Brick Township Public Schools

Central Registration
101 Hendrickson Avenue
Brick, NJ 08724
(732) 785-3000 x1067 or 1068

REGISTRATION REQUIREMENTS

Grades 1 - 12

ONLY THE NATURAL PARENT OR GUARDIAN MAY REGISTER
A STUDENT!! **PHOTO ID IS REQUIRED!**

I. Proof of Residency (necessary before beginning any registration);

A. Two (2) Proofs of Residency must be presented indicating the student lives in the sending district. Acceptable examples of proof are:

1. Tax bill, Deed, Contract of Sale, Closing or Mortgage Statement; or Lease/Rental receipt with address of property; and
2. Utility bill or Digital Driver's License (Acceptable as second proof only!)

B. In the event the student and parent are residing with a third party, the third party must prove residency as listed above. A "Third Party Residency Form" ("B" Form) must be completed and notarized by both the third party and the parent/guardian before the student will be registered. In addition, one proof of residency for the registering party is required.

C. In the event the student is not residing with the parent/guardian, or does not have a court order indicating placement, then the registering party must apply for an Affidavit of Guardianship/Residency Agreement ("C" Form).

II. Health Records (Immunizations)

III. Original Birth Certificate with raised seal (Bureau of Vital Statistics)

IV. Transfer Card/Withdrawal Information from Previous School

V. Latest Report Card

BRICK TOWNSHIP PUBLIC SCHOOLS
STUDENT REGISTRATION FORM

Student Information: Please print/fill in all information for each student registering.						
Student Name (First, Middle, Last):						
Date of Birth:			Gender:	☐ Male ☐ Female	Grade Placement:	

Student Residential Address Information:			
Home Address:		Apartment/Unit #	
City/Zip Code:			
		Third Party Residence?	☐ Yes ☐ No

Student Resides With/Head of Household:	☐ Both Parents ☐ Mother * ☐ Father * ☐ Guardian* * Do you have legal custody of the above-named child? ☐ Yes ☐ No If yes, ☐ Sole Custody ☐ Joint Custody ☐ Restricted Release - If there are any problems relating to custody and releasing your child, please be aware that the school must have a copy of the legal documents in our files.

Parent/Guardian #1:			☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Guardian		
Home Phone:		Cell Phone:		Business Phone:	
Marital Status:		Occupation:			

Parent/Guardian #2:			☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Guardian		
Home Phone:		Cell Phone:		Business Phone:	
Marital Status:		Occupation:			

Central Registration Office Use Only!								
School to Attend:	☐ BCPLC	☐ DP	☐ EHY	☐ HERB	☐ LM	☐ MID	Session:	☐ KA ☐ KP ☐ KAD
	☐ OSB	☐ VMES	☐ LRMS	☐ VMMS	☐ BTHS	☐ BMHS		
	☐ EEC						Year of Graduation:	
☐ Affidavit of Guardianship attached				Letter of Request/Approval Attached:			☐ Yes ☐ No	
Present Grade:				Enrollment Date:				
Student ID#		SID#				Family Code:		
Registration Date:		Registrar:						

Emergency Contact Information:

Name:		Phone:		Relationship to student:	
Name:		Phone:		Relationship to student:	

If dual notification of Progress Reports and Report Cards are needed, please complete below:			(Used for joint custody only!)
Name:		Relationship to student:	
Mailing Address:		Contact Phone:	

Sibling Information: Please list ALL children in the family from oldest to youngest. If additional room is needed, please list on back of page.

Name:		☐ Male ☐ Female	Date of Birth:	
Does sibling attend school in Brick?	☐ Yes ☐ No	Which school?		

Name:		☐ Male ☐ Female	Date of Birth:	
Does sibling attend school in Brick?	☐ Yes ☐ No	Which school?		

Name:		☐ Male ☐ Female	Date of Birth:	
Does sibling attend school in Brick?	☐ Yes ☐ No	Which school?		

Name:		☐ Male ☐ Female	Date of Birth:	
Does sibling attend school Brick?	☐ Yes ☐ No	Which school?		

District Curricular Information:			
Was the student previously enrolled in Brick Township Schools?	☐ Yes ☐ No	If so, which school?	
Last school attended:			
My child was receiving the following assistance in his/her previous school:			
☐ Student seen by the CST	☐ Speech Therapy	☐ Basic Skills	☐ 504 Plan
☐ Student referred to the CST		☐ Math ☐ Reading	
☐ Student classified by the CST	☐ Gifted & Talented	☐ Free or Reduced Lunch	☐ Student Retained
☐ ELL/Bilingual Education			

Parent/Guardian Signature:		Date:	

BRICK TOWNSHIP PUBLIC SCHOOLS

CONSENT TO EMERGENCY STUDENT TREATMENT

I ____________________________________, parent/legal guardian of the student named below, do hereby CONSENT (in advance) to any emergency treatment and/or hospital care rendered to the student at a Medical Center of Ocean County facility in the event that any situation should arise during school hours or during any school activities that would require emergency treatment or care rendered to the named student.

This consent is given at the request of the Brick Township Board of Education and the Medical Center of Ocean County so that prompt emergency treatment of the student may be rendered. This consent extends to the Hospital and its affiliated physicians, nurses, employees and administrative officer.

I understand that this consent will be lodged with the school that is attended by the student so that it will be immediately available for delivery to a Medical Center of Ocean County facility in the event that emergency treatment of the student is required.

I further understand that in the event of the rendering of any emergency treatment to the student by the Hospital that the Hospital will promptly communicate with me at the telephone number listed below in order to advise me of the emergency situation and treatment rendered to the student.

I further understand that any costs incurred as a result of Hospital treatment will be my responsibility and not that of the Brick Township Public School District.

AS TO THE STUDENT: ____ ____________________

(Name) (Age)

____ ____________________

(Street Address – Town – State – Zip Code) (Date of Birth)

____

ALLERGIES **that the hospital and/ or emergency care provide would need to be aware of**

AS TO THE PERSON SIGNING THE CONSENT: ____

(Name)

______________________ ____ ____________________

(Relationship to Student) (Street Address – Town – State – Zip Code) (Phone Number)

____ ________________________

(Signature of Person Giving Consent – Parent/Legal Guardian) Date

Copies: School Nurse – Athletic Office

HEALTH OFFICE/NEW ENTRANT QUESTIONNAIRE

Student's Name ____ ID# ___________ D.O.B. ______________

Birthplace ______________________________________ Age _______ Sex _______ Grade __________

Please check the following questions and explain any "Yes" answer on the space provided.

MEDICATIONS:

Does your child take any daily medications? Yes _____ No _____

If Yes, please list daily medications and doses: ____

Will your child require medication given in school? Yes _____ No _____

ALLERGIES: Is your child allergic to any of the following:

Medications: Yes _____ No _____

If Yes, please list: ____

Seasonal Allergies: Yes _____ No _____

If Yes, please explain: ____

Bee Sting/Insect Bites: Yes _____ No _____

If Yes, list medication needed for allergic reaction: ____

Food Allergies: Yes _____ No _____

If Yes, which foods? ____

Type of reaction? ____

Type of medication needed for reaction? ____

Asthma: Yes _____ No _____

If Yes, frequency of attacks? ____

Known triggers? ____

Current daily asthma medications? ____

Normal Peak Flow ____

HEART DISEASE/HEART MURMUR: Yes _____ No _____

If Yes, any limitations in activity? ____

<u>Please note</u>: A doctor's note is required stating there is no limitation of activity to participate in gym, sports, or recess.

KIDNEY DISEASE: Yes _____ No _____

If Yes, please list: ____

DIABETES: Yes _____ No _____

If Yes, we will discuss and formulate careplan for the school year.

SEIZURES: Yes _____ No _____

Medications/Limitations: ____

Date of last seizure: __________________________ Type of seizure: _______________________

If current seizure disorder, we will meet and formulate careplan for the school year.

LYME DISEASE: Yes _____ No _____

If Yes, date of diagnosis: _____________ Current medications/limitations? _______________________

GLASSES: Yes _____ No _____

If Yes, when are they to be worn? ____

HEARING DIFFICULTIES: Yes _____ No _____

If Yes, we please explain: ____

FREQUENT EAR INFECTIONS: Yes _____ No _____

If Yes, approximately how many infections and what age(s)? _____________________________________

FREQUENT STREP INFECTIONS: Yes _____ No _____

History of any of the following?

HEAD INJURIES: Yes _____ No _____
BROKEN BONES: Yes _____ No _____
HOSPITALIZATIONS: Yes _____ No _____
SURGERIES: Yes _____ No _____

If you answered Yes to any of the above, please give dates and explain: __________________________________

____

Please list any other disabilities, limitations, or health concerns: ____

____

____

Previous School Attended: ____ Phone: _____________________

Parent Signature: ____ Date: _________________

NJ Family Care 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. Brick Township Schools may release my name and address to NJ Family Care Program to contact me about health insurance.

____

Signature Printed Name Date

BRICK TOWNSHIP PUBLIC SCHOOLS

THE INFORMATION REQUESTED BELOW IS REQUIRED BY THE STATE OF NEW JERSEY NJ SMART INITIATIVE
Asterisk (*) indicates this field must be completed

________________________	________________________	________________________
Last Name (*)	**First Name (*)**	**Middle Name**
________________________	________________________	________________________
Date of Birth (yyyy/mm/dd) (*)	**Gender(*) (Male/Female)**	**Current City of Residency (*)**
________________________	________________________	________________________
City of Birth (*)	**State of Birth (*)**	**Country of Birth (*)**

________________________	________________________
Date (yyyy/mm/dd) Student Entered the Brick School District (*)	**Anticipated Year of Graduation from Brick Schools**

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ETHNICITY **(*) The ethnic category which most clearly reflects the individual's recognition of his/her community or with which the individual most identifies. (Yes or No must be entered)**

Hispanic or Latino – a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture of origin Regardless of race. (Note: If positive identification of Hispanic or Latino is not possible, "NO" should be entered)

____ YES (to Hispanic or Latino) **____ NO (to Hispanic or Latino)**

RACE **(*) The racial category which clearly reflects the individual's recognition of his/her community or with which the individual most identifies. More than one race category may be reported for an individual. (Yes or No must be entered)**

Race Indian	**____ YES (to American Indian or Alaskan)**	**____ NO (to American Indian or Alaskan)**
Race Asian	**____ YES (to Asian)**	**____ NO (to Asian)**
Race Black	**____ YES (to Black or African American)**	**____ NO (to Black or African American)**
Race Pacific	**____ YES (to Native Hawaiian or Other Pacific Islander)**	**____ NO (to Native Hawaiian or Other Pacific Islander)**
Race White	**____ YES (to White)**	**____ NO (to White)**

Both "Ethnicity" and "Race" must be entered. Some examples include the following:
Hispanic Only (enter Ethnicity=Y – All Races=N) * Hispanic, White (enter Ethnicity=Y – Race White=Y All other races=N) * Non-Hispanic White (enter Ethnicity=N –Race White=Y – All Other Races=N) * Non-Hispanic Black or African American (enter Ethnicity=N - Race Black=Y – All Other Races=N) * Non-Hispanic Asian & Black or African American (enter Ethnicity=N – Race Black=Y – Asian=Y - All Other Races=N) *Asian Only (enter Ethnicity=N - Asian=Y – All Other Races=N), etc.

HEALTH

Current Health Insurance Status of your child **Coverage (YES) _______** **Coverage (NO) _____________**

If "YES" Name of Health Insurance Company ____

Date of your child's last medical examination ____

Date of your child's last LEAD blood test ____________________ **Lead Level ______________________**

________________________	________________________	__________
Name of Parent/Legal Guardian (please print)	**Signature of Parent/Legal Guardian**	**Date**