



Document Checklist – Grades 1st through 5th

For registering children into the East Orange School District

In order to register your child into the East Orange School District you **MUST** bring the documents listed below to your appointment. Your child will **NOT** be registered without them.

1. Parent/Guardian/Foster Parent must show Photo ID
(GUARDIANSHIP PAPERS OR FOSTER PARENT PLACEMENT LETTER MUST BE SHOWN)
2. Child's birth certificate
3. Any three (3) of the proof of residency requirements listed on the Proof of Residency List
4. Proof of immunization (shot) records
REGISTRATION CAN NOT TAKE PLACE WITHOUT A COPY OF THE SHOT RECORDS AND A CURRENT PHYSICAL!
5. Child/Children must be present at the time of registration
6. Copy of most recent report card
7. Transfer from previous school
8. If your child has been accepted into a Charter School please return to the web-site and download the Charter School Registration Packet
9. If your child has an active/current IEP please call (862) 233-7300 ext. 28337 to make an appointment with the Special Education Department.

For grades 1 thru 5, your child must have a current record of immunization (shot) records that are age appropriate. These shots are required and are without exception:

- DTaP series (Diphtheria, Tetanus, and Pertussis): A minimum of four (4) doses is required provided one dose is given on or after the 4th birthday.
- Polio series: A minimum of three (3) doses is required provided one dose is given on or after the 4th birthday.
- MMR series (Measles, Mumps, Rubella): Two (2) doses of Measles, One (1) dose of Mumps and Rubella or two (2) MMR series.
- 3 doses Hepatitis B series, appropriately spaced.
- 1 dose Varicella (Chicken Pox)
- TB testing is required for foreign-born students from select countries

To schedule an appointment for registration please visit our web-site @

enrollment.eastorange.k12.nj.us

Confirmation Code: _____



An ink pen is necessary to fill out the Registration Packet.

Grades 1 thru 5

To register your child for school they must have a transfer and a current report card. **All children must be present at the time of registration, and the registration must be done by the parent or a legal guardian (guardianship papers must be presented at the time of registration).** Parent or legal guardian must have a valid photo ID present at the time of registration. **Birth certificates and immunization (shot) records are mandatory.** All persons coming to register children must bring **three (3) proofs of residency. Current physical.**

Proof of Residency List

Verification of a child's residency in East Orange requires the presentation of:

Any three (3) of the following items listed:

- Homeowner — East Orange property tax bill, mortgage statement, or signed Contract of Purchase.
- Tenant — Active lease
- Child and Parent Living with an East Orange Resident — Signed, notarized Sworn Statement of Residency (Residency Check Form) completed by the East Orange resident and parent or guardian. **(MUST BE PICKED UP FROM THE ENROLLMENT CENTER – 74 HALSTED ST) (PLEASE BE ADVISED AN ATTENDANCE OFFICER WILL VISIT THE HOME TO VERIFY YOUR RESIDENCY)**
- Child Placed in East Orange by Court — Court order placing child in home of East Orange resident.
- Child Placed in East Orange by Child Welfare Agency — Document of child welfare agency ordering that child be placed in home of East Orange resident or Foster Parent Placement Letter.
- Driver's license
- Vehicle registration
- Auto insurance card
- Current utility bill
- Current cable television bill
- Current credit card bill
- Hospital/Medical bills
- Official mail (bank statement, government correspondence: Internal Revenue, Division of Taxation, Social Security Administration)
- Public assistance documents
- Income tax return (current year received thru the mail)
- Unemployment benefit verification
- Recent paycheck/stub

For grades 1 thru 5, your child must have a current record of immunization (shot) records that are age appropriate. These shots are required and are without exception:

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- 1 dose Varicella (Chicken Pox)
- TB testing is required for foreign-born students from select countries
- Current physical

Charter Schools

If your child has been accepted into a Charter School please return to the web-site and download the Charter School Registration Packet.

Special Education

If your child has an active/current IEP you must contact the Special Education Department for registration requirements at (862) 233-7300 ext. 28337 or 28510.

Children must be present at time of registration.

An ink pen is necessary is necessary to fill out the Registration Packet.

Registration must be done by parent/legal guardian (must present guardianship papers)

Home Language Survey*
Parent/Guardian Language Questionnaire

Student Name: _____ Age: _____
 [First] [Middle] [Last]
Date of School Entrance _____

Person completing the survey: Mother Father Grandparent
 Guardian Other _____

Directions: 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/his 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] _____
7. In which language do you wish to receive school communication?
English _____ Other _____
[specify] _____

Signature: _____ Date: _____
 [Person completing the survey]

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

Nombre del estudiante: _____ Edad: _____
 [Nombre] [Inicial] [Apellido]

Fecha de la entrada a la escuela: _____
Persona que completa la Encuesta: Madre Padre Abuelo(a)
 Guardián Otro: _____

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

1. ¿Que idioma aprendió su hijo(a) cuando empezó a hablar por primera vez? Ingles: Español:
 Otro [Especifique cual]: _____
2. ¿Que idioma se habla en su hogar la mayoría del tiempo?
Ingles: Español:
 Otro [Especifique cual]: _____
2. ¿Que idioma le habla ustedes al niño(a) la mayoría del tiempo?
Ingles: Español:
 Otro [Especifique cual]: _____
4. ¿Que idioma habla el niño(a) con ustedes la mayoría del tiempo?
Ingles: Español:
 Otro [Especifique cual]: _____
5. ¿Que idioma le habla el niño(a) a sus hermanos(as) la mayoría del tiempo? Ingles: Español:
 Otro [Especifique cual]: _____
6. ¿Que idioma habla el niño(a) a sus amigos la mayoría del tiempo?
Ingles: Español:
 Otro [Especifique cual]: _____
7. ¿En que idioma desea recibir comunicados de la escuela?
Ingles: Español:
 Otro [Especifique cual]: _____

Firma: _____ Fecha: _____
 [Persona que lleno la encuesta]

EAST ORANGE SCHOOL DISTRICT

Sondaj Lang Matènèl Lang Paran/Gadyen an

Non elèv la _____ Laj li _____
Dat Antre nan Lekòl la _____ Nivo: _____

Moun ki ap konplete kesyonè a : [] Manman [] Papa [] Granparan
[] Gadyen [] Lèt: _____

Direksyon: Chwazi oswa ekri repons kòrek la pou chak kesyon sa yo konsènan pitit ou a.

1. Ki lang ou toujou pale lakay ou?
[] Anglè [] Yon lòt lang Ki lang sa a ? _____
2. Èke elèv ke'w ap enskri jodia pale yon lòt lang ke anglè? (Pa konte lang etranje ke li aprann nanlekòl.) [] Non [] Wi
Si'w reponn wi: Ki lang sa-a? _____
3. Nan ki lang ou [gadyen an] pale tout tan? [] Anglè [] Yon lòt lang
Ki lang sa a? _____
4. Nan ki lang pitit ou a pale ak ou [gadyen an] tout tan?
[] Anglè [] Yon lòt lang Ki lang li sa a ? _____
5. Nan ki lang èske pitit ou a pale ak frèl/sèl tout tan?
[] Anglè [] Yon lòt lang Ki lang sa a? _____
6. Nan ki lang ou pale pi souvan lè ou ap pale ak pitit ou a?
[] Anglè [] Yon lòt lang Ki lang sa a? _____
7. Nan ki lang ou [gadyen an] ta renmen resevwa kominikasyon de lekòl la? [] Anglè [] Yon lòt lang? Ki lang sa a? _____

Siyati Paran/Gadyen _____ Dat jodi a _____
Moun ki konplete kesyonè a

EAST ORANGE SCHOOL DISTRICT

Sondage de Langue Maternelle Langue des Parents/Gardiens

Nom de l'élève: _____ Age _____

Date d'Entrée à l'Ecole _____ Nivo _____

Personne qui remplit le Sondage : [] Mère [] Père [] Grandparent
[] Gardien [] Autre _____

Directions: Choisissez ou écrivez la réponse correcte pour chacune des questions suivantes concernant votre enfant.

1. Quelle langue parlez-vous couramment à la maison? [] anglais [] français
[] une autre langue Spécifiez _____
2. Est-ce que l'enfant que vous inscrivez parle autre langue que l'anglais?
(Exclues les langues étrangères étudiées à l'école.) ____ Non ____ Oui
Si oui: Quelle langue est-ce? _____
3. Quelle langue parle t-on à la maison la plupart du temps?
[] Anglais [] français [] Une autre langue Spécifiez _____
4. Quelle langue est ce que vous le parent [gardien] parle à votre enfant la plupart du temps?
[] anglais [] français [] Une autre langue Spécifiez _____
5. En quelle langue est-ce que votre enfant parle avec ses frères et soeurs?
[] anglais [] français [] Une autre langue Spécifiez _____
6. En quelle langue est ce que l'élève parle avec ses amis le plus souvent?
[] anglais [] français [] Une autre langue Spécifiez _____
7. Dans quelle langue est-ce que vous aimeriez recevoir les communications de l'école. [] anglais [] français [] Une autre langue Spécifiez _____

Signature du Parent/tuteur _____ Date du jour _____

UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health*

SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)	
		Height (must be taken within 30 days for WIC)	
		Head Circumference (if <2 Years)	
		Blood Pressure (if ≥3 Years)	
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:	
MEDICAL CONDITIONS			
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i>	
Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-326-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
 - Weight - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
 - Height - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
 - Head Circumference - Only enter if the child is less than 2 years.
 - Blood Pressure - Only enter if the child is 3 years or older.
2. Immunization - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-828-4860.
 - The Immunization record must be attached for the form to be valid.
 - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. Medical Conditions - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
 - a. Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow. A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15_dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
 - b. Medications - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

- c. Limitations to physical activity - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
 - d. Special Equipment - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
 - e. Allergies/Sensitivities - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
 - f. Special Diets - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
 - g. Behavioral/Mental Health issues - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
 - h. Emergency Plans - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. Screening - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
 - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
 - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
 - Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
 5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
 - Print the health care provider's name.
 - Stamp with health care site's name, address and phone number.