

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.

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

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.: _____

<u>GENDER:</u>	<u>ETHNICITY:</u> DATA IS REQUIRED FOR ALL NJ PUBLIC SCHOOLS	
<input type="checkbox"/> MALE	<input type="checkbox"/> HISPANIC OR LATINO	
<input type="checkbox"/> FEMALE	<input type="checkbox"/> NOT HISPANIC OR LATINO	
<input type="checkbox"/> NON/BINARY UNDESIGNATED	<u>RACE:</u>	
<u>BIRTH GENDER:</u>	<input type="checkbox"/> WHITE	<input type="checkbox"/> ASIAN
<input type="checkbox"/> MALE	<input type="checkbox"/> BLACK (AFRICAN AMERICAN)	<input type="checkbox"/> NATIVE HAWAIIAN/PACIFIC ISLANDER
<input type="checkbox"/> FEMALE	<input type="checkbox"/> AMERICAN INDIAN/ALASKAN	<input type="checkbox"/> OTHER: _____

LEGAL RESIDENCE:

OWN RENT OTHER _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HAS YOUR CHILD EVER BEEN EVALUATED FOR SPECIAL EDUCATION SERVICES?

YES NO

<input type="checkbox"/> IEP	<input type="checkbox"/> IFSP	<input type="checkbox"/> ISP	<input type="checkbox"/> 504	<input type="checkbox"/> EVALUATIONS
<input type="checkbox"/> DOCTOR'S NOTE		<input type="checkbox"/> TEACHER/SCHOOL CORRESPONDENCE		<input type="checkbox"/> 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:

<u>NAME:</u>	
<u>CITY/STATE:</u>	
<u>GRADE LEVEL:</u>	<u>DATES ATTENDED:</u>

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

DATE: _____

GRADE LEVEL: _____

STUDENT NAME: _____

PARENT/GUARDIAN INFORMATION:

GUARDIAN 1:

<u>NAME:</u>		<u>RELATIONSHIP:</u>
<u>ADDRESS:</u>		<u>APT #:</u>
<u>CELL PHONE:</u>	<u>CELL PHONE CARRIER:</u>	<u>HOME PHONE:</u>
<u>EMAIL:</u>		

GUARDIAN 2:

<u>NAME:</u>		<u>RELATIONSHIP:</u>
<u>ADDRESS:</u>		<u>APT #:</u>
<u>CELL PHONE:</u>	<u>CELL PHONE CARRIER:</u>	<u>HOME PHONE:</u>
<u>EMAIL:</u>		

SIBLING(S) ATTENDING THE RIDGEFIELD PARK SCHOOL DISTRICT:

<u>NAME:</u>	<u>SCHOOL:</u> PLEASE CIRCLE ONE	<u>GRADE:</u>
	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: _____

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

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:

<u>LIST ALL THE NAMES OF THE ADULTS AND CHILDREN AUTHORIZED TO LIVE AT THE ABOVE SAID ADDRESS</u>	
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

ACADEMIC RECORDS REQUEST FORM

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

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.

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

DATE: _____

MEDICAL HISTORY FORM

CHILD'S NAME: _____

LAST

FIRST

MIDDLE

DATE OF BIRTH: ____/____/____

AGE: _____

Please complete the child's health history below.

<u>DIAGNOSIS</u>	<u>YES</u>	<u>NO</u>	<u>DATE OF DIAGNOSIS</u>	<u>TREATMENT AND/OR RESTRICTIONS</u>
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.

<u>NAME OF MEDICINE</u>	<u>DOSAGE</u>	<u>TIME</u>	<u>REASON</u>

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

<u>HOSPITALIZATION REASON</u>	<u>DIAGNOSIS</u>	<u>YEAR</u>

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

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO CHILD: _____

DATE: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c. 71

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____