RIDGEFIELD PARK PUBLIC SCHOOLS
712 Lincoln Avenue, Ridgefield Park, NJ 07660
Tel: 201-807-2640 // www.rpps.net

Welcome to the Ridgefield Park Public School District

PLEASE NOTE:

The following is a list of documents that must be presented in order to enroll a student in the Ridgefield Park Public School System. All items listed below **MUST BE SUBMITTED** or your registration will not be processed.

- ☐ Application for Enrollment
- ☐ Birth Certificate
- ☐ Parent/Guardian ID
- ☐ Affirmation of Residency
  a. **Own -** Deed, Property Tax Records, and/or Mortgage Statement
  b. **Rent -** Current Lease with Landlord's contact information OR Landlord Affidavit completed and notarized with Landlord's contact information
  c. **Utility Bill -** Must be current.
- ☐ Transfer Card from the previous school district.
- ☐ Special Education Students: If your child has an IEP or 504 you must include the most recent IEP from the current school district.
- ☐ Medical Records
  a. **Elementary Students (K-6)**: Universal Health Record Form completed by a physician along with immunization records.
  b. **High School Students (7-12)**: Preparticipation Physical Evaluation History Form along with immunization records.

ADDITIONAL INFORMATION REQUIRED:

High School students must provide academic records (transcripts) from the previous school showing course work and credits completed. If the student is entering the 9th grade, you must show proof that the student has completed the 8th grade. If coming from a New Jersey school, please provide NJASK and HSPA scores if available.

Custody or Guardianship paperwork from the Bergen County Courthouse Surrogate Court must be presented when a student is not living with the parent.

Once you have completed the online registration application you will be contacted by the district.

Should you have any questions prior to or after completing the online registration please contact kthompson@rpschools.net.

All registration packages will be reviewed within 48 hours of confirmation.

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DATE:_____ **GRADE LEVEL**:_____

STUDENT INFORMATION:

LAST NAME: _____

FIRST NAME: _____ **MIDDLE NAME:** _____

BIRTH INFORMATION: IF BORN IN THE US

DATE OF BIRTH: _____ **BIRTH CITY:** _____ **BIRTH STATE:** _____

BIRTH INFORMATION: IF BORN OUTSIDE THE US

DATE OF BIRTH: _____ **BIRTH CITY/COUNTRY:** _____

DATE OF ENTRY IN U.S.: _____

GENDER:	**ETHNICITY**: DATA IS REQUIRED FOR ALL NJ PUBLIC SCHOOLS	
☐ MALE	☐ HISPANIC OR LATINO	
☐ FEMALE	☐ NOT HISPANIC OR LATINO	
☐ NON/BINARY UNDESIGNATED	**RACE**:	
BIRTH GENDER:	☐ WHITE	☐ ASIAN
☐ MALE	☐ BLACK (AFRICAN AMERICAN)	☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
☐ FEMALE	☐ AMERICAN INDIAN/ALASKAN	☐ OTHER: _____

LEGAL RESIDENCE:

☐ OWN ☐ RENT ☐ OTHER _____

ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HAS YOUR CHILD EVER BEEN EVALUATED FOR SPECIAL EDUCATION SERVICES?

☐ YES ☐ NO

☐ IEP	☐ IFSP	☐ ISP	☐ 504	☐ EVALUATIONS
☐ DOCTOR'S NOTE		☐ TEACHER/SCHOOL CORRESPONDENCE		☐ OTHER: PLEASE SUPPLY

MILITARY CONNECTED INFORMATION:

☐ ACTIVE DUTY – DEPENDENT OF AN ACTIVE FULL TIME MEMBER OF THE ARMED FORCES (ARMY, NAVY, MARINE, AIR FORCE OR COAST GUARD
☐ NOT MILITARY CONNECTED

PREVIOUS SCHOOL INFORMATION:

NAME:	
CITY/STATE:	
GRADE LEVEL:	**DATES ATTENDED:**

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DATE:_____ **GRADE LEVEL**:_____

STUDENT NAME: _____

PARENT/GUARDIAN INFORMATION:

GUARDIAN 1:

NAME:		**RELATIONSHIP:**
ADDRESS:		**APT #:**
CELL PHONE:	**CELL PHONE CARRIER:**	**HOME PHONE:**
EMAIL:		

GUARDIAN 2:

NAME:		**RELATIONSHIP:**
ADDRESS:		**APT #:**
CELL PHONE:	**CELL PHONE CARRIER:**	**HOME PHONE:**
EMAIL:		

SIBLING(S) ATTENDING THE RIDGEFIELD PARK SCHOOL DISTRICT:

NAME:	**SCHOOL**: PLEASE CIRCLE ONE	**GRADE**:
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	

ACKNOWLEDGEMENT:

I certify that the information made by me is true, I am aware that if any of the foregoing statements made by me are false, I am subject to punishment under the law and may result in financial responsibility for school attendance.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

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AFFIRMATION OF RESIDENCY

DATE: _____

I, HEREBY CERTIFY, THAT I, _____, AM THE LEGAL PARENT/GUARDIAN OF:
(PRINT NAME OF PARENT OR GUARDIAN)

NAME OF CHILD	AGE	GRADE

I FURTHER CERTIFY THAT MY CHILD/CHILDREN AND I ARE LEGALLY RESIDING IN THE CITY OF RIDGEFIELD PARK AT THE FOLLOWING:

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

THE FOLLOWING DOCUMENTS WHICH ESTABLISH THAT WE ARE LEGALLY RESIDING IN THE CITY OF RIDGEFIELD PARK HAVE BEEN SUBMITTED FOR VERIFICATION.

OWNER OF DWELLING:

1. Deed, Property Tax Record, or Mortgage Statement reflecting the Ridgefield Park address.
2. Current Utility Bill

RENTER OF DWELLING:

1. Current original lease verifying names, status, and duration of lease. The lease must have the landlord's name, address, and phone number. If you do not have your current lease available you can complete the Landlord Affidavit of Residency.
2. Landlord Affidavit of Residency. The affidavit must have the landlord's name, address, and phone number and be notarized.
3. Current Utility Bill

****PLEASE NOTE ADDITIONAL DOCUMENTATION MAY BE REQUIRED****

I,_____, affirm that I am the parent/guardian of the student(s) listed on this form. I further state that this form and the attached documents constitute true and accurate proof that the student(s) listed on this form reside with me within the City of Ridgefield Park and will continue to do so for the school year. If any student listed on this form stops living with me, or if I move my residence out of the City of Ridgefield Park within the school year, I will promptly notify the Ridgefield Park Board of Education in writing.

If it is determined that the address stated on this form is not my valid residence, I acknowledge that I will be responsible to pay the tuition rate; established by the State of New Jersey, to the Ridgefield Park Board of Education for each child attending school in the Ridgefield Park Public School system until residency has been established.

I certify that the following statements made by me are true, I am aware that if any of the foregoing statements made by me are false, I am subject to punishment under the law.

_____ _____ _____

NAME (PRINTED) **SIGNATURE** **DATE**

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LANDLORD AFFIDAVIT OF RESIDENCY

DATE: _____

STATE OF NEW JERSEY
COUNTY OF BERGEN

I, _____ of full age, being duly sworn upon his or her oath, according to the law, depose and say:

1. I am the owner of property located at _____ in the City of Ridgefield Park.
2. _____ is a tenant and has been a tenant at the above premises since _____ (month) _____(year).
3. The names of permissible tenants are as follows:

LIST ALL THE NAMES OF THE ADULTS AND CHILDREN AUTHORIZED TO LIVE AT THE ABOVE SAID ADDRESS	
1.	5.
2.	6.
3.	7.
4.	8.

I am making this affidavit knowing that the Board of Education of the Village of Ridgefield Park will rely on the same in determining whether _____ will be considered a pupil who is entitled to an education free of charge.
(NAME OF STUDENT)

LANDLORD'S NAME: _____
LANDLORD'S ADDRESS: _____
_____
LANDLORD'S CONTACT #: _____
LANDLORD'S SIGNATURE: _____

SWORN AND SUBSCRIBED BEFORE ME
THIS _____ DAY OF _____
YEAR _____.

_____
NOTARY PUBLIC

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ACADEMIC RECORDS REQUEST FORM

Grant School	Lincoln School	Roosevelt School	RPJRSRHS	Office of Special Services
104 Henry Street	712 Lincoln Avenue	508 Teaneck Road	One Ozzie Nelson Drive	98 Central Avenue
201-641-0441	201-994-1830	201-440-0808	201-440-1440	201-807-2650

Date: _____

The child named below has enrolled in one of our schools. The parent/guardian has authorized that the following records should be sent to the school circled above as soon as possible:

- ☐ Academic (including report card, transcript, standardized test scores, I.E.P.)
- ☐ Attendance
- ☐ Disciplinary
- ☐ Medical/Health
- ☐ Confidential

Full name of previous school: _____
Street Address: _____
City/State/Zip: _____
Telephone No.: _____
Fax No.: _____
Contact Email: _____

Thank You for your cooperation.

I hereby give permission to release all academic, attendance, health, disciplinary, and any confidential school records to the school circled above for:

Child's Name: _____

Current Grade Level: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

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SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI)

RIDGEFIELD PARK 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 identifiable 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 public 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 does not 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, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Date of Birth: _____

Parent/Guardian Signature: _____

Date: _____

I give consent to bill for SEMI:

- ☐ YES
- ☐ NO

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

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Home Language Survey

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of Residence.

Student Information:

Student Name: _____

Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

_____

2.) Was the first language used by the student a language other than English?

_____ No _____Yes

3.) Does the student speak or understand a language other than English?

_____ No _____Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ No _____Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ No _____Yes

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DATE: _____

MEDICAL HISTORY FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE: _____**

Please complete the child's health history below.

DIAGNOSIS	YES	NO	DATE OF DIAGNOSIS	TREATMENT AND/OR RESTRICTIONS
ASTHMA				
BLOOD DISORDER				
CHICKEN POX				
DIABETES				
HEAD INJURY				
HEART PROBLEM				
SEIZURE				
SKIN CONDITION				
SPEECH/LANGUAGE				
URINARY PROBLEM				
VISION/GLASSES				

Current Medications: Please include the name of the medicine, the dosage, time, and reason for use.

NAME OF MEDICINE	DOSAGE	TIME	REASON

Hospitalizations for illness or surgery: Please include diagnosis and year.

HOSPITALIZATION REASON	DIAGNOSIS	YEAR

I GIVE MY PERMISSION FOR THIS INFORMATION TO BE SHARED WITH APPROPRIATE SCHOOL STAFF.

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO CHILD: _____

DATE: _____

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DATE: _____

ALLERGY RECORD FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

If your child has **NO** allergies/reactions please check here ☐ and sign below.

ITEM	YES	NO	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN
DAIRY PRODUCTS					
EGGS					
PEANUTS					
OTHER FOODS PLEASE LIST BELOW					
BEES					
OTHER ANIMALS PLEASE LIST BELOW					
PENICILLIN					
ERYTHROMYCIN					
OTHER MEDS PLEASE LIST BELOW					
SEASONAL ALLERGIES					
OTHER ALLERGIES PLEASE LIST BELOW					

ADDITIONAL INFORMATION

OTHER FOOD:

FOOD	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ANIMALS:

ANIMAL	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER MEDICATION:

MEDICATION	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ALLERGIES:

ALLERGIES	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

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DATE: _____

MEDICATION FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO CHILD: _____

A child must not bring to school any prescribed or over-the-counter medication...not one single dose! Any such products must be brought to the school nurse by a parent/guardian with directions for use from a physician. Only a a school nurse may administer the medication.

By my signature, I certify that my child does not need to take any prescribed or over-the-counter medication during the school day.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

There are few exceptions to this rule:
Permission may be granted to your child for self-administration of medication for asthma or other potentially life threatening conditions if the school receives written permission from a parent/guardian and authorization by a physician. Even in this case, we may require that the medication be self-administered in the presence of the school nurse.

By my signature below I give permission for my child to self-administer the medication indicated by the physician. I understand that Ridgefield Park Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and I shall indemnify and hold harmless the Ridgefield Park Board of Education and its employees and agent against any claims arising as a result of the self administration of medication by my child.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE:

Diagnosis	Name of Medication	Form of Medication	Dose	Time	How soon the dose can be repeated	List of significant side effects	Length of time this treatment is recommended

☐ **The above mentioned child has asthma and/or other life threatening condition and has been instructed in and is capable of self-administering the medication noted above.**

Physician's Signature and Stamp: **PLACE STAMP HERE**

Physician's Name: _____

SIGNATURE: _____

ADDRESS: _____

_____

TELEPHONE: _____

APPENDIX H

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 ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐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 give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐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	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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.***

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 1-800-328-3838.

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 609-826-4860. 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 heath 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.