of WIDA ID Exam: _____ Overall Score: _____

Please Note:

In accordance with ESSA §1112(e)(3), parents/guardians must be notified of program placement by mail within 30 days of the beginning of the school year or 14 days from the time of identification for mid-year enrollees. The notice must be in English and in the language in which the parents/guardians possesses a primary speaking ability.

NOTES OF IMPORTANCE OR SPECIAL CIRCUMSTANCES:

In compliance with NJDOE a Home Language Survey must be on file for all students in district. If a second language is spoken at home the child must be tested for English Proficiency by a certified ESL Teacher using the appropriate district and state approved Diagnostic tests.

FOR OFFICE USE ONLY:

This information is completed by school staff only:

Student Identification Number: _____

District Attendance Zone: _____

Center/School: _____

Level/Grade (*circle one*): UN P3 P4 1 2 3 4 5 6 7 8 9 10 11 12



IRVINGTON PUBLIC SCHOOLS

Verification of Residency

Date: _____

Dear Irvington Public Schools:

Please be advised that I, _____ and my child(ren)
Print Name(s)

_____ lost/moved our residence
Print Name(s) of Child(ren)

located at _____, _____, _____, _____.
Last permanent address City State Zip Code

As of _____, we are now living with _____
Date Name of person responsible for temporary address

at _____, _____, _____, _____.
Temporary Address City State Zip Code

If my housing situation changes, I will immediately notify the Building Homeless Liaison/HSSC and make them aware of my new address. If I falsely represent my residency or circumstances, it can result in me repaying Irvington Public Schools for the cost of bus tickets and tuition.

Parent/Guardian Signature

_____ Date: _____

I, _____, am providing temporary housing and proof of
Name of person responsible for temporary address

residency in the form of a signed lease/mortgage statement or PSE&G bill to the family listed above. I understand that any person that fraudulently represents a homeless or displaced circumstance commits a disorderly persons offense and can be held financially responsible for damages (student tuition, transportation costs, and educational materials).

Signature of person responsible for temporary address _____

Date: _____

***This document must be completed and signed in the presence of a notary public*
(MUST BE NOTARIZED)**

Notary Seal



IRVINGTON PUBLIC SCHOOLS
STUDENT-ATHLETE RESIDENCY AFFIDAVIT *

NJSIAA STUDENT-ATHLETE RESIDENCY AFFIDAVIT

Print Student Full Name

I, _____, of full age, being duly sworn to law, upon my oath depose and say:

1. I am the parent/legal guardian of the above listed student.

2. I currently reside at: _____
I have resided at the above address since: _____

3. The above-named student moved with me at my new address on: _____

4. Prior to moving to the new residence address listed above, I resided at the following address: _____

5. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.

6. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.

7. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Parent/Guardian Signature

Print Parent/Guardian Full Name

STATE OF NEW JERSEY

COUNTY OF _____

The above-named affiant appeared before me, a notary public of the State of New Jersey,

on the _____ day of _____, 20_____, and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

*** FORM IS REQUIRED IF A STUDENT IS TRANSFERRING FROM A HIGH SCHOOL WHERE THEY PLAYED VARSITY SPORTS IF THE STUDENT PLAYED JUNIOR VARSITY, FRESHMAN, OR MIDDLE SCHOOL SPORTS, THE FORM IS NOT REQUIRED.**

Copies of this Affidavit will be sent to the New Jersey State Interscholastic Athletic Association upon request.