

MIDDLETOWN TOWNSHIP PUBLIC SCHOOLS

Office of Assistant Superintendent of Schools

PO Box 4170

Middletown, NJ 07748

(732) 671-3850 X 1030

William O. George III, Ed.D.
Superintendent of Schools

Kimberly Pickus
Assistant Superintendent
for Curriculum & Instruction

KINDERGARTEN REGISTRATION
for the 2017-18 School Year
March, 6, 7, 8, 9, 10, 2017
9:30 - 11:30 A.M. 12:45 - 2:15 P.M.

Dear Parent/Guardian:

A child must be five years old by October 1, 2017, to be enrolled in kindergarten for the 2017-18 school year. You must register your child at the "home school" in your designated attendance area. It is not necessary for your child to be present at registration. The following **evening registration** sites will be available from **7:00 p.m. - 9:00 p.m.** for any parent in the district who is unable to come during the afternoon registration sessions:

•Tuesday (3/7/17)
Leonardo

•Wednesday (3/8/17)
Fairview

•Thursday (3/9/17)
Nut Swamp

The following documents must be presented at the time of registration:

- 1) Your child's original birth certificate.
- 2) Record of physical examination conducted by the child's doctor after July 1, 2016 if available at time of registration. (Note: Proof of immunizations & physical must be turned into the nurse's office. There will be no admission to school without completed immunizations and physicals by July 1, 2017.)
- 3) **PROOF OF RESIDENCE**: Please see the attached documents.
- 4) If enrolled in the Pre-School disability program at New Monmouth, Ocean Avenue or Harmony, **YOU STILL MUST REGISTER AT YOUR DISTRICTED ELEMENTARY SCHOOL.**
- 5) A doctor's certificate or official record certifying that your child has the following NJ state mandated immunizations must be received for enrollment in school:

MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY

Disease (s)	Meets Immunization Requirements	Comments
Diphtheria, Tetanus, Pertussis (Whooping Cough)	4 doses, with one dose given on or after the 4 th birthday	OR any 5 doses
Poliovirus	3 doses, with one dose given on or after the 4 th birthday	OR Any 4 doses
Measles, Mumps, Rubella	2 doses given after the first birthday	OR Laboratory evidence of immunity to each disease
Hepatitis B	3 doses	OR Laboratory evidence of immunity
Varicella (Chicken pox)	1 dose given on or after the first birthday	OR Laboratory evidence of disease OR Physician's or parental statement of previous varicella disease

(N.J.A.C. 8:57-4: Immunization of Pupils in School)

Student Emergency Information

Student Information

Name: _____ ID#: _____
Address: _____ Birthday: _____
City, State, Zip: _____ Gender: _____
Home Phone: _____ Grade: _____ Ethnic Code: _____
Homeroom Teacher: _____ Home Room#: _____

Parent/Guardian Information

Name: _____ Relationship: _____ Primary Residence: Y/N
Street Address: _____ Legal Guardian: Yes ___ No ___
City, State, Zip: _____ Email: _____
Employer: _____ Home Phone: _____
Street Address: _____ Work Phone: _____
City, State, Zip: _____ Mobile Phone: _____

Name: _____ Relationship: _____ Primary Residence: Y/N
Street Address: _____ Legal Guardian: Yes ___ No ___ Extra Mailing: Yes ___ No ___
City, State, Zip: _____ Email: _____
Employer: _____ Home Phone: _____
Street Address: _____ Work Phone: _____
City, State, Zip: _____ Mobile Phone: _____

Contact Information

The individuals below have authorization to pick up my child and can be reached during school hours at the number listed.

Name: _____ Name: _____
Street Address: _____ Street Address: _____
City, State, Zip: _____ City, State, Zip: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____
Mobile Phone: _____ Mobile Phone: _____

Name: _____ Name: _____
Street Address: _____ Street Address: _____
City, State, Zip: _____ City, State, Zip: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____
Mobile Phone: _____ Mobile Phone: _____

Health Information

*In case of serious accident or illness at school, your child will be sent to an emergency medical facility.
The parent(s)/guardian(s) is responsible for all expenses*

Physician's Name: _____ Phone: _____

Do you have health insurance?: Yes ___ No ___ If yes, provide company name: _____

If no, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.
For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.
You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

Health Comments: _____
Emergency Comments: _____
Medical Alerts: _____

MIDDLETOWN TOWNSHIP SCHOOL DISTRICT

Office of the Superintendent

P. O. Box 4170
Middletown, NJ 07748
(732) 671-3850

MEDIA PERMISSION SLIP

Dear Parent/Guardian:

We as a school district want to celebrate your child, his/her work, and his/her participation in certain programs or events. We are requesting permission for your child's image to be published.

Please check the choice below that is most appropriate for your family. Then detach the bottom of the form, sign it, and return it to your child's school with him/her by **the end of the third week in September**.

Your signature/permission will remain in effect for the duration of the child's schooling at Middletown. However, you may change this agreement/ permission at any time by writing to the principal of your child's school. Your wishes will be honored immediately upon receipt of your request.

-----DETACH AND RETURN BY THE END OF THE THIRD WEEK OF SEPTEMBER -----

MEDIA PERMISSION SLIP

The choice below that is most appropriate for my child's participation in various programs or events, or presentation of his/her work, is as follows:

 Full permission is granted.

This includes the following, as appropriate: Image/audio of my child, and/or personal identifiers such as name, grade, school, and teacher's class. This may include, but is not limited to, school/district website, school/district social media, local papers and school publications, including yearbooks/memory books, DVD's of school events (performances/ shows), etc.

 Partial permission is granted.

This includes the following, as appropriate: Image/audio only, with no personally identifying information except school to the above mentioned school/district/media tools of communication.

 Permission is NOT granted.

My child's image/audio may not to be published on the district and/or school's website or in social/print media generated by and under the control of the school district.

Student Name (please print clearly): _____

Student Current Grade: _____

Signature of Parent/Guardian: _____

Date: _____

5111. ELIGIBILITY OF RESIDENT/NONRESIDENT PUPILS (M)

M

The following is an excerpt from the above regulation:

F. Proof of Eligibility

1. The district shall accept a combination of any of the following or similar forms of documentation from persons attempting to demonstrate a pupil's eligibility for enrollment in the district, however, for the purposes of Middletown Township Board of Education, **one document from item (a) must be included and three others from the list provided below:**
 - a. Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency;
 - b. Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location;
 - c. Court orders, State agency agreements and other evidence of court or agency placements or directives;
 - d. Receipts, bills, cancelled checks, insurance claims or payments, and other evidence of expenditures demonstrating personal attachment to a particular location, or, where applicable, to support of the pupil;
 - e. Medical reports, counselor or social worker assessments, employment documents, unemployment claims, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency;
 - f. Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, legal guardian, person keeping an "affidavit pupil," adult pupil, person(s) with whom a family is living, or others as appropriate;
 - g. Documents pertaining to military status and assignment; and
 - h. Any other business record or document issued by a governmental entity.
2. The district may accept forms of documentation not listed above, and shall not exclude from consideration any documentation or information presented by a person seeking to enroll a pupil.

Middletown Township Public Schools
PO Box 4170
Middletown, NJ 07748

I, _____, am providing the attached documents as
(Parent/Guardian Name)

verification of my residency in the community of Middletown, which entitles my child/children to a free public education.

(One document from item (a) must be included and three others from the list provided below:)

- a. Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency;
- b. Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location;
- c. Court orders, State agency agreements and other evidence of court or agency placements or directives;
- d. Receipts, bills, cancelled checks, insurance claims or payments, and other evidence of expenditures demonstrating personal attachment to a particular location, or, where applicable, to support of the pupil;
- e. Medical reports, counselor or social worker assessments, employment documents, unemployment claims, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency;
- f. Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, legal guardian, person keeping an "affidavit pupil," adult pupil, person(s) with whom a family is living, or others as appropriate;
- g. Documents pertaining to military status and assignment; and
- h. Any other business record or document issued by a governmental entity.

2. The district may accept forms of documentation not listed above, and shall not exclude from consideration any documentation or information presented by a person seeking to enroll a pupil

Please list the names of All your children

Name	School	Grade

Date _____ Signature: _____

Middletown Lions Club
P.O. Box 75, Middletown, NJ 07748

Dear Parent or Guardian:

Every child needs a regular vision screening and the American Academy of Ophthalmology (AAO) suggestion “that during childhood, babies up to age 2 should have vision screening during regular pediatric visits, and screening every one to two years for ages 3 to 19.”

To effectively address vision issues in children, SPOT, a revolutionary automated vision screening technology has been developed to quickly detect indications of the most common treatable sight threatening conditions in children such as: **refractive errors** (nearsightedness, farsightedness, unequal power and astigmatism), **amblyopia** (lazy eye), **strabismus** (crossed eyes), and a comparative analysis for unequal refractive power (**anisometropia**) and unequal pupils (**anisocoria**).

By using the latest technology for screening, we are taking a leadership role in the community to identify vision issues. Many of these vision issues can hamper your child’s ability to learn. The prevalence of vision issues has a profound social impact.

- 80% of what a child learns until age 12 is visually acquired.
- 25% of school age children have a vision issue
- Unlike other ailments, pain is not associated with vision issues
- Children with vision issues do not have a reference point for good vision

Kids love how easy SPOT is. The screening is performed from a comfortable distance of about 3 feet away, similar to having a picture taken at home with a digital camera. It only takes a few seconds to administer, is quick, safe and fast. Parents love how it can provide an objective printed summary of the vision screening.

Automated screening does not replace a complete and comprehensive eye examination by an optometrist or ophthalmologist, nor can it detect all eye diseases or conditions. Screening determines if your child requires the attention of a vision care specialist.

YES, I give permission to have an automated vision screening performed on my child.

NO, I will seek vision care from an eye specialist independently.

Student First Name	Last Name	Date of Birth	Gender	Eyeglasses
_____	_____	_____	_____	_____
Parent Signature		Date	School	
_____		_____	_____	

MIDDLETOWN TOWNSHIP SCHOOL NURSE'S GUIDELINES

Your cooperation in helping us provide a safe and healthy school environment for your child is needed and appreciated. If your child manifests any of the following symptoms, please do not send him/her to school.

INFLUENZA: Children who have a combination of any flu like symptoms should be kept home 24 hours without any anti-fever medicine. These symptoms include fever, cough (deep croupy cough), sore throat, runny/stuffy nose, body aches, headache, chills, fatigue, diarrhea and/or vomiting.

FEVER: Temperature of over 100 degrees may be an indication of illness and the child will be sent home. Children who have fevers upon awakening in the morning or who may have had a fever during the night should not be sent to school. Children should be fever free for at least 24 hours without Tylenol, Advil or any other anti-fever medicine before being sent back to school. If sent home from school with fever, the 24-hour rule applies.

DIARRHEA: Children are not to come to school if they have diarrhea. The child's physician should be consulted if diarrhea persists. Should diarrhea occur in school, the parent will be notified and requested to pick up their child from school. The child should remain home until there are no further episodes of diarrhea for 24 hours.

VOMITING: Children are not to come to school if they are experiencing vomiting. Whenever a child has the combination of vomiting and diarrhea, a physician should be consulted. The child should remain home for 24 hours without diarrhea or vomiting before returning to school.

CONJUNCTIVITIS (Pink Eye): Sometimes whites of the eyes are red, eyelids are red and irritated, and sometimes the lids and lashes are crusted. This is a common, contagious condition that clears up easily with medication for 24 hours. Students can return to school if eyes have no redness or drainage.

RASH/SKIN LESIONS: If suspicious rash or lesion is present the child is to be excluded from school until a physician's note allows the student to return or rash/lesion disappears or heals.

IMPETIGO: Sores, some with crusts or scabs usually on the face around the nose and mouth. The contagious condition requires medication. The child must be cleared by a physician and will require a doctor's note upon return to school.

LICE: In the event the child has head lice, he/she will not be allowed back to school until examined by the school nurse.

RINGWORM: Ringworm of the scalp and/or body requires treatment by a physician and requires a doctor's note stating the child is under treatment and may return to school.

EAR/NOSE (PURULENT) DRAINAGE: If the discharge is thick, yellow, green, excessive or uncontrollable the child should remain home. The child will be readmitted to school after receiving clearance from the doctor.

STREPTOCOCCAL INFECTION: Caused by Group A-Beta Hemolytic-incubation period 1-3 days and communicability 10-21 days (untreated). Child can return to school after a minimum of 24 hours antibiotic therapy and physician's note.

MIDDLETOWN TOWNSHIP SCHOOLS
MIDDLETOWN, NEW JERSEY
PRE-KINDERGARTEN PHYSICIAN'S EXAMINATION FORM

This form must be completed by the child's physician and returned to **YOUR** school nurse by July 1st.
Physical must be completed AFTER July 1 of the current school year.

Child's Name _____ Date of Birth _____

Address _____ Telephone No. _____

History and date of serious illness, injury and operations: _____

Please check if any of the following are required:

Glasses _____ Hearing Aid _____ Corrective Shoes _____ Other _____

Is this child presently taking any prescribed medication? If so, please explain _____

****MUST COMPLETE**

Physical Examination: **Height _____ ** Weight _____ B.P. _____

Eyes _____	Skin _____	Abdomen _____	Speech _____
Ears _____	Lymph nodes _____	Hernia _____	Heart Murmur Yes ___ No ___
Nose _____	Heart _____	Orthopedic _____	Activity Restrict. Yes ___ No ___
Throat _____	Lungs _____	Gen'l appearance _____	

History (Give dates where applicable):

Asthma _____	Hernia _____	Scoliosis _____
Allergies (type) food ___ insect ___	Lyme disease _____	Seizure disorder _____
Chicken pox (date) _____	Meningitis _____	Strep throat _____
Drug allergies (type) _____	Mononucleosis _____	Tonsillitis _____
Ear infections _____	Pneumonia _____	Other _____

The following vaccines are required for admission to school. Please record month, day and year.

DPT (1) _____ (2) _____ (3) _____ (4) _____ Booster(s) _____
(Minimum of 4 doses of DPT required - one dose must be given after age 4)

POLIO (1) _____ (2) _____ (3) _____ Booster(s) _____
(Minimum of 3 doses polio vaccine required (IPV or OPV) - one dose must be given after age 4)

MMR (Measles, Mumps, Rubella): (1) _____ (2) _____
(Minimum 2 doses after age one) or _____ (Date) _____ (Date)
Copy of Lab report for immunity titer.

(Minimum 1 dose after age one)

VARICELLA: _____
(Date) (One dose after age one, **OR** Lab report of immunity, or Physician's statement)

HEPATITIS B: _____
(minimum three doses) (1) _____ (2) _____ (3) _____

Previous Immunizations Not required for entry into Kindergarten

Hib: _____
(Date) (Date) (Date) (Date)

Pneumococcal Conjugate Vaccine (PCV 7) _____
(Date)

Influenza (by Dec. 31st) _____
Hep A: _____, _____: Other: _____, _____, _____
(Date)

Tuberculin Test (Mantoux only)(If born in country of high incident) _____
(Date) (Result)

Physician's Name _____
(Please print) Physician's Signature and Stamp

Date of Examination _____

MIDDLETOWN TOWNSHIP PUBLIC SCHOOLS
Student Data Base For Registration

Home Phone # (_____) _____ Registration Date _____

E-mail (if available) _____ State ID (if available) _____

Student's Legal Name _____ Male Female
Last First Middle

Date of Birth _____ Place of Birth _____
City, State Country

Student's Address _____
Street Address City Zip

Parent/Guardian 1 _____ Relationship to student _____

Cell # _____ Work # _____

Parent/Guardian 2 _____ Relationship to student _____

Cell # _____ Work # _____

Ethnicity/Race: Please check all that apply

Hispanic/Latino Amer. Indian/Alaskan Asian Black White Pacific Islander

Both parents at same address? Yes No if no, with which parent does student reside? _____

If no, mail duplicate records to Address: _____

Are you a member of the military? Yes No Service/Branch _____

English Usually Spoken at Home? Yes If not, what language? _____

Pre-school Experience Yes Pre-School Name _____

Name/Address of Last School _____ Dates/years attended _____

Was student ever enrolled in the Middletown Twp. School System before? Yes No

Which Middletown School? _____ Dates Attended _____

Is student in Academic Assistance program? _____ Is student taking English as a second language? _____

Is student classified by Child Study Team? _____ Is student working with a speech teacher? _____

Signature – Parent/Guardian

Month/Day/Year

***** Section Below To Be Completed By School Personnel *****

Entering Date: _____ Homeroom # _____ School (in district) _____

Guidance Counselor: _____ Grade: _____ ID# _____

All forms for residency verification have been submitted. (4 forms, per policy #5111) Yes No

Evidence of Age: Birth Certificate School Records

Signature-School Personnel

Month/Day/Year

MIDDLETOWN TOWNSHIP BOARD OF EDUCATION
MIDDLETOWN, NEW JERSEY 07748

GROWTH AND DEVELOPMENT HISTORY

Place of Birth: _____

Date of Birth _____

Child's Last Name First Middle Male or Female School

Address (Number, Street, Town, State, Zip) Phone Number

Parent 1 Name/Guardian Parent 2 Name/Guardian Name and Address of Last School Attended

Development: Age Walked _____ Age Talked _____

Has your child had a history of: (Please circle - give dates)

- | | | |
|------------------------|---------------------|---------------------|
| Chicken Pox | Lyme Disease | Orthopedic Injuries |
| Diabetes | Mononucleosis | Other _____ |
| Enuresis (bed wetting) | Speech Difficulties | |
| Epilepsy | Strep Throat | |
| Eye Glasses/Injury | Operations: | |
| Heart Disease | Appendectomy | |
| Head Injury | Ear Operation | |
| Hernia | Tonsillectomy | |
| High fever | Hernia Repair | |

MEDICATION/FOOD ALLERGY:

- Type of medication/food _____
- Approximate date of initial treatment _____
- Approximate date of last treatment _____
- Specific symptoms student exhibits _____
- Presently under medical care for allergy Yes _____ No _____
- If Yes, Name of Doctor _____
 Specific medications/treatment _____
- Other _____

MIDDLETOWN TOWNSHIP PUBLIC SCHOOLS

P.O. Box 4170, Middletown, New Jersey 07748

TEL(732)671-3850 FAX(732)291-2364

www.middletownk12.org

William O. George III, Ed.D.
Superintendent of Schools

Mary E. Walker
Assistant Superintendent for Operations

January 2017

Dear Parent/Guardian:

Please review the information below and keep in mind that this information applies to all Kindergarten children whether they are in a general or special education program. If your child was in the Preschool Disabilities program but is no longer classified, you will need to register for Kindergarten at your home school and follow the Kindergarten registration and mandated immunization procedures.

Middletown Township Board of Education policy requires a physical examination, performed by the child's physician **after July 1, 2016, and recorded on the enclosed medical examination form, for all students entering Kindergarten. Students will not be able to start school unless the form is completed and on file in the school office.** Parents who cannot afford this medical service should contact the local building's school nurse before the end of 2016-17 school year. Your child is required to have received:

4 doses of DPT – with one dose given on or after the 4th birthday, OR any 5 doses.

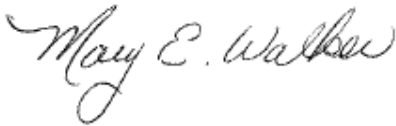
3 doses of IPV – with one dose given on or after the 4th birthday, OR any 4 doses.

2 doses of a live Measles, Mumps and Rubella vaccine given on or after the 1st birthday OR Laboratory evidence of immunity.

1 dose of Varicella (Chickenpox) given on or after the 1st birthday, OR Laboratory evidence of immunity. Second dose is recommended to be given between 4 and 6 years of age, but is not required for entry at this time.

3 doses of Hepatitis B, OR Laboratory evidence of immunity.

Contact your private physician regarding your child's immunization status. The Middletown Township Board of Health (732-615-2095), the Monmouth County Regional Health Commission #1, 1540 West Park Avenue, Ocean Township, (732-493-9520), and the Monmouth County Board of Health, 3435 Highway 9, Freehold, (732-431-7456), have clinics for children who have no insurance or are underinsured. You may contact them for more information regarding immunization services.



Thank you for your cooperation regarding this matter.

Sincerely,

Mary E. Walker
District Director of Operations

Standing Orders for Medications with Parental Permission

Student Name _____ Grade _____ Date of Birth _____

Medication taken on a regular basis: _____

I request that the following medications may be **administered** to my child.

I will **supply the medication** (please circle 1-4 as desired):

For headache/earache/menstrual cramps/muscle aches/fever >101 degrees:

- 1.** Acetaminophen (TYLENOL) <http://www.healthychildren.org/English/tips-tools/symptom-checker/Pages/Acetaminophen-Dosage-Table.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token>

Child's Weight (pounds)	18-23	24-35	36-47	48-59	60-71	72-95	96+	lbs
Syrup: 160 mg/1 teaspoon	3/4	1	1 1/2	2	2 1/2	3	4	tsp
Chewable 80 mg tablets	1 1/2	2	3	4	5	6	8	tabs
Chewable 160 mg tablets	--	1	1 1/2	2	2 1/2	3	4	tabs
Adult 325 mg tablets	--	--	--	1	1	1 1/2	2	tabs
Adult 500 mg tablets	--	--	--	--	--	1	1	tabs

- 2.** Ibuprofen (ADVIL/MOTRIN) <http://www.healthychildren.org/English/tips-tools/symptom-checker/Pages/Ibuprofen-Dosage-Table.aspx>

Child's Weight (pounds)	18-23	24-35	36-47	48-59	60-71	72-95	96+	lbs
Liquid 100 mg/ 1 teaspoon	3/4	1	1 1/2	2	2 1/2	3	4	tsp
Chewable 50 mg tablets	--	2	3	4	5	6	8	tabs
Junior-strength 100 mg tablets	--	--	--	2	2 1/2	3	4	tabs
Adult 200 mg tablets	--	--	--	1	1	1 1/2	2	tabs

For upset stomach:

- 3.** Chewable antacid tablets (Tums) 1-2 tablets

For mild allergic reaction (Circle dose that applies to your child):

- 4.** Diphenhydramine (BENADRYL)
 Under 6 year of age - 12.5mg (1 teaspoon of 12.5mg/teaspoon)
 6-12 Years of age 25 mg (2 teaspoon = 25 mg)
 >12 years old 25mg-50mg (2-4 teaspoon of 12.5mg/teaspoon)

I understand that the school nurse, with the established protocol that has been developed and approved by Middletown Township School district physician, can administer the above medications. Be advised that the district shall incur NO liability as a result of any injury arising from the administration of medication and the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

 Signature of parent/Guardian

 Date

 Contact #