ROOSEVELT PUBLIC SCHOOL
www.rps1.org

2a School Lane. P.O. Box 160
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Mrs. Stephanie Bilenker
CSA/Principal

REGISTRATION FORM

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
___ Tuition Ad/Newspaper
___ Internet
___ 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_____

ROOSEVELT PUBLIC SCHOOL

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 _____

<u>COMMENTS, RESTRICTIONS, RECOMMENDATIONS</u>

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Date Physician's Signature

Phone #_____