



Bethlehem Township School District

Thomas B. Conley School



940 Iron Bridge Road
Asbury, New Jersey 08802
Phone: (908) 537-4044
Fax: (908) 537-7224

Jane F. Smith, Principal

Dear Parent/Guardian:

The following items are required prior to enrollment in the Bethlehem Township School District.

1. Completed **Registration Packet** in addition to:
 2. Proof of Identity and Age
 - **Original** Birth Certificate with raised seal
 - Kindergarten age is 5 years on or before October 1st
 - First Grade age is 6 years on or before October 1st
 3. Proof of Residency in Bethlehem Twp. (contract/lease/property tax document)
 4. Student Information
 - Latest report card/progress report
 - Standardized Test Scores (grades 3-5)
 5. Health Office Requirements
 - Physician's Documentation of:
 - A recent physical examination (done within the past year) completed by a physician
 - Record of Immunization from Physician or School*
 - For current immunization state requirements, please consult this website:
<http://www.state.nj.us/education/students/safety/health/cdpr/immune/>
 - Health History & Physical Exam Forms
- * **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.**
6. Custodial and/or Legal Guardianship Documents (if applicable)
 7. Home Language Survey

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

**BETHLEHEM TOWNSHIP SCHOOL DISTRICT
FAMILY RECORD FORM**

(PLEASE PRINT)

NAME OF STUDENT: _____ LAST _____ FIRST _____ SEX: M _____ F _____ NICKNAME (IF ANY) _____

DATE OF BIRTH: _____ MONTH / DAY / YEAR _____ BIRTHPLACE: _____ TELEPHONE #: _____
(INDICATE IF UNLISTED)

MAILING ADDRESS: _____

PARENT CHILD IS LIVING WITH	LAST NAME (IF DIFFERENT)	LIVING	CITIZEN	OCCUPATION	BUSINESS ADDRESS	BUSINESS TELEPHONE #
FATHER						
MOTHER						
GUARDIAN (ONLY IF APPLICABLE)						

OTHER CHILDREN IN FAMILY: # OF BOYS OLDER? _____ YOUNGER _____
OF GIRLS OLDER? _____ YOUNGER _____

MARITAL STATUS OF PARENTS (PLEASE CHECK ONE): MARRIED _____ SEPARATED _____ DIVORCED _____ REMARRIED _____
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 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 _____

PARENT/ GUARDIAN SIGNATURE: _____ PARENT/GUARDIAN NAME: _____ DATE: _____

ETHNICITY (PLEASE CHOOSE ONE; THIS INFORMATION IS USED FOR STATE REPORTING PURPOSES ONLY):
_____ AMERICAN INDIAN / ALASKAN NATIVE _____ ASIAN / PACIFIC ISLANDER _____ BLACK - NOT HISPANIC ORIGIN _____ HISPANIC _____ WHITE - NOT HISPANIC ORIGIN

IS ENGLISH THE PRIMARY LANGUAGE SPOKEN IN THE HOME? YES _____ NO _____
(IF NO, INDICATE PRIMARY LANGUAGE): _____

BETHLEHEM TOWNSHIP SCHOOL DISTRICT
Thomas B. Conley School _____ or Ethel Hoppock Middle School _____

EMERGENCY INFORMATION FORM

PLEASE PRINT CLEARLY

STUDENT'S NAME: _____ Today's Date _____
 Last First Grade/Homeroom _____

ADDRESS: _____ HOME PHONE _____
 Street Town Zip

PARENT INFORMATION

E-mail address: _____

Ethnic background for State Information — optional _____

Mother: _____ Business Name: _____ Phone _____

Business Address: _____ Cell/Pager _____

Father: _____ Business Name: _____ Phone _____

Business Address: _____ Cell/Pager _____

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:

1. Name: _____ Address: _____ Phone: _____

2. Name: _____ Address: _____ Phone: _____

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 indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

(Signature of parent) X _____

Recent illnesses or injuries: _____

Latest Tetanus Immunization _____

Allergies: _____ Medication: _____

Siblings: Names _____ Ages _____ School _____

Name of Physician: _____ Office Phone: _____

Address: _____

Name of Dentist: _____ Office Phone: _____

Address: _____

Hospital of Choice:

_____ Hunterdon Medical Center _____ St. Luke's Hospital (Warren Campus)

CHECK HERE IF DO NOT WANT YOUR ADDRESS/PHONE NUMBER RELEASED FOR PUBLICATION IN THE CLASS ROSTER.

BETHLEHEM TOWNSHIP SCHOOL DISTRICT

Asbury, New Jersey 08802

To: Parents/Guardians
From: Cynthia Arancio RN, Helena Kelvaara-Laine RN
Re: Medications

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. For your convenience, I am working to have this form available on the website.

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

Don't hesitate to contact us with any questions.

Office number: 908-479-6336, ext. #2225 EHMS

Office number: 908-537-4044, ext. #1225 TBC

Email: carancio@btschools.org

Email: hkelvaara-laine@btschools.org

Bethlehem Township School District

Student Health History and Physical Examination Form

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

Birth Date _____ 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?

DISEASE HISTORY	Yes	No	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

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:

Student's Name: _____ Date of Physical Exam: _____

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

Height:	Weight	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:
		NORMAL EXAM	ABNORMAL FINDINGS:
Head			
Eyes			
Ears			
Nose			
Throat			
Lymph Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Genitalia			
Skin			
Orthopedic			
Scoliosis			
Neurological			
Speech			
Nutrition			

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: _____

Name and Address Stamp:

BETHLEHEM TOWNSHIP



PTA

Fostering cooperation and communication between the school, home, and community in order to best meet the needs of the students of Bethlehem Township

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:

<u>Name</u>	<u>Birth Date</u>	<u>Grade</u>	<u>Teacher</u>

Parent's/Guardian Information:

	<u>Mom</u>	<u>Dad</u>
<u>Name:</u>		
<u>Cell #:</u>		
<u>E-Mail:</u>		