2a School Lane. P.O. Box 160
Roosevelt, NJ 08555-0160

T 609.448.2798
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REGISTRATION FORM

Resident Student_____ **Choice Student____** **Tuition PreK_____**

Grade:____________________

Student's Name:______________________________________Date of Birth:_______________

Address:____PO Box__________

City:_______________________State_______ Zip___________Phone #___________________

Place of Birth:____Age:______________________

Birth Authentication:________________________(Original Birth Certificate must be presented.)

Father's Full Name:___________________________ Place of Birth:______________________

Work Phone ________________________________ Cell Phone _________________________

Mother's Full Name:__________________________ Place of Birth:______________________

Work Phone ________________________________ Cell Phone _________________________

E-mail Address____

Guardian's Full Name:_______________________ Place of Birth:________________________

Guardian's Relationship to Child:____

Parent's Living; Mother ___yes ___no, Father ___yes ___no.

With whom is the child living with? ____

If parents are divorced, which parent has legal custody?______________________________

Please indicate specific instructions regarding custody of the child.________________________

____

____

Please list any known **food allergies**:____

What language is mostly spoken at home:____

Brothers: (Names and birth dates)____

Sisters: (Names and birth dates)____

If the student attended other schools, specify the name and address of the last school attended and the last grade
attended:____

____

____

Date of Registration:___________ Parent's/Guardian's Signature:_______________________

How did you hear about RPS?

___ Word of mouth ____ Internet

___ Tuition Ad/Newspaper Other____

MINIMUM IMMUNIZATION REQUIREMENTS
FOR SCHOOL ATTENDANCE IN NEW JERSEY

For Pre-school attendance (required BEFORE entering school):
DTP/ DTaP (Diptheria, Tetanus, Pertussis)- 4 doses
IPV/OPV (Polio)- 3 doses
MMR (Measles, Mumps, Rubella) - 1 dose
Varicella (Chickenpox)- 1 dose
Hib (Haemophilus influenzae B)- 1 dose
Pneumococcal- 1 dose
Influenza- 1 dose to be given between September 1 and December 31 of each year

For Kindergarten (required BEFORE entering school) through grades 5:
DTP/DTaP- 4 doses with **one given on or after the 4th birthday**
IPV/OPV- 3 doses with **one given on or after the 4th birthday**
MMR- 2 doses
Varicella- 1 dose
Hep B (Hepatitis B)- 3 doses

For Sixth Grade attendance (required BEFORE the first day of school):
All of the above plus:
Tdap (Tetanus, diptheria and acellular pertussis)- 1 dose given no earlier than the 10th birthday
Meningococcal- 1 dose given on or after the 11th birthday (must provide school with documentation of receiving the vaccination after their birthday if student turns 11 after the start of the year)

Tuberculosis Screening (PPD/ Mantoux) will be required only of those students entering a United States school system for the first time who were born or living in a country listed by the New Jersey Department of Health and Senior Services as having a high incidence of TB (Tuberculosis).

LANGUAGE SURVEY

Dear Parents/Guardians:

In order to plan for your child's educational needs, we are asking you to answer the questions listed below regarding your child's native language.

Please answer all questions and sign the form. Thank you for your cooperation.

****

Student's Name:_______________________________ Grade:_________________________
School_______________________________________ Date:__________________________

1. What language do you most often use when speaking to your child?_______________
2. What language did your child first use for communication?_______________________
3. What language does your child most often use when speaking to brothers, sisters, and other children at home? ____
4. What language does your child often use when speaking with you or other adults in the home? (grandparents, aunts, uncles) ________________________________
5. What language does your child most often use when speaking with friends or neighbors? ____

****

In which language do you wish to receive communication?

____

Parent/Guardian
Signature:____________________________Date:__________________________

(Definition of native language from New Jersey Department of Education: The language first used by student, or the language most often spoken at home regardless of the language spoken by the student.)

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FOR SCHOOL USE ONLY

Language _______________________________ Code____________________

HEALTH HISTORY and PHYSICAL EXAMINATION FORM

(To be completed by Physician)

Student's Name_________________________________Birth Date:______________________

Address____Telephone_____________________

____

Doctor's Name__________________________________ Telephone_____________________

Address____

____

Father's Name____

Mother's Name____

Immunizations: Please attach a copy of your child's updated immunization record from their primary care physician.

Health History Questionnaire:

Does your child have any ongoing or chronic illness?

____

____

Has your child had any recent injuries?____

Has your child had surgery?____

Does your child take any prescribed medications?

____

____

Does your child have any allergies or asthma?_______________________________________

____

Does your child have a life threatening allergy that may require the administration of an epinephrine auto-injector?

____

*****If your child caries an epinephrine auto-injector (such as EPIPEN), please contact the school nurse as soon as possible to discuss the care of your child during the school year.*****

Are there any other health conditions that we should be aware of?_______________________

____

____

____

____

Student's Name______________________________ Birth Date:____________________

NOTES

HEIGHT ____________________
WEIGHT ____________________
HEAD ____________________
EYES ____________________ VISION SCREENING ________________
EARS ____________________ HEARING SCREENING ______________
NOSE ____________________
MOUTH ____________________
TEETH ____________________
THROAT ____________________
NECK ____________________
CHEST ____________________
HEART ____________________
LUNGS ____________________
ABDOMEN ____________________

GENITALIA ____________________
EXTREMITIES ____________________
SKIN ____________________
BACK ____________________
ADENOPATHY ____________________
DEEP REFLEXES ____________________
SUPERFICIAL REFLEXES ____________________
NUCHAL RIGIDITY ____________________
POSTURE ____________________
DEVELOPMENT ____________________
NOURISHMENT ____________________
BLOOD COUNT ____________________

COMMENTS, RESTRICTIONS, RECOMMENDATIONS

____
____
____
____
____
____
____
____

______________________________ ______________________________
Date ***Physician's Signature***

Phone #______________________________