New Student Registration Packet Instructions

The following information will be required at the time of registration:

1. Proof of Identity and Age:
   Official Birth Certificate (original with raised seal, we will make a copy)
   • Kindergarten age is 5 years on or before October 1st
   • First Grade age is 6 years on or before October 1st

2. Proof of Residency in Bethlehem Township (contract/lease for property, copy of a tax bill, utility bill, etc. that indicates family’s address)

3. Student Information
   • Latest report card/progress report
   • Standardized Test Scores (grades 3-5)
   • I.E.P. Information (if applicable)

4. Health Office Requirements
   • Physician’s Documentation of:
     o A recent physical examination (done within the past year) completed by a physician
     o Record of immunization from Physician or School*
     o For current immunization state requirements, please consult this website:
       https://www.state.nj.us/health/cd/imm_requirements/

   *ALL immunizations must be submitted before entering school, preferably at the time of registration so the School Health Nurse can review the dates and doses of vaccine administration. We will NOT be able to register any student without proof of his/her most recent immunizations.

5. Custodial and/or Legal Guardianship Documents (if applicable)

6. Complete and Return the Attached Forms:
   a. Home Language Survey
   b. Family Record Form
   c. Emergency Information Form
   d. Health Information Forms (Part A & Part B)
   e. Permission to Request Records Form (for use by 1st-6th grades only)

If all of the above requirements are not available at the time of registration, your child’s registration will not be considered complete.

Registration and enrollment into the Bethlehem Township School District may take up to one week pending completion of registration forms.

If you have any questions or concerns, please call the phone number listed above. Thank you and welcome!
BETHLEHEM TOWNSHIP SCHOOL DISTRICT
FAMILY RECORD FORM
PLEASE PRINT CLEARLY

STUDENT'S NAME: ____________________________
LAST FIRST
SEX: ___ M ___ F NICKNAME (IF ANY): ______________________

DATE OF BIRTH: ____________________________
MONTH/DAY/YEAR
BIRTHPLACE: ____________________________

TELEPHONE: ____________________________
IF # IS UNLISTED, CHECK HERE __

MAILING ADDRESS: __________________________

ETHNIC BACKGROUND FOR STATE INFORMATION --- CHECK ONE (OPTIONAL):
___WHITE ___ BLACK OR AFRICAN AMERICAN ___ AMERICAN INDIAN OR ALASKA NATIVE ___ ASIAN ___ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ___ HISPANIC OR LATINO

<table>
<thead>
<tr>
<th>PARENT CHILD IS LIVING WITH</th>
<th>LAST NAME (IF DIFFERENT)</th>
<th>LIVING</th>
<th>CITIZEN</th>
<th>CELL PHONE</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER:</td>
<td></td>
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<tr>
<td>FATHER:</td>
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<tr>
<td>GUARDIAN:</td>
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<td>(ONLY IF APPLICABLE)</td>
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</tbody>
</table>

MARITAL STATUS OF PARENTS (Please check one) ___ MARRIED ___ SEPARATED ___ DIVORCED ___ REMARRIED

<table>
<thead>
<tr>
<th>SIBLING INFORMATION</th>
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<tbody>
<tr>
<td>SIBLING NAME:</td>
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<td>SIBLING NAME:</td>
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<tr>
<td>SIBLING NAME:</td>
</tr>
</tbody>
</table>

AS PART OF OUR REQUIRED DISTRICT REPORTING PROCESS, WE NEED ALL PARENTS AND GUARDIANS TO SUPPLY THE FOLLOWING INFORMATION

DOES YOUR CHILD HAVE HEALTH INSURANCE? ___ YES ___ NO
IF YES, PLEASE LIST YOUR INSURANCE PROVIDER: ____________________________

IF YOU ANSWERED NO ABOVE, MAY WE RELEASE YOUR NAME AND ADDRESS TO THE NEW JERSEY FAMILY CARE PROGRAM SO THEY CAN CONTACT YOU ABOUT HEALTHCARE COVERAGE? ___ YES ___ NO

DOES YOUR CHILD HAVE A PARENT/GUARDIAN ACTIVE IN THE MILITARY? ___ YES ___ NO

IS ENGLISH THE PRIMARY LANGUAGE SPOKEN IN THE HOME? ___ YES ___ NO
IF NO, INDICATE PRIMARY LANGUAGE SPOKEN: ____________________________

PARENT/GUARDIAN SIGNATURE: ____________________________ PARENT/GUARDIAN NAME: ____________________________ DATE: _____________

PLEASE PRINT CLEARLY
BETHELHEM TOWNSHIP SCHOOL DISTRICT

Home Language Survey*
Parent/Guardian Language Questionnaire

Name: ___________________________________________ Age: _____
[ ] [ ] [ ]
[first] [middle] [last]

Date of School Entrance ________________________________

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

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?
   English _____ Other [specify] ________________________________

2. What language does the family speak at home most of the time?
   English _____ Other [specify] ________________________________

3. What language does the parent [guardian] speak to the child most of the time?
   English _____ Other [specify] ________________________________

4. What language does the child speak to his/her parent [guardian] most of the time?
   English _____ Other [specify] ________________________________

5. What language does the child speak to her/his brothers and sisters most of the time?
   English _____ Other [specify] ________________________________

6. What language does the child speak to his/her friends most of the time?
   English _____ Other [specify] ________________________________

7. In which language do you wish to receive school communication?
   English _____ Other [specify] ________________________________

Signature: ___________________________________________ Date: __________________
[person completing the survey]

*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
BETHLEHEM TOWNSHIP SCHOOL DISTRICT
EMERGENCY INFORMATION FORM
PLEASE PRINT CLEARLY

STUDENT’S NAME: ___________________________ GRADE ENTERING: ____________

Last Name: ___________________________ First Name: ___________________________

ADDRESS: 

Street: ___________________________ Town: ___________________________ ZIP: __________________

PARENT INFORMATION

MOTHER Name: ___________________________ Email Address: ___________________________

Home Phone: ___________________________ Cell Phone: ___________________________

Address (if different from student address): 

Street: ___________________________ Town: ___________________________ ZIP: __________________

Employer Name: ___________________________ Work Phone: ___________________________

Employer Address: 

Street: ___________________________ Town: ___________________________ ZIP: __________________

FATHER Name: ___________________________ Email Address: ___________________________

Home Phone: ___________________________ Cell Phone: ___________________________

Address (if different from student address): 

Street: ___________________________ Town: ___________________________ ZIP: __________________

Employer Name: ___________________________ Work Phone: ___________________________

Employer Address: 

Street: ___________________________ Town: ___________________________ ZIP: __________________

CHILDCARE/EMERGENCY CONTACT INFORMATION

PROVIDE BABYSITTER/DAYCARE INFORMATION IF THE BUS WILL NOT BE DROPPING YOUR CHILD OFF AT HOME.

CIRCLE WHICH DAYS - M T W Th F or ALL

Name: ___________________________ Address: ___________________________ Phone: ___________________________

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO ARE HOME DURING THE DAY AND WITH WHOM YOU HAVE MADE ARRANGEMENTS TO ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED IN CASE OF AN EMERGENCY.

Emergency Contact 1: Name: ___________________________ Phone: ___________________________ Relationship ___________________________

Emergency Contact 2: Name: ___________________________ Phone: ___________________________ Relationship ___________________________

MEDICAL INFORMATION

Name of Physician: ___________________________ Office Phone: ___________________________ Address: ___________________________

Name of Dentist: ___________________________ Office Phone: ___________________________ Address: ___________________________

Hospital of Choice (check one):   ___Hunterdon Medical Center   ___St. Luke’s Warren County Campus

Recent Illness/Injury: ___________________________

Latest Tetanus Immunization: ___________________________ Allergies: ___________________________ Medications: ___________________________

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician/dentist indicated and to follow his instructions. If it is impossible to contact the medical care providers, the school may make whatever arrangements seem necessary.

SIGNATURE OF PARENT/GUARDIAN ___________________________ TODAY’S DATE: __/__/__
To Parents/Guardians:

To meet current NJ State School Health Services Guidelines medication can only be given in school and school sponsored functions when a pupil’s health and continuing attendance in school requires it. It must be administered in accordance with the medication policy. Here are some of the highlights of the policy.

- **All medications, prescription and over the counter, must be accompanied by a written request from a physician or advanced practice nurse.** These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, the side effects, interactions with other drugs and activity restrictions based on the medication. Written orders must be renewed each school year.

- **The parent or guardian must also provide a written request for the administration of prescription and over the counter medications at school.** The parent note must include the student’s name, grade, homeroom, medication, dosage, time of administration, purpose of the medication and dates to be administered.

  **Medications must be brought to the school nurse in the original labeled container.**

- **Administration of Epinephrine and self-administration of medication for asthma or other potentially life-threatening illnesses require additional documentation.** The physician must document that the student has been instructed on self-administration and has demonstrated proper use.

For routine daily medication or if you anticipate that a doctor visit will result in medication which needs to be taken in school, contact the nurse for the Medication Authorization Form.

It is recommended that a copy of your student’s recent physical be on the record in the health office.

Do not hesitate to contact me with any questions.

Cynthia Arancia, R.N.
908-537-4044, ext. #1225

carancia@btschools.org
Part A: Health History – Completed by the parent/guardian and reviewed by examining licensed provider
Part B: Physical Examination – Completed by examining licensed provider

Student’s Name: _______________________________  Sex: ___ M  ____ F
Date of Birth: ___________________  Grade: _________  Languages Spoken at Home: _______________________
Parent/Guardian Names: ____________________________

### PART A: HEALTH HISTORY

Does the student have or have had any of the following medical conditions?

<table>
<thead>
<tr>
<th>DISEASE HISTORY</th>
<th>YES</th>
<th>NO</th>
<th>DISEASE HISTORY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Seasonal Allergies</td>
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<td></td>
<td>ADHD/ADD</td>
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<tr>
<td>Chronic Otitis Media</td>
<td></td>
<td></td>
<td>Autism Spectrum Disorders</td>
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<tr>
<td>Lyme Disease</td>
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<td>Concussions</td>
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<td>Hepatitis</td>
<td></td>
<td></td>
<td>Neuromuscular Disease</td>
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<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td>Convulsive Disorder</td>
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<tr>
<td>Strep Infections</td>
<td></td>
<td></td>
<td>Auto Immune Disorders</td>
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<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td>Juvenile Rheumatoid Arthritis</td>
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<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
<td>Congenital Disorders</td>
<td></td>
<td></td>
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<tr>
<td>Influenza (Flu)</td>
<td></td>
<td></td>
<td>Hematologic Disorders</td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td>Vision Disorder</td>
<td></td>
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<tr>
<td>Fractures</td>
<td></td>
<td></td>
<td>Hearing Disorder</td>
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</tbody>
</table>

Please provide further details on any “yes” answers, including the year:

Operations or Serious Hospitalizations:

Current Medications (Name, Dose, Frequency and Reason used):

Allergies (Name, reaction to exposure):

Drug: __________________________
Food: __________________________
Environmental: ______________________

Any other additional comments or information that you would like to provide:

______________________________
# PART B: ANNUAL PHYSICAL EXAMINATION
(Completed by examining licensed provider)

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>Pulse:</th>
<th>B/P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision: Uncorrected</td>
<td>Right:</td>
<td>Left:</td>
<td></td>
</tr>
<tr>
<td>Vision: Corrected</td>
<td>Right:</td>
<td>Left:</td>
<td></td>
</tr>
<tr>
<td>Hearing Screen:</td>
<td>Right:</td>
<td>Left:</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>NORMAL EXAM</th>
<th>ABNORMAL FINDINGS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
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<tr>
<td>Eyes</td>
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<td>Ears</td>
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<td>Nose</td>
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<td>Throat</td>
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<tr>
<td>Lymph Glands</td>
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<td>Heart</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<td>Hernia</td>
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<td>Genitalia</td>
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<td>Skin</td>
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<td>Orthopedic</td>
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<tr>
<td>Scoliosis</td>
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<tr>
<td>Neurological</td>
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<tr>
<td>Speech</td>
<td></td>
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<tr>
<td>Nutrition</td>
<td></td>
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</tbody>
</table>

**Physical Exam Comments:**

**Any Limitation of Activity or Other Recommendations?**  
___No ___Yes (please define):

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic illness, please fill out the appropriate medication packets.
2. Please attach a copy of the student’s immunization records, and include any recent TB screening results.

**Physician Signature:** ____________________________  **Date:** ____________________________
Dear Families,

The Bethlehem Township PTA would like to welcome you to the Bethlehem Township School District. Our goal as a PTA is to work with the school community to enhance the educational experiences of our children by providing cultural and social events throughout the year.

In order for us to send you information about the BTPTA, we will need you to fill out the following information and return it through either backpack mail or USPS mail to:

Backpack address: Mrs. Michelle Stegens c/o Joseph Stegens 1C
USPS address: Mrs. Michelle Stegens, BTPTA, 940 Iron Bridge Road, Asbury, NJ 08802

Thank you for taking the time to provide us with this information.

Sincerely,
Michelle Stegens
BTPTA President

Family Name: __________________________
Mailing Address: _______________________
Home Phone #: _________________________  Cell Phone#: _________________________

☐ I do not wish to be published in the Bethlehem Township School Directory.
   Your information will not be shared with anyone outside the Bethlehem Township School District.

Child(ren)'s Information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Grade</th>
<th>Teacher</th>
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</table>

Parent's/Guardian Information:

<table>
<thead>
<tr>
<th>Mom</th>
<th>Dad</th>
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<tbody>
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</tbody>
</table>

Name: __________________________
Cell #: _________________________
E-Mail: __________________________
BETHLEHEM TOWNSHIP SCHOOL DISTRICT
THOMAS B. CONLEY ELEMENTARY SCHOOL
940 Iron Bridge Road
Asbury, New Jersey 08802

Jane F. Smith
Principal

(908) 537-4044
fax (908) 537-7224

______________________________ has entered our _________ grade as of ______________

In order to better serve the needs of the pupil, we need the following information:

1. Official Administrative Record (identifying data, grade level completed, grades, attendance records).
2. Health Records
3. Teacher Observations and Ratings
4. Standardized Achievement and Aptitude Test Scores
5. Diagnostic Evaluations (may include psychological, psychiatric and/or learning evaluations, social history, etc.)
6. Other (specify) __________________________________________

________________________________________
Jane F. Smith
Principal

The above school records for ____________________________ may be released to the Thomas B. Conley Elementary School from:

School: _________________________________

Address: _______________________________

Phone Number: __________________________

Parent/Guardian Signature: ___________________________

Date: _________________________________