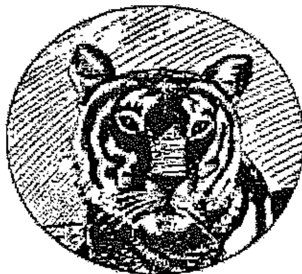
MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIIPOLA
Business Administrator/Board Secretary
973-875-3344 ext. 316
Fax: 973-875-2663



Lafayette Township School District

178 BEAVER RUN ROAD • LAFAYETTE, NJ 07848
973-875-3344 • FAX: 973-875-3066

Thank you for your interest in registering your child in the Lafayette Township School District. Please find the following documents, which need to be completed and brought with you on the day of kindergarten registration:

- Student Registration Form
- Home Language Survey
- Student Physical Exam Form (Universal Health form also accepted)
- Student Emergency Contact and Health Information Form
- Picture/Video Release Form
- Kindergarten Social History
- School Health Screening Form
- Prescription Medication Administration Form

In addition to the above completed registration forms, you must also include the following to register your child for public school within the state of New Jersey:

- A copy of your child's birth certificate
- A copy of your child's most recent immunization records
- A copy of your child's most recent physical
- 4 proofs of residency (driver's license, deed, tax bill, signed lease, utility bill, etc.)

Thank you for your prompt attention to returning these documents so we can begin the registration process. We look forward to working with you to ensure a smooth transition for both you and your child. If you have any questions or concerns, please do not hesitate to call me at 973-875-3344, ext. 6, and I will be happy to help you.

Sincerely,
Sue Webster
Secretary to the Superintendent

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Student Registration Form

Name:____
Last Name First Name Middle Name

Mailing Address:____
Street or P.O. Box

____
Town State Zip Code

Date of Birth: ______________________ Age: ____________ Grade: ________________

Gender: M_______ F_______ Proof of Residency: ______________________________

Birth Certificate Presented: __________ City & State of Birth: ______________________

Race: (Please check all with which you identify): _______Asian ________Black _______Hispanic/Latino

________ American Indian/Alaskan Native ________ Native Hawaiian/Pacific Islander _______ White

Father's Name: ____

Phone Numbers: Home:_________________________ Cell: __________________________

Work:__________________________ E-Mail Address: _____________________________

Mother's Name ____

Phone Numbers: Home:_________________________ Cell: __________________________

Work:__________________________ E-Mail Address: _____________________________

Guardian name *if applicable*: ________________________ Phone: _____________________

Emergency contact other than parents: __________________ Phone: _____________________

Any legal restrictions as to who may pick the child up from school? (Court order must be provided)

____

Pupil Resides with: Both Parents ____ Mother Only____ Father Only____ Mother/Stepfather____

Father/Stepmother____ Legal Guardian ____ Mother/Civil Union Partner____ Father/Civil Union Partner____

Foster Care____ Grandparents ____ Parent(s) Deceased ____ Parents Separated ____

Transfer Information

School Transferred From: ______________________________________ Grade Entering: ________

School Mailing Address: ____

School Phone # ___________________________ Transfer Date ___________________________

Name of Preschool (for Kindergarten registrations only) _____________________________

Transportation Information

Physical Address if different from mailing: ______________________________
Street Name Town Zip Code

House location/describe exact location of your house: ______________________________

Nearest Intersection ______________________________

Student medical information (please fill in any information needed for bus driver) ______________________________

____

Family doctor name: ______________________ Dr.'s phone: ______________________

Day Care Arrangements: ______________________________

Sibling Information

Brothers or sisters in school:

Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F
Last Name	First Name	Middle Name	Date of Birth	M/F

Any history of dyslexia in the family? ______________________________

Does your child have an IEP? ______________________ or a 504 Plan? ______________________

Date of registration: ______________________ Parent/Guardian Signature: ______________________

Required forms for registration:

- ______ Affidavit of Residency – Notarized
- ______ Language Survey
- ______ Transfer Student – Release of Records
- ______ Preschool/Kindergarten Registration – Physical Form (due at the start of school)
- ______ Transfer Student – Physical Form (most recent – signed by doctor)
- ______ Health History Form

Required Forms

- ______ Copy of Student Birth Certificate
- ______ Copy of Immunizations (most recent)
- ______ Copy of Deed/Lease/Bill/Parent License etc... (4 proofs of residency required)
- ______ Any Special Needs Information for IEP/504

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Home Language Survey*
Parent/Guardian Language Questionnaire

Directions: Fully complete and turn in with enrollment paperwork

Student Name:____ Age:_______
[first] [middle] [last]

Date of School Entrance______________________

Person completing the survey:

___ Mother ____ Father ___ Grandparent ___Guardian Other: _______________

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/her 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]______________________________

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, Sa11 Diego University, San Diego, CA 92182

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**Encuesta del Idioma usado en el Hogar*
]Idioma de Padres/Guardianes**

Instrucciones: Complete completamente y incluya con las olros papeles para matricularse

Nombre: ______________________________ Edad: ____________
[Nombre] [Inicial] [Apellido]

Fecha de la entrada a la escuela: __________

Persona que completa la Encuesta: [ ] Madre [ ] Padre [ ] Abuelo(a) [ ] Guardian [ ] Otro: __________

Direcciones: Selccoioue o escriba la respuesta eorrecta para cada una de las siguientes preguntas acerca de su hijo.

1. ¿Cual idioma aprendi6 su hijo(a) cuando empez6 a hablar por primera vez?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

2. ¿Cual idioma se habla en su hogar la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

3. ¿Cual idioma le habla usledes al nino(a) la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

4. ¿Cual idioma habla el nino(a) con ustedes la mayoda del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

5. ¿Cual idioma le habla el nino(a) a sus hennanos(as) la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otro [Especifique cual]: __________

6. ¿Cual idioma habla el nino(a) a sus amigos la mayoria del tiempo?

   Ingles: [ ] Espanol: [ ] Otl·0 [Especifique cual]: __________

Finna: __________________ Fecha: __________

[Persona quc lleno la cncuesta]

* Adnptado de In encuesla cjemplar en A Mnin1al for Conmmnily Reprcscnlalivc ofIhe Title VI Steering Commillcc, publicatio en 9/76, pc>r cl Inslilulo de Plumlismo Cultural, Luu Gcncml Assistance Center, Sm Diego University, San Diego, CA 9218

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
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STUDENT EMERGENCY CONTACT & HEALTH INFORMATION

Student's Name: ______________________________**Male/Female:** _______**Date of Birth:** _________________
Grade:______ **Homeroom:** ___________________**City of Birth:** ______________________________

Home Address: ____
Address City State Zip

Mailing Address: ____
Address City State Zip

Mother's Name: ________________________________ **Resides With Student? Yes**_____ **No**_____
Address: ____
Mother's Home Phone: ___________________________
Mother's Employer: ___________________________ Daytime Phone: ___________________
Mother's Cell Phone: ___________________________ Mother's Email: ___________________

Father's Name: ________________________________ **Resides With Student? Yes**_____ **No**_____
Address: ____
Father's Home Phone: ___________________________
Father's Employer: ___________________________ Daytime Phone: ___________________
Father's Cell Phone: ___________________________ Father's Email: ___________________

Guardian's Name & Relationship: ____________________ **Resides With Student? Yes**_____ **No**_____
Address: ____
Guardian's Home Phone: ___________________________
Guardian's Employer: ___________________________ Daytime Phone:___________________
Guardian's Cell Phone: ___________________________ Guardian's Email: ___________________

List a maximum of 5 persons who you authorize to pick up your child at any time from school.
A note from you is required for all persons whose names do NOT appear on this list.

Contract 1
Name: ______________________________Relationship: ______________________
Home Phone____
Daytime Phone: ___________________________ Cell Phone: ______________________

Contact 2
Name: ______________________________Relationship: ______________________
Home Phone: ____
Daytime Phone: ___________________________ Cell Phone: ______________________

Contact 3
Name: ______________________________Relationship: ______________________
Home Phone: ____
Daytime Phone: ___________________________ Cell Phone: ______________________

Contact 4
Name: ______________________________Relationship: ______________________
Home Phone: ____
Daytime Phone: ___________________________ Cell Phone: ______________________

Contact 5
Name: ______________________________Relationship: ______________________
Home Phone: ____
Daytime Phone: ___________________________ Cell Phone: ______________________

Student's Name: ____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Emergency Information:

Family Physician and/or Clinic Facility: ______________________

Address: ______________________

Phone: ______________________

All medications, including Tylenol, require written parental permission renewed annually. Prescription and non-prescription medications must be sent in the original container accompanied by the school's Prescription Medication Administration form.

I hereby give permission for the school nurse to administer acetaminophen (generic Tylenol) to my child who is not allergic to it: YES_____ NO_____

My son/daughter has the following medical problems, chronic disease, or allergies:

____

My son/daughter takes the following medication(s) on a regular basis:

____
____

**Information regarding my child's medical history and/or condition may be shared with school staff on a need to know basis: YES_____ NO_____

______________________ ______________
Parent/Guardian Signature **Date**

Insurance Information Requested By
State of New Jersey Department of Education

Does this child have Health Insurance?

YES_______ If YES, name of insurance company______________________

NO_______ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information and to apply to the program, call 800-701-0710 or visit www.njfamilycare.org to apply online.

Upon request by NJFamilyCare, do we have your permission to release your name and address to the NJ FamilyCare Program so that they may contact you about health insurance? If yes, please sign below. We cannot guarantee they will contact you so please call the number above or visit their website if you are interested in learning more about or applying for this program.

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

____
Signature Printed Name Date

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
178 Beaver Run Road
Lafayette, NJ 07848
Phone: (973) 875-3344 Fax: (973) 875-3066

Parental/Guardian Consent Form
For Release of Student Name And/Or Picture/Video

Dear Parent /Guardian,

From time to time during the school year we take pictures and/or videos of class activities and special events for the school newspaper, yearbook, or for other classroom projects. There are also times when we are asked or choose to submit this information, along with our students' names, to the local newspapers for recognition of our school programs and students.

We would like to work with you in determining the level of consent for your child. We will not publish personally identifiable information for your child without written consent from you as parents(s) or guardian(s). The following are some examples of "personally identifiable" information: student name, photo/image, grade, residence, etc.

Please be advised that your consent will continue for the duration of your child's enrollment in the Lafayette Township School District. If you, as a parent or guardian, wish to rescind this agreement, you may do so at any time, in writing, by sending a letter to the superintendent and such action will take effect upon receipt of this request in the school's main office.

Please indicate your choice of level of consent and return the entire page to Lafayette Township School District as soon as possible. If you have more than one child, please use a separate form for each child.

~~~~~~

Parental/Guardian Consent Form
For Release of Student Name And/Or Picture/Video

Date: ____________________

Student's Full Name (please print): ____ Grade__________

_____ YES: Your selection of "YES" grants your permission for Lafayette Township School administration, staff or its designees to photograph or video record your child during school sponsored events or activities with your understanding these photos, images or videos, along with your child's name, could appear in local newspapers and school publications in recognition of school programs and/or accomplishments.

_____ NO: Your selection of "NO" indicates your preference to exclude your child from having his/her picture and or video taken during school sponsored events and activities and that your child's name will not be published in any publications.

____ ____

Parent/Guardian Signature Parent/Guardian Printed Name
~~~~~~

LAFAYETTE TOWNSHIP SCHOOL DISTRICT
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Kindergarten Registration Social History Form

GENERAL INFORMATION

Child's Name________________________________ Date of Birth____________________

Parent(s)Guardian(s)____

Home Address____

Home Phone______________________________

PHYSICAL INFORMATION

1. Conditions which may affect school progress:

   ___hearing ___speech ___eyesight ___other

   Explain:____

   ____

2. Walked at age:____________________ Talked at age:____________________

3. Which hand does your child use? left / right

4. Usual bed time:__________________ Usual waking time:____________________

5. Can your child use the bathroom independently all the time? yes / no

6. Can your child tie shoes? yes / no Zip a jacket? yes / no

SOCIAL & EMOTIONAL DEVELOPMENT

1. List all siblings and their ages:____

   ____

2. Does your child have preschool experience? yes / no Where?____________________

For how long?____________________

(OVER)

3. Does your child share, take turns, respect the rights of others?____________________

____

4. Does your child makes friends easily?____________________

5. Is there a preference to play with older children or younger children?____________________

____

6. Are there any special circumstances that you feel the teacher should be made aware of (new baby, family illness, death, divorce/separation)?____________________

____

____

____

COGNITIVE / FINE MOTOR DEVELOMENT

1. Does your child enjoy books?____________________

2. Does your child spend time coloring, writing, cutting with scissors, and using glue?____________________

____

3. Does your child express ideas and/or needs well?____________________

____

4. Can your child: write his/her name?____________________

recognize letters of the alphabet?____________________

count objects?____________________

5. Is there a family history of any learning or behavioral concerns that the teacher should be aware of?____________________

____

____

Lafayette Township School
178 Beaver Run Road, Lafayette, NJ 07848

<u>Student Physical Examination Form</u>

Phone 973-875-3344 Fax 973-875-3066

Student________________________________ Parent/Guardian Contact #__________________
Date of Birth____________________ Sex_______ Date of Last Medical Exam__________________
Height_______________ Weight____________ Blood Pressure________________________________

______Ears	______Heart	______Skin
______Eyes	______Lungs	______(non-communicable)
______Lymph Glands	______Abdomen	______Nutrition
______Thyroid	______Hernia	______Nervous System
______Nose	______Genito-Urinary	______Speech
______Throat	______Orthopedic	______Other
______Teeth	______Allergies	

General Comments____
Surgery____
Injuries____
Disabilities____
Activity Restrictions____
Is this child on any medication?____________ If so, what?______________________________

____

<u>Immunization Record</u> – Indicate below as Day/Month/Year or attach Complete Immunization Record.
Pneumococcal (required for entrance to Pre-School only) 1.___________ 2.___________
Flu Shot (required for entrance to Pre-School only) 1.___________
DTAP 1.__________ 2.__________ 3. __________ 4. __________ 5.__________ 6.__________
MMR 1.__________ 2.__________
Hepatitis B 1.__________ 2.__________ 3.__________
Meningococcal __________
Polio Vaccine – Indicate Type: _____IPV or _____OPV
1.__________ 2.__________ 3.__________ 4.__________
HIB 1.__________ 2.__________ 3.__________ 4.__________
Mantoux – Date:__________ Results: __________
Lead Level – Date:__________ Results: __________
COVID-19 Vaccine:______________

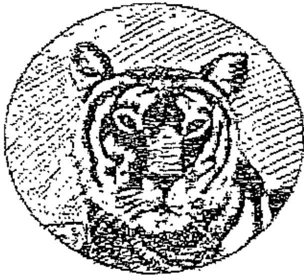
<u>Illness/Disease Record</u> - Write <u>*YES*</u> or <u>*NO*</u> & include <u>*DATE*</u>

Chicken Pox____________________	Pertussis____________________
Rubella____________________	Convulsive Disorder____________________
Measles____________________	Asthma____________________
Mumps____________________	Diabetes____________________
Scarlet fever____________________	Otis media____________________
Rheumatic fever____________________	Other____________________

Physician's Name (Print)________________________________ Phone #________________

Examining Physician's Signature & Date________________________________

HCP Office Stamp (required)



Lafayette Township School District

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973-875-3344 • FAX: 973-875-3066

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Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

ERIN SIIPOLA
Business Administrator/Board Secretary
973-875-3344 ext. 316
Fax: 973-875-2663

Dear Parent/Guardian:

The following information is needed to up-date your Child's Health Record.
Please complete and return to school as soon as possible.

Student Name______________________________ Grade __________

Teacher's Name______________________________ School Year____________

I am aware that my child will participate in the following School Health Services where applicable:

1. Vision and hearing screening
2. Height and weight
3. Blood pressure
4. Scoliosis screening-starting at age 10, to be completed every other year

_________**I wish to be present for scoliosis screening.**
_________**I decline to have the following screenings completed on my child at school:**
____

My child was seen by his/her pediatrician on ______________________(date) for a physical.

If you decline screenings, **you must attach a copy of your child's physical**The physical must include: Vision and hearing screening, height and weight, blood pressure and scoliosis.

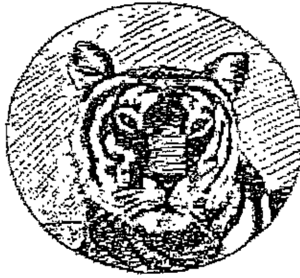
______________________________ ____________________
Signature of Parent/Guardian Date

Please fill out the following pertinent information: (Any changes from last school year)

Immunizations:______________________________
Allergies:______________________________
Surgery:______________________________
Injuries:______________________________
Medication:______________________________

Sincerely,

Lillian MacRae
Certified School Nurse



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Authorization For Dispensing Medication in School:

NOTE: Whenever possible, medication should be given at home and every effort should be made to avoid school hours.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child________________________________, grade _________receive medication in school as prescribed by his/her physician in the form below. The medication will be given to my child per Board Policy. understand that the district is rendering a service and does not assume any responsibility for this matter, I further understand that the school nurse will administer the medication.

Signature____Parent or Guardian

Phone Number:__________________________ Date____________________

TO BE COMPLETED BY PHYSICIAN: I request that my patient receive the following medication:

Name of Student: ____

Diagnosis: ____

Name of Medication: ____

Prescribed dosage and means of Administration: ______________________________

Time to be taken during school hours: ____________________________________

Expected duration of treatment: ____________________________________

Possible side effects and adverse reactions: ______________________________

Other recommendations:____

Physician's Signature: ___________________________ Physician Stamp:

Phone number:___________________________
Date: ___________________________

Lillian MacRae
Certified School Nurse

Mr. MICHAEL GALL
Superintendent
973-875-3344 ext. 315

GERARD FAZZIO
Principal
973-875-3344 ext. 314

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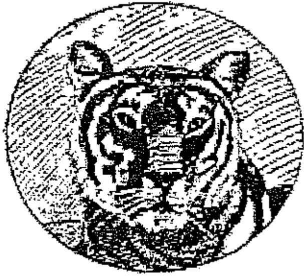

Lafayette Township School District

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Medication Information:

The Lafayette Township School District Nurses will administer medication in school according to the State of New Jersey law.

MEDICATION GIVEN IN SCHOOL BY THE SCHOOL NURSE:

- Medication will be given in school during regular school hours only when the student's attendance depends on the timely administration of such medication. "Medication" as per this law means any prescribed drug, or over-the-counter medication including but not limited to aspirin and cough drops.
- Requests for medicating a student in school must be made in writing and signed by the student's physician.

NOTE: ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER WITH THE PHARMACY LABEL ATTACHED.
MEDICATION CAN NOT BE EXPIRED.

IMPORTANT: PARENTAL HANDWRITTEN NOTES WILL NOT BE ACCEPTED TO ADMINISTER MEDICATION. NEW JERSEY REGULATION REQUIRES PHYSICIAN ORDERS. PARENTS MAY CALL THE PEDIATRICIAN TO FAX OR EMAIL ORDERS TO THE BUILDING NURSE.

Feel free to contact the nurse with any questions or concerns:

Sincerely,

Lillian MacRae
Certified School Nurse