REGISTRATION REQUIREMENTS

Please complete the attached forms and return them to the appropriate school at the time of registration:

☐ PROOF OF AGE:

Original birth certificate or passport.

☐ MEDICAL:

Copy of immunization records. Please note that your child will not be able to attend school unless the Physical Examination/Immunization Form is completed and signed by your child's physician. The physical exam must be no more than one year old as of the first day of attendance. If your child's last physical exam does not meet these guidelines, please bring in proof of his/her immunization records and submit the updated physical before the first day of school. **Also note that there are additional immunization requirements if you are registering a student in the 6th grade or higher.**

☐ PROOF OF RESIDENCE:

Homeowners – Deed or Property Tax Statement

Renters – Current, signed lease with full names of all persons living at the address.

Non-Leaseholders – (You rent but do not have a lease or you reside with a family member.) Please complete the attached Affidavit of Owner/Landlord. If you are renting from the owner please attach a copy of the owner's deed or property tax statement. If you are renting from a renter please attach a copy of the renter's current signed lease.

☐ Unofficial copy of transcript and / or report card from previous school.

THE SOMERSET HILLS SCHOOL DISTRICT

Entrance Registration

Part 1: Student Information:

Student's Legal Name_____ **Date of Birth:**_____
(last, first, middle)

Residence Street, City, Zip_____ **Gender:** M F

Mailing address (if different) _____ **Siblings in District (name & grade)**
(street, city, state, zip)

1_____

Ethnic Background (*Required* – Please check all that apply. See end of form for explanation.) 2_____

____American Indian/Alaskan Native _____Native Hawaiian/Pacific Islander ____Asian 3_____

____Black or African American _____White or Caucasian ____Hispanic or Latino

Country of Birth_____ **State of Birth** _____ **City of Birth**_____

What was the first language your child learned to speak? _____

Please indicate the primary language spoken at home, regardless of the language spoken by the student:

English_____ **Spanish**_____ **Other**_____**(please specify)**

What is the language most often spoken by the student? _____

Part 2: Parent Information:

Parent(s)/Guardian(s) with whom student resides:

Name_____ **Relationship**_____ **Cell Phone**_____

Name_____ **Relationship**_____ **Cell Phone**_____

Home Telephone _____ **Other Telephone** _____ **(specify)**

Mother email address _____**Father email address** _____

*****If student does not reside with parent(s), proof of legal custody or guardianship papers must be attached*****

Information about non-resident parent (if applicable):

Name_____ **Relationship**_____

Mailing address_____ **City, State, Zip**_____

Home Phone_____ **Cell or Business Phone**_____ **Addl mailing required Y N**

Does 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 call 800-701-0710 or visit www.njfamilycare.org to apply online.**

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ **Printed Name** _____ **Date** _____

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

Revised November 2016

Part 3: School information

Grade registrant is entering:_____ **Last grade completed:**_____

School name and address transferring from:_____

_____
(city, state)

What date did your child first enter a U.S. School (mm/dd/yyyy)? _____

Is your child currently receiving, or has your child ever received special education services through the school? Y N

Does your child currently have an IEP (Individual Educational Program)? Y N

Has your child ever been excluded from school as a result of a weapons charge? Y N

Has the registrant ever attended school in the Somerset Hills School District? Y N If Yes, Grades attended_____

I certify that the information provided herein is true and accurate:

Signature of parent or legal guardian_____ **Date** _____

Explanation of ethnicity questions:

Hispanic or Latino *– A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race.*

American Indian or Alaska Native *– A person having origins in any of the original people of North and South America (including Central America) and who maintains a tribal affiliation or community attachment.*

Asian *– A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

Black or African American *– A person having origins in any of the black racial groups of Africa.*

Native Hawaiian or Other Pacific Islander *– A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

White or Caucasian *– A person having origins in the original peoples of Europe, the Middle East, or North Africa.*

For Office Use Only

Type of Proof of Residency Submitted:_____ **Type of DOB proof:**_____

Starting date: _____ **Student #:**_____ **Counselor:**_____ **Homeroom:** _____

Copies made of original documents to be placed in file:_____ **Date:** _____

THE SOMERSET HILLS SCHOOL DISTRICT

Student Transportation Request Form

(for eligible students)*

Student: _____ Grade: _____

Home Address: _____

Mailing Address: _____

Home Telephone: _____

Cell Phone: _____

Nearest intersection to student's residence: _____

Parent/Guardian Name: _____

Siblings in district (list names, grades) _____

Will you be using before or after care program: _____ Before ____ After ____

Will your child be going to a childcare provider: _____

If yes, please provide child care provider name/address/telephone

Name: _____

Address: _____

Telephone: _____

Transportation requests for new students will take five (5) days for processing

***The Transportation Office will determine eligibility for state-mandated or subscription busing**

****

Office Use Only:

Bus Pass Issued _____ Bus Route #_____ Bus Stop # _____
Subscription _____ Payment received _____ Check # _____
Walker _____
Train Pass Issued (9-12 only) _____ Student ID# _____

SOMERSET HILLS SCHOOL DISTRICT

AFFIDAVIT OF OWNER/LANDLORD

Landlord Information	**Tenant Information**
Name of Landlord:	*Name of the Family:*
Street Address:	*Street Address:*
City:	*City:*
Phone Number(s):	*Phone Number(s):*
Lease Information	
Please specify the terms of the lease: Relation to Renter: ___ No Relation ___ Family Member(s) When did the tenant(s) move in? ___/___/___ How long is the agreement effective? Until: ___/___/___ What kind of rental agreement? _____	
List the names of all persons living in the apartment/house:	

I attest that, to the best of my knowledge, the information is true and correct and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.

Sworn and subscribed before me this

_____ day of _____

_____ _____
Signature of Tenant *Date*

_____ _____
Signature of Landlord *Date*

_____
Notary Public of New Jersey

Somerset Hills School District
Please send records to appropriate school listed below

RELEASE OF RECORDS

I hereby give my permission for:

_____
Name of school student is leaving

_____
Street Address

_____
Town State Zip Code

To send all records (HEALTH, STANDARDIZED TEST RESULTS, PAST & MOST RECENT REPORT CARDS, ANY DISCIPLINARY AND/OR SPECIAL SERVICES RECORDS) for the student(s) listed below who are in the process of registering.

1. _____ Grade____

2. _____ Grade____

3. _____ Grade____

4. _____ Grade____

Send complete records to the appropriate school listed below:

Bedwell Elementary K-4
141 Seney Drive
Bernardsville, NJ 07924
Fax # 908-204-0481

Bernardsville Middle School 5-8
141 Seney Drive
Bernardsville, NJ 07924
Fax# 908- 953-2874

Bernards HS 9-12
25 Olcott Avenue
Bernardsville, NJ
Fax# 908-766-8223

_____ Date_____
Parent/Guardian Signature

*Return this form **ONLY** if you **DO NOT** want your child to be photographed*

The Somerset Hills School District
25 Olcott Avenue
Bernardsville, NJ 07924

Date:_____

I **DO NOT** want The Somerset Hills School District, or anyone authorized by The Somerset Hills School District, to use and reproduce photographs/videos of my child participating in school events for use in the newspapers or Somerset Hills School District publications.

Student:_____Grade:_____

Address:_____

City:_____State:_____Zip:_____

Signature of Parent or
Guardian:_____

(If this form is not returned, The Somerset Hills School District understands permission is granted for use of all photographs.)

THE SOMERSET HILLS SCHOOL DISTRICT

– HEALTH EXAMINATION RECORD –

TO PARENTS: *A health examination by your family physician is important to your child's welfare and to the school in adapting its program to individual needs. It is recommended that your child be examined before entering school and periodically thereafter according to the recommendations of your child's physician and the school district. Please fill out your portion of this form. Have your physician complete their part when your child is examined.*

TO BE COMPLETED BY PARENTS

CHILD'S NAME _____ (Last) _____ (First) _____ (Initial) _____ (Date of Birth) _____ (Age) _____ (Sex)

NAME OF PARENT: *(or Guardian)* _____ **PHONE** (Work) ( ) _____

(Home) ( ) _____

(Cell) ( ) _____

_____ (Address)

IN EMERGENCY NOTIFY: _____ (Name & Relationship) _____ (Address) _____ (Phone)

_____ (Physician) _____ (Address) _____ (Phone)

_____ (Dentist) _____ (Address) _____ (Phone)

HEALTH HISTORY (Check)

DISEASES:

- Chicken Pox _____
- Ear Infections _____
- Strep Throat _____
- Diabetes Mellitus _____
- Seizure Disorder _____
- Behavior Problems _____
- Other _____

ALLERGIES:

- Hay Fever _____
- Asthma _____
- Medications _____
- Insect Stings _____
- Ivy, Oak, Etc. _____
- Food _____
- Other _____

OPERATIONS OR SERIOUS INJURIES (Dates)

_____

_____

_____

HOSPITALIZATIONS

_____

_____

_____

SUGGESTIONS FROM PARENTS:

OTHER DISEASES OR DETAILS OF ABOVE

_____

_____

_____

_____

ANY OTHER PERTINENT INFORMATION

SPECIFIC ACTIVITIES TO BE RESTRICTED: _____

_____

SPECIAL MEDICAL OR DIETARY REGIMEN: _____

_____

PARENT'S SIGNATURE _____ **Date** _____

(Over)

TO BE COMPLETE BY PHYSICIAN

Student Name: _____

IMMUNIZATIONS*

DTP or DTaP	1	2	3		
	4	5			
Td	1	2	3		
Polio	1	2	3		
	4				
Hib	1	2	3		
Specify Type:	4				
MMR	1	2			
Measles					
Rubella					
Mumps					
Hepatitis B	1	2	3		
HBG					
Varicella (Specify):	☐ Disease ☐ Vaccine	1	2		
Pneumococcal Conjugate (PCV 7)	1	2	3		
	4				
Pneumococcal					
Influenza	1a	1b	2	3	
Hepatitis B Serology	Date:		Titer:		
Varicella Serology	Date:		Titer:		
Measles Serology	Date:		Titer:		
Other					

IS THIS PUPIL SUBJECT TO ANY CONDITION WHICH LIMITS:

Classroom Activities	Yes ☐	No ☐
Physical Education	Yes ☐	No ☐
Competitive Athletics	Yes ☐	No ☐

Physical Examination

DATE OF EXAMINATION: _____ CODE: SATISFACTORY √
NOT SATISFACTORY X
NOT EXAMINED O

Height		Throat	
Weight		Teeth	
B.P.		Heart	
Appearance, Nutrition		Lungs	
		Abdomen	
Eyes	Without Glasses R20/ L20/	Genitalia	
		Hernia	
	With Glasses R20/ L20/	Skin	
		Musculoskeletal	
Ears	Hearing R	Scoliosis	
	L	Urinalysis	
Nose		(Hb/Hct)	

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS:

Give Details of Management of Significant Illnesses

Address: (Stamp) _____

Tel. No. ( ) _____

Signature: _____ **M.D.**