

Bernards Township Public Schools  
Office of the Registrar

**Instructions for Kindergarten – 12<sup>th</sup> Grade Registrations**

**FOR ALL STUDENTS:**

Please **print out one copy of the registration forms** for each student you need to register.

In addition to the completed registration forms, you will need an original birth certificate and three proofs of residency.\* **Please have one photocopy of the birth certificate and residency proofs.** Originals will be returned to you.

Please note that your child will not be able to attend school unless the **Physical Examination / Immunization Form** is completed, signed and stamped by your child's physician. The physical exam must be completed in the U.S. by a U.S. licensed physician. The physical exam must be completed within 365 days prior to the date of school entry. **Also note that there are additional immunization requirements if you are registering a student in 6<sup>th</sup> grade or higher – please read the entrance requirements on the Physical Examination form carefully.**

Once all of your paperwork is complete, **please call our District Registrar, Michele Vitiello, at (908) 204-2585, Ext. 105,** to set up a registration appointment. **Mrs. Vitiello's office is located in the Counseling Office at Ridge High School, 268 South Finley Avenue, Basking Ridge.** If you have any questions about the paperwork, please email Mrs. Vitiello at [mvitiello@bernardsboe.com](mailto:mvitiello@bernardsboe.com). **PLEASE NOTE that if you will be enrolling your kindergartner in your districted school on registration day in February, you do not need to call the District Registrar for an appointment.**

**FOR WILLIAM ANNIN MIDDLE SCHOOL STUDENTS:**

In addition to the general registration information above, please go to the William Annin Middle School website (under "Schools" tab on the district website, [www.bernardsboe.com](http://www.bernardsboe.com)) and click on "Counseling." Go to "New to District," and download the grade-appropriate course selection form. This form must also be completed and signed by you and your child and brought to the registration meeting with your child's most recent report card. Your child does not need to accompany you to this appointment.

**FOR RIDGE HIGH SCHOOL STUDENTS:**

In addition to the general registration information above, please go to the Ridge High School website (under "Schools" tab on the district website, [www.bernardsboe.com](http://www.bernardsboe.com)) and click on "Counseling." Go to "Scheduling," and download the grade-appropriate Course Selection sheet. Review the Program of Studies and then fill out the Course Selection sheet with your child and bring it to the registration/scheduling meeting with your child's most recent report card (for incoming 9<sup>th</sup> grade students) or transcript (for incoming 10<sup>th</sup> through 12<sup>th</sup> grade students), as well as course/curriculum descriptions from the prior school. Documentation must be in English. Your child should attend this meeting.

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\* **Acceptable proofs of residency include:**

- Settlement Disclosure Form (if you have just closed on the sale of a new residence)
- Deed or current Lease Agreement
- Mortgage statement
- Bernards Township property tax bill
- Bernards Township sewer bill
- Homeowner's insurance bill
- Utility bills (e.g., gas, electric, cable, telephone) or service set-up confirmations

Bernards Township Public Schools  
Office of the Registrar

Registration Date: \_\_\_\_\_

**REGISTRATION FORM**

- Cedar Hill School       Liberty Corner School       Oak Street School       Mt. Prospect School  
 William Annin Middle School       Ridge High School

Birth Certificate \_\_\_\_\_  
Proof of Residency (3) \_\_\_\_\_

Classroom Assignment: \_\_\_\_\_  
Starting Date: \_\_\_\_\_  
Student ID: \_\_\_\_\_  
SID: \_\_\_\_\_

In the space below, please write the student's name **EXACTLY** as it appears on the birth certificate:

\_\_\_\_\_

Last Name	First Name	Middle Name
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_____	_____	_____
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Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

City/State of Birth: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Language student uses to communicate at home: \_\_\_\_\_

If not born in the US, date child first enrolled in a US school: \_\_\_\_\_ Does the child speak English? \_\_\_\_\_

**Ethnicity** (Check all that apply – see page 2 for explanation):

- Black/African American       Native Hawaiian/Pacific Islander       White or Caucasian  
 Asian       American Indian/Alaska Native       Hispanic/Latino

<b>Father</b>	Last Name _____	<b>Mother</b>	Last Name _____
	First Name _____		First Name _____
	Home Phone _____ <input type="checkbox"/> primary		Home Phone _____ <input type="checkbox"/> primary
	Work Phone _____ <input type="checkbox"/> primary		Work Phone _____ <input type="checkbox"/> primary
	Cell Phone _____ <input type="checkbox"/> primary		Cell Phone _____ <input type="checkbox"/> primary
	Email: _____		Email: _____

**Student resides with:**     Parents     Mother     Father     Other (specify): \_\_\_\_\_

If the student does **not** reside with both parents, please provide the mailing address of the joint custodial or non-custodial parent entitled by law to receive reports:

Name \_\_\_\_\_ Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name and Address of School Last Attended: \_\_\_\_\_

Has the student previously attended a Bernards Township School?     Yes     No

If yes, School: \_\_\_\_\_

Dates: \_\_\_\_\_

**Emergency Contacts (other than parents) -- please list name and telephone number where contacts can be reached during the school day):**

Contact #1: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contact #2: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does student have siblings already attending school in the Bernards Township School District?  Yes  No

If yes, please list names below:

Last Name	First Name	Middle Name	Date of Birth	M/F
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**Please check one:**

Student is a dependent of a member of the full-time, Active Duty Forces (Army, Navy, Air Force, Marine Corps, Coast Guard) Yes  No

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 peoples 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 Islanders** – 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.

Bernards Township Public Schools  
Nursing Department

**HEALTH HISTORY**

(To be completed by Parent(s)/Guardian)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_  
Last First

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Entering School From: \_\_\_\_\_

Siblings: Name _____ Age: _____ Name _____ Age: _____	City / State / Country	Name _____ Age: _____ Name _____ Age: _____
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Please review the conditions listed below and indicate any that apply with a check ( ✓ ) Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items.

✓	CONDITION	COMMENTS
<input type="checkbox"/>	ADD/ADHD	
<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	Food	
<input type="checkbox"/>	Medication	
<input type="checkbox"/>	Bee Sting	
<input type="checkbox"/>	Environmental	
<input type="checkbox"/>	Anaphylactic Reaction (give date)	
<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	Asthma / Bronchitis	
<input type="checkbox"/>	Bowel Problem	
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	Chronic / Recurrent Illness	
<input type="checkbox"/>	Convulsions/Seizures	
<input type="checkbox"/>	Concussion/Head Injury (give date)	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Ear Infections	
<input type="checkbox"/>	Eating Disorders	
<input type="checkbox"/>	Emotional / Psychiatric Problems	
<input type="checkbox"/>	Fainting	
<input type="checkbox"/>	Fracture / Dislocation / Sprain	
<input type="checkbox"/>	Frequent Colds / Sore throat	
<input type="checkbox"/>	Frequent Headaches	
<input type="checkbox"/>	Frequent Stomach Aches	

✓	CONDITION	COMMENTS
<input type="checkbox"/>	Hearing Problem	
<input type="checkbox"/>	Heart Problem	
<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	Hypertension	
<input type="checkbox"/>	Kidney/Urinary Problem	
<input type="checkbox"/>	Leukemia	
<input type="checkbox"/>	Lyme Disease	
<input type="checkbox"/>	Mononucleosis	
<input type="checkbox"/>	Neuromuscular Disease	
<input type="checkbox"/>	Orthopedic Problem	
<input type="checkbox"/>	Operations / Conditions Requiring Hospitalization	
<input type="checkbox"/>	PDD / Autism	
<input type="checkbox"/>	Rheumatic Fever	
<input type="checkbox"/>	Scoliosis	
<input type="checkbox"/>	Sickle Cell Anemia	
<input type="checkbox"/>	Skin Condition	
<input type="checkbox"/>	Speech Communication Problem	
<input type="checkbox"/>	Strep Infections	
<input type="checkbox"/>	Sustained illness past 3 months	
<input type="checkbox"/>	Substance Abuse (alcohol, drugs)	
<input type="checkbox"/>	Toothache, Dental problem	
<input type="checkbox"/>	Tumor	
<input type="checkbox"/>	Vision Problem	
<input type="checkbox"/>	<b>None of the above</b>	

List any other concerns you may have about your child's health, development, learning, behavior or home situation, which might affect his/her performance: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Bernards Township Public Schools  
Nursing Department

**Health Entrance Requirements**  
*Kindergarten through 12<sup>th</sup> Grade*

- **Physical examination** completed between **September 1** of the year your child is entering school and **September 1** of the previous year.
- **Immunizations**
  - **DTP (Diphtheria, Tetanus Toxoid and Pertussis)**
    - **Age 1-6 years** - 4 doses, with one dose given on or after the fourth birthday, OR any 5 doses
    - **Age 7 or Older** - 3 doses of Td or a combination of DTP, DtaP, and Td.
  - **Tdap booster**
    - Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher
  - **Poliovirus Vaccine**
    - **Age 1 – 6 years** - 3 doses, with one dose given on or after the 4<sup>th</sup> birthday, OR any 4 doses
    - **Age 7 – 17 years** - 3 doses, either OPV or IPV separately or in combination
  - **Measles**
    - 2 doses of a measles containing vaccine. First dose given on or after the first birthday (if before first birthday, re-immunization is required). Intervals between first and second measles/MMR cannot be less than one month. Laboratory evidence of immunity is also acceptable.
  - **Rubella**
    - 1 dose OR laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).
  - **Mumps**
    - 1 dose OR laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).
  - **Hepatitis B Virus Vaccine**
    - 3 doses (age 1- 15) OR 2 doses Adult Formulation (age 11- 15) OR laboratory evidence of immunity.
  - **Varicella (Chicken Pox) Vaccine**
    - 1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity
  - **Meningococcal Vaccine 6th - 12th grades**
    - Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher
  - **Mantoux Test (PPD)**
    - Students entering a US school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test.
      - Antigua and Barbuda
      - Australia
      - Austria
      - Barbados
      - Belgium
      - Bermuda
      - Canada
      - Cayman Islands
      - Cuba
      - Cyprus
      - Czech Republic
      - Denmark
      - Finland
      - France
      - Germany
      - Greenland
      - Grenada
      - Iceland
      - Ireland
      - Israel
      - Italy
      - Jamaica
      - Jordan
      - Lebanon
      - Luxembourg
      - Malta
      - Monaco
      - Montserrat
      - Netherlands
      - Netherlands Antilles
      - New Zealand
      - Norway
      - Oman
      - Puerto Rico
      - Saint Kitts and Nevis
      - San Marino
      - Sweden
      - Switzerland
      - Trinidad and Tobago
      - United Kingdom of Great Britain and Northern Ireland
      - United States of America
      - United States Virgin Islands

Bernards Township Public Schools  
Nursing Department

**Health Entrance Requirements**  
*Pre-Kindergarten*

- **Physical examination** completed between **September 1** of the year your child is entering school and **September 1** of the previous year.
- **Immunizations**
  - **DTP (Diphtheria, Tetanus Toxoid and Pertussis)**
    - **Age 1-5 years** - 4 doses
  - **Poliovirus Vaccine**
    - **Age 1 – 5 years** - 3 doses
  - **Measles**
    - 1 dose of a measles containing vaccine given on or after the first birthday.
  - **Rubella**
    - 1 dose given on or after the first birthday.
  - **Mumps**
    - *1 dose given on or after the first birthday*
  - **Varicella (Chicken Pox) Vaccine**
    - 1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity
  - **Haemophilus influenza type b (Hib) conjugate Vaccine**
    - At least one dose of a separate or a combination Hib conjugate vaccine, on or after the first birthday.
  - **Pneumococcal Conjugate Vaccine**
    - At least 1 dose, on or after the first birthday
  - **Influenza Vaccine**
    - Shall receive one dose of influenza vaccine between September 1 and December 31 of each year.
  - **Mantoux Test (PPD)**
    - Students entering a US school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test.

- Antigua and Barbuda
- Australia
- Austria
- Barbados
- Belgium
- Bermuda
- Canada
- Cayman Islands
- Cuba
- Cyprus
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greenland
- Grenada
- Iceland
- Ireland
- Israel
- Italy
- Jamaica

- Jordan
- Lebanon
- Luxembourg
- Malta
- Monaco
- Montserrat
- Netherlands
- Netherlands Antilles
- New Zealand
- Norway
- Oman
- Puerto Rico
- Saint Kitts and Nevis
- San Marino
- Sweden
- Switzerland
- Trinidad and Tobago
- United Kingdom of Great Britain and Northern Ireland
- United States of America
- United States Virgin Islands

## Physical Examination

(To be completed by Physician)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex : M \_\_\_ F \_\_\_

Vaccine Type	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR
Diphtheria, Tetanus, Pertussis <small>(Please Specify Type, Td, DT)</small>							
Tdap <b>**Entering grade six OR above</b>							
Polio- (Please Indicate)	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV
Measles, Mumps, Rubella (MMR)					Document single antigen, serology, varicella disease		
Haemophilus B (HIB)					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Meningococcal- (Please Indicate) <b>**Entering grade six OR above</b>	MCV4 / Non-MCV4	MCV4 / Non-MCV4	MCV4 / Non-MCV4	MCV4 / Non-MCV4	Measles	Date:	Titer:
Varicella					Mumps	Date:	Titer:
Hepatitis A					Rubella	Date:	Titer:
Pneumococcal Conjugate							
HPV (Human Papillomavirus) - <small>(Please Indicate)</small>	4 / 9	4 / 9	4 / 9				
Flu <b>**Ages 6-59 months</b>							
Other							
Mantoux TB Test <b>**See EXEMPT countries</b>	Date Given: ____ / ____ / ____		Date Read: ____ / ____ / ____		Result: ____ MM		

Date of Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ B/P: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Significant Medical / Surgical History: \_\_\_\_\_

Vision (without glasses): Rt.: 20 / \_\_\_\_ Lt.: 20 / \_\_\_\_ (with correction): Rt.: 20 / \_\_\_\_ Lt.: 20 / \_\_\_\_

Hearing: Rt.: \_\_\_\_\_ Lt.: \_\_\_\_\_ **\*\*\*Vision and Hearing MUST be completed by physician's office**

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Ears (otoscopic)				Genito-Urinary			
Eyes				Orthopedic			
Lymph Glands				Structural			
Thyroid				Posture			
Nose				Feet			
Throat				Skin			
Teeth / Mouth				Nutrition			
Heart				Nervous System			
Lungs				Speech			
Abdomen				Other			
Hernia				General Appearance			

Based on the above physical exam, this patient is capable of FULL participation in all school activities: \_\_\_\_ Yes \_\_\_\_ No

Exceptions: \_\_\_\_\_

**STAMP**

(MUST BE PRESENT FOR THIS TO BE VALID)  
Rev.1-2017

Examining Practitioner: \_\_\_\_\_

Bernards Township Public Schools  
Nursing Department

Student ID: \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

**Student Name** \_\_\_\_\_ **School** \_\_\_\_\_

Reliable information is necessary should a sudden accident or illness occur while your student is at school.

We will attempt to contact you if any type of medical attention is needed. However, in the event that treatment is necessary and we are unable to contact you, your signature below will authorize the school authorities, doctor, or hospital to use their best judgment in the interest of your child's health.

**Emergency Treatment Permission**

Authorization is given to perform necessary emergency treatment of my child whose medical history is listed on the bottom of this form.

\_\_\_\_\_  
(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

**Tylenol Authorization**

I hereby authorize the nurse with the school physician's order to administer Tylenol (acetaminophen), (age and weight appropriate).

\_\_\_\_\_  
(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

**Release of Medical Information**

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that the medical information may be shared, **when necessary**, with appropriate professional staff involved in the care of my child.

\_\_\_\_\_  
(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

**Emergency Health Information**

List any illnesses; injuries or surgeries that have taken place in the last year: \_\_\_\_\_

\_\_\_\_\_

List allergies to food, medications, insect bites or stings (list and be specific): \_\_\_\_\_

\_\_\_\_\_

List any physical disorders, conditions or limitations: \_\_\_\_\_

\_\_\_\_\_

List **ANY** medications that are currently being taken: \_\_\_\_\_

\_\_\_\_\_

**Epi-Pen:** Yes No **Inhaler for:** \_\_\_\_\_ Yes No Type \_\_\_\_\_

Is this student covered by health insurance? _____		
<b>If yes</b> , please provide Insurance Company name: _____		
<b>If no</b> , you may release my name and address to NJ Family Care** to contact me about health insurance.		
_____	_____	_____
Signature	Printed Name	Date