Pine Hill School District

1003 Turnerville Rd. Pine Hill, NJ 08021

Kenneth K. Koczur, Ed.D. Office 856-783-6900
Superintendent

ENROLLMENT RESIDENCY CHECKLIST

To be completed by district enrollment clerk

In accordance with New Jersey State Law (N.J.S.A. 18A:38-1 and 18A: 7B-12), it is necessary to determine the residence of students entering the school district by answering the following question:

1. Does the student reside in any of the following facilities? (Please check where applicable.)

____ A home the parent/guardian owns or is renting ***(Skip remaining homeless registration procedures. Pages2-4)***

____ family* or friend's home by choice
(* grandparent, aunt, uncle, brother, sister, cousin, etc.)

____ family* or friend's home **out of necessity**
(* grandparent, aunt, uncle, brother, sister, cousin, etc.)

____ home for adolescent school-age mothers

____ motel

____ migrant family dwelling

____ shelter

____ transitional housing facility

____ other (identify):_____

Student's Name _____ Date_____

Parent's Name _____ Date_____

School District Staff: Forward this completed checklist and the Declaration of Residency Form to the Pine Hill School District's Homeless Liaison within two days.

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DECLARATION OF RESIDENCY FORM

To be completed at time of enrollment by parent/guardian

This is to inform the Pine Hill Board of Education that my child(ren)

_____

_____

and I _____ (Parent/Guardian)

are temporarily residing at the following address:

_____

We are living with _____ Telephone # _____
(Name & Relationship)

My last address that I rented, leased or owned was _____

_____

The school district that my child(ren) attended while living at that address was _____

My child(ren) attended _____School.

The causes of my becoming homeless are _____

_____

____ I request to register my child(ren) in the Pine Hill School District.

____ I prefer for my child(ren) to attend school in the former school district.

Name of former district _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____

Date _____

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PARENT/GUARDIAN AFFIDAVIT

To be completed by the parent/guardian

I, _____, of full age, being duly sworn upon my oath, deposes and says:

1. I am domiciled at the following address:

   _____

   _____

2. I affirm that my child(ren)_____ is/are temporarily residing in the residence of relatives or friends named here:

   _____

   because my family lacks a regular or permanent residence of our own in accordance with N.J.A.C. 6A:17-2.3(a)(3).

3. I certify that I am not capable of supporting or providing care to my child(ren) due to family or economic hardship and my child(ren) is/are not residing with relatives or friends solely to receive a free and/or better education per N.J.A.C. 6A:22-3.2.
4. I understand that my child(ren)'s eligibility may be subject to re-evaluation, and that tuition may be sought in the event that my child(ren) is/are determined not to be eligible as a result of fraud or untruthful information.
5. I have been consulted and understand that the district of residence will make the decision regarding the educational placement of my child(ren). If I disagree with that decision, I have the right to appeal to the County Superintendent of Schools.
6. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-1 and N.J.A.C. 6A:17-2.
7. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

_____
Parent/Guardian Signature

Sworn and Subscribed to before me the _____day of _____.

_____
Signature of Notary Public

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RESIDENT AFFIDAVIT

To be completed by the homeowner

I, _____, of full age, being duly sworn upon my oath, deposes and says:

1. I am domiciled at the following address within Pine Hill:

   _____

   _____

2. I affirm that the school aged child(ren):

   _____

   is/are residing in my residence temporarily out of necessity because the child(ren)'s family lacks a regular or permanent residence of their own in accordance with N.J.A.C. 6A:17-2.3(a)(3).

3. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-1 and N.J.A.C. 6A:17-2.
4. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

_____
Signature of homeowner

Sworn and Subscribed to before me this _____ day of _____.

_____
Signature of Notary Public

PARENT CONSULTATION

I, the parent/guardian of the above named child(ren) understand that the district of residence will make the decision for his/her/their educational placement based upon the best interests of the child(ren) after consulting with me. If I disagree with that decision, I know that I may appeal to the county Superintendent of Schools.

Parent/Guardian agrees with placement: Yes: _____ No: _____

Parent/Guardian Signature: _____ Date: _____

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Registration Form

Date_____ SID#_____

FULL NAME AS IT APPEARS ON LEGAL DOCUMENTS

STUDENT		
LAST NAME	FIRST NAME	MIDDLE NAME

STUDENTS PERSONAL INFORMATION

Date of birth (mm/dd/yyyy)	Grade Level at Registration	Gender ○ Male ○ Female
Birthplace: City	State	Country
Former Pine Hill Student yes/no	Country of Birth	Date first enrolled in ANY U.S. School (mm/dd/yyyy)

ETHNICITY AND RACE INFORMATION

Ethnicity (check only one): ○ Hispanic or Latino ○ Not Hispanic or Latino	Race: (check one or more) ○ American Indian ○ Asian ○ Black or African American ○ Native Hawaiian or other ○ White

OTHER SCHOOL AGE CHILDREN

Child's Name	School Name/Location	Grade	DOB

PREVIOUS SCHOOL ATTENDED

School Name	Date of Attendance
School Address	Grade Level(s) Attended
School Phone Number	Public School Private School Other_____
School Name	Date of Attendance
School Address	Grade Level (s) Attended
School Phone Number	Public School Private School Other_____

Preschool Attendance

Yes / No	Name and Location	Attendance Dates

PARENT/ LEGAL GUARDIAN NAME- PRIMARY

		Circle:
First Name	Last Name	Mr./Mrs/Ms./Dr.
For Security Purposes Only Parent/Guardian Date of Birth (MM/DD/YYYY)		
Relationship to Child: o Mother o Father Other:_____	Divorced or Separated? Y / N *If yes, o Sole Custody o Joint Custody Please provide documentation of physical custody.	

PHONE/EMAIL CONTACT INFORMATION

Phone	Type (choose one)	Phone Number (Ext)	Automated Contact System
Primary	○ Cell ○ Home ○ Work ○ Other		
Phone 2	○ Cell ○ Home ○ Work ○ Other		

Email Address:

PHYSICAL ADDRESS

Street #	Street Name	Apt # (if applicable)
City/Town	State	Zip Code

PARENT/ LEGAL GUARDIAN NAME- SECONDARY

Can pick up child : Yes / No		Circle:
First Name	Last Name	Mr./Mrs/Ms./Dr.
For Security Purposes Only Parent/Guardian Date of Birth (MM/DD/YYYY)		
Relationship to Child: ○ Mother ○ Father Other:_____	Divorced or Separated? Y / N *If yes, ○ Sole Custody ○ Joint Custody Please provide documentation of physical custody.	

PHONE/EMAIL CONTACT INFORMATION

Phone	Type (choose one)	Phone Number (Ext)	Automated Contact System
Primary	○ Cell ○ Home ○ Work ○ Other		
Phone 2	○ Cell ○ Home ○ Work ○ Other		

Email Address:

PHYSICAL ADDRESS

Street #	Street Name	Apt # (if applicable)
City/Town	State	Zip Code

EMERGENCY CONTACT –PRIMARY- **OTHER THAN GUARDIAN**

			Circle:
	First Name	Last Name	Mr./Mrs/Ms./Dr.
Relationship to Child:		Is this person authorized to pick-up/transport your child in case of emergency Y/N	

Phone	Type (choose one)	Phone Number	Ext
Primary	○ Cell ○ Home ○ Work ○ Other		
Phone 2	○ Cell ○ Home ○ Work ○ Other		

EMERGENCY CONTACT –SECONDARY-*_OTHER THAN GUARDIAN_*

			Circle:
	First Name	Last Name	Mr./Mrs/Ms./Dr.
Relationship to Child:		Is this person authorized to pick-up/transport your child in case of emergency Y/N	

Phone	Type (choose one)	Phone Number	Ext
Primary	○ Cell ○ Home ○ Work ○ Other		
Phone 2	○ Cell ○ Home ○ Work ○ Other		

HEALTH INSURANCE INFORMATION

Health Insurance Provider	Name of Provider:
Primary Care Doctor	Name: Number: Address:

IEP / 504 PLAN – Yes / No

IEP	504 Plan
○ Special Ed ○ Speech ○ Basic Skills Math ○ Basic Skills Reading ○ Resource Room	○ Basic Skills Math ○ Basic Skills Reading ○ Other

Person Enrolling Student _____

Relationship to student if other than parent _____

Parent/Guardian Signature _____

Date _____

For Office Use Only	
Home School_____ School Enrolled, If different_____ Missing Documents _____ _____	Out of Assigned District Program placement (ELL,Spec.Ed) _____ Tuition Student _____ Date of Packet Complete_____

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Request for Records

Students Name: _____

Date of Birth: _____ Grade: _____

Please send all academic records, including test results, reading and math levels, report cards, any child study team evaluation records, speech files, attendance record, copy of grading scale, discipline records, transfer card, withdraw papers, including exit grades and any other cumulative folder items, including medical records. PLEASE SEND ORIGINALS.

FORWARD TO:

____ Dr. Albert Bean School
70 East Third Avenue
Pine Hill, NJ 08021

____ John H. Glenn
1005 Turnerville Rd
Pine Hill, NJ 08021

____ Pine Hill Middle School
1100 Turnerville Rd.
Pine Hill, NJ 08021

____ Overbrook High School
1200 Turnerville Rd.
Pine Hill, NJ 08021

____ Special Services/ Child Study Team
1200 Turnerville Rd.
Pine Hill, NJ 08021
(856)767-8000 ext 3020

Parent Consent:
I have enrolled my child in the above school and authorize you to release the records as indicated to the school marked above. I also give permission to Pine Hill Public School to obtain or release records to Out of District programs if that is the program my child requires.

_____ _____
Authorized Signature Date

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Special Education Medicaid Initiative (SEMI) Parental Consent Form

_____ School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act,34 CFR 99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR 300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally indefinable information, such as student records or information about services provided to your child including evaluations, and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district <u>does not</u> impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, and loss of eligibility or impact on lifetime benefits.

Child's Name _____

Child's Date of Birth _____/_____/_____

Parent _____ Date _____/_____/_____

I give consent to bill for SEMI: Yes
No

This consent can be revoked at any time by contacting the administrator at your child's school.

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Medical History Form

Student Name: _____

Prenatal History:

Was baby full term? Yes_____ No_____

Were there any concerns about the pregnancy? Yes_____ No _____

If yes, reason for concern _____

Did mother take any medications during pregnancy? Yes_____No_____

If yes, please list medications _____

Postnatal History

Birth weight of child _____

Did the baby experience any of the following:

	Yes	No
Oxygen Therapy		
Difficulty Breathing		
Difficulty Swallowing		
Jaundice		

Did the baby leave the hospital when mom was discharged Yes____ No____

If no, please explain _____

Family Medical History

Has anyone in the family ever had:

	Yes	No	Explain
Diabetes	____	____	_____
Tuberculosis	____	____	_____
Heart Disease	____	____	_____
High Blood Pressure	____	____	_____
Stroke	____	____	_____
Kidney Disease	____	____	_____
Cancer	____	____	_____
Mental Illness	____	____	_____
Asthma	____	____	_____
Genetic Diseases	____	____	_____

Has Child Had:

Allergies	____	____	_____
Chronic Illness	____	____	_____
Asthma/Wheezing	____	____	_____
Chickenpox	____	____	_____
Pneumonia/bronchitis	____	____	_____
Frequent sore throat	____	____	_____
Frequent ear infections	____	____	_____
Frequent vomiting/diarrhea	____	____	_____
Convulsions/seizures	____	____	_____
Eczema/hives	____	____	_____
Reaction to insect bites	____	____	_____
Bleeding problems	____	____	_____
Thumb/Finger sucking	____	____	_____
Nightmares/Sleep disturbance	____	____	_____
Temper Tantrums	____	____	_____
Bed wetting/toilet problems	____	____	_____
Problems with vision	____	____	_____
Problems with hearing	____	____	_____
Problems with speech	____	____	_____
Any SEVERE injury	____	____	_____
Any operations	____	____	_____
Any long-time chronic illness	____	____	_____
Any special medication	____	____	_____
Any physical restrictions	____	____	_____
Physical abnormality/disability	____	____	_____
Diabetes	____	____	_____
Heart trouble	____	____	_____

Nutrition:

Unusual weight gain or loss, explain _____

Food Allergy _____

Treatment for food allergy _____

Summary

Is there anything in regard to your child's health or behavior that you would like to comment upon?

_____

May we share this information with your child's teacher? Yes____ No____

_____ _____

Parent signature Date

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Speech and Language Case History Summary

Dr. Albert Bean School
Paulette Taylor
Speech/Language Specialist

John H. Glenn School
Ruth Blake
Speech/Language Specialist

Child's Name_____ Telephone #_____

Address _____

Date of Birth _____ Age _____

Parents/Guardians _____

Brothers/Sisters (Names and Ages) _____

_____

Speech and Language History

Yes	No	
___	___	Are there any relatives who have speech, language or hearing problems?
		If yes, please explain_____
___	___	Did your child babble as an infant?
___	___	Does your child understand directions and carry them out appropriately?
___	___	Does your child have any difficulty expressing themselves?
___	___	Does your child have trouble pronouncing words?
		If yes, please explain_____
___	___	Has your child had ear infections or shown difficulty hearing?
___	___	Has your child had two or more upper respiratory problems per year?
___	___	Does your child have allergies? Medication taken _____
___	___	Does your child have visual problems? Glasses?
___	___	Does your child visit the dentist regularly? Any dental problems?
		When did your child speak their first word? _____
		When did your child begin combing two or more words as a sentence?_____