



2a School Lane, P.O. Box 160
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REGISTRATION FORM

Resident Student Choice Student Tuition PreK

Student's Name: _____ Grade: _____
Date of Birth: _____
Address: _____ PO Box _____
City: _____ State _____ Zip _____ Phone # _____
Place of Birth: _____ Age: _____
Birth Authentication: _____ (Original Birth Certificate must be presented.)
Ethnicity: Hispanic _____ Non-Hispanic _____
Race: (Mark applicable) White: ___ Black: ___ Asian: ___ Native American: ___ Hawaiian: ___
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

___ Tuition Ad/Newspaper

___ Internet

___ Other



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.)

FOR SCHOOL USE ONLY

Language _____

Code _____



MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY

For Pre-school attendance (required BEFORE entering school):

DTP/ DTaP (Diphtheria, 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, diphtheria 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).



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 carries 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 # _____



School Health Services

DENTAL FORM

Dear Parent/Guardian,

Healthy teeth and gums are an important part of a child's overall well being.

By encouraging healthy food choices with limited sweets, daily brushing and flossing, and regular dental examinations, dental problems can often be minimized or avoided.

Please ask your child's dentist to complete this form, then return it to the school nurse.

Student's Name _____

D.O.B. _____ Grade _____ Teacher _____

Please Check (for Dentist to complete):

___ The necessary dental service has been completed.

___ The student is receiving dental treatment for _____.

___ The student does not need dental treatment at this time.

Date of last dental exam _____

Dentist's Signature _____ Date _____

Office Stamp