

School District of Union City

4405 Palisade Avenue, Union City, New Jersey 07087

Internet Application

Tel: 201-392-3629 o 3639 Fax: 201- 863-5565

To All Persons Registering a child. Registration packets must be written in **PEN**

At the time of registration, *ALL DOCUMENTS PRESENTED MUST BE ORIGINAL.*

STUDENT AGE FIVE TO TEEN MUST BE PRESENT WITH PARENT OR LEGAL GUARDIAN TO REGISTER

"Proof of Residence" ITEMS MUST BE PROVIDED TO PROCESS A STUDENT'S REGISTRATION

FROM the following to establish residency from the Parent or Legal Guardian with their name & address on document:

SELECT TWO (2) Proofs

Court orders, State Agency agreements, Court Agency placements or Directives

OR - Utility: PSE&G, Water, or Cable

OR- Property Owner: Property tax bills, deed, contract of sale, mortgage, and other evidence of property ownership.

OR- Tenant Lease or Notarized letter of agreement with **rent receipt, including deposit slip** demonstrating the property address and tenant name.

OR- Evidence of circumstances demonstrating family or economic hardships, or temporary residency such as medical reports, counselor or social worker assessments, employment documents, unemployment claims, etc.

OR- Affidavits, certifications, and sworn attestations pertaining to statutory criteria for school attendance from the parent, guardian, person keeping an "affidavit student", adult student, person(s) with whom a family is living, or others, as appropriate.

OR- Medical reports; counselor or social worker assessments; employment documents; unemployment claims; benefit statements; and other evidence of circumstances.

OR- Voter registration card

OR- Military status including assignment documents

NOTE: *If the child's last name differs from the last name of parent (s), proof of parentage is required. Parent's name change must be documented (i.e. marriage or divorce certificate)*

"Student Certificates"

Birth Certificate OR Baptismal Certificate.

AND- Immunization Records showing all immunizations are current. TB SKIN TEST (MANTOUX method of PPD TEST). Students cannot register until after the TB, skin test has been read and the doctor/clinic has provided you with written results. If the TB test is positive, student needs to provide proof of normal chest X-ray and/or proof of INH medication treatment including dosage, date started and date completed.

AND- Medical Exam "State of New Jersey Physician Form for Union City"

AND -Report Card and prior school records, INCLUDING state testing.

AND- Withdrawal Form & Transfer Card from the previous school. Both the transcript and withdrawal form help our counselors place your student in the most appropriate classes for academic success.

Special Accommodations:

If the student currently has an I.E.P., please bring documentation outlining services required.

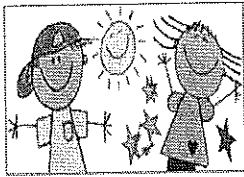
" Legal Guardianship " Custody court document must be signed and sealed by a Judge

"Guardian" means a person to whom a court of competent jurisdiction has awarded guardianship or custody of a child, provided that a residential custody order shall entitle a child to attend school in the residential custodian's school district subject to a rebuttable presumption that the child is actually living with such custodian; it also means the Department of Children and Family's for purposes of N.J.S.A. 18A:38-2 (e)

The totality of information and documentation you offer will be considered in evaluating an application, and, unless expressly required by law, the student will not be denied enrollment based on your inability to provide certain form(s) of documentation where other acceptable evidence is presented.

"EARLY CHILDHOOD PROGRAM"

Student must be 3, 4 or 5 years of age on or before September 1st recommended to be toilet trained



Union City Board of Education
 Central Registration Office Internet Application
 4405 Palisade Avenue, Union City, New Jersey 07087
 Public School Student Registration Information Form
Must be written in PEN



Student age Five to Teen must be present with Parent or Guardian to Register

Student information:

(Last): _____ (First) _____ (Middle I.) _____
 Address: _____ City: _____ State: _____
 Telephone: _____ and Cell: _____
 Date of Birth: ____/____/____ Sex: ___ M ___ F Age: ____
 Birthplace: City: _____ State: _____ Country: _____

Previous school name: (IF APPLICABLE MUST BE FILLED OUT)

Name: _____ Grade: Attending: _____ or Finished _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____

Has your child ever attended school in Union City? ___ Yes ___ No (If Yes) Please fill out below.

Name of School: _____ Grade Attended: _____ Year: _____

Name of person enrolling student: _____ Relationship to student: _____

Native Language of person enrolling student? _____ How long have you lived at this address? _____

Parent information:

Mother:

Name: (Last): _____ (First): _____ (Maiden): _____
 Date of birth: ____/____/____ Place of birth: _____ If deceased state year: _____
 Address: _____ City: _____ State: _____
 Telephone: _____ and Cell: _____

Father:

Name: (Last): _____ (First): _____
 Date of birth: ____/____/____ Place of birth: _____ If deceased state year: _____
 Address: _____ City: _____ State: _____
 Telephone: _____ and Cell: _____

Name of Sibling: _____ Age: ___ School: _____ Gr: ____
 Name of Sibling: _____ Age: ___ School: _____ Gr: ____

Who has legal custody of the student/s: _ Mother _ Father _ Legal Guardian _ DYFS
 If you are the legal Guardian of the student, you have to provide details subsequently requested. Submit all original court credentials from a United States Court with the original court seal and a signature of a Judge.

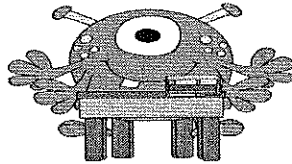
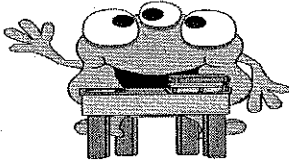
Guardian information:

Name: (Last): _____ (First): _____ (Middle Initial) _____
 Address: _____ City: _____ State: _____
 Telephone: _____ and Cell: _____

Does the student need any Accommodations? ___ NO ___ YES (If YES) must provide documentation

Signature of Parent/Guardian: _____ Date _____

Student age 5 to teen must be present with parent or legal guardian to register



Union City Board of Education

Central Registration Office

4405 Palisade Avenue, Union City, New Jersey 07087

P: (201) 392-3629 or 3639 Fax: (201) 863-5565

Public School Student Registration Information Form

Write clearly and legibly in ink.

Student age five (5) to teen must be present with parent or legal guardian to register

Student information:

(Last): _____ (First) _____ (Middle I.) _____

Address: _____ Apt. # _____ City: _____ State: _____

Telephone: _____ and Cell: _____

Date of Birth: ____/____/____ Sex: ____ M ____ F Age: _____

Birthplace: City: _____ State: _____ Country: _____

Previous school name: (IF APPLICABLE MUST BE FILLED OUT)

Name: _____ Grade: Attending: _____ OR (Finished) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Has your child ever attended school in Union City? ____ Yes ____ No (If Yes) Please fill out below.

Name of School: _____ Grade Attended: _____ and Year: _____

Name of person enrolling student: _____ Relationship to student: _____

How long have you lived at this address? _____

Parent information:

*Mother:

Name: (Last): _____ (First): _____ (Maiden): _____

Date of birth: ____/____/____ Place of birth: _____ If deceased state year: _____

Address: _____ Apt.# _____ City: _____ State: _____

Telephone: _____ and Cell: _____

*Father:

Name: (Last): _____ (First): _____

Date of birth: ____/____/____ Place of birth: _____ If deceased state year: _____

Address: _____ Apt.# _____ City: _____ State: _____

Telephone: _____ and Cell: _____

Name of Sibling: _____ Age: ____ School: _____ Gr: ____

Name of Sibling: _____ Age: ____ School: _____ Gr: ____

Who has legal custody of the student/s: _Mother _Father _Legal Guardian _DYFS

If you are the legal Guardian of the student, you have to provide details subsequently requested. Submit all original court credentials from a United States Court with the original court seal and a signature of a Judge.

Guardian information:

Name: (Last): _____ (First): _____ (Middle Initial) _____

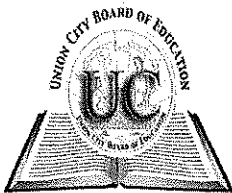
Address: _____ Apt.# _____ City: _____ State: _____

Telephone: _____ and Cell: _____

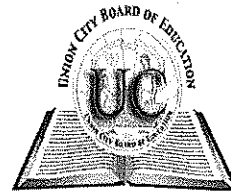
*Does the student need any Accommodations? ____ NO ____ YES (If YES) must provide documentation

Signature of Parent/Guardian: _____ Date: _____

Student age five (5) to teen must be present with parent or legal guardian to register



**Union City
Public Schools
Office of Bilingual/ ESL Education**



HOME LANGUAGE SURVEY_a

Please answer the following questions:

Student's Name: _____ U.S. Date of Entry: _____

Address: _____ Telephone: _____

Birth Date: _____ Place of Birth: _____

Please us only ONE LANGUAGE for each answer:

1. What language did your child first learn to speak? _____
2. What language do you use most often when speaking to your child at home? _____
3. What language does your child use most often when speaking to you at home? _____
4. What language does your child use most often when speaking to brother/sister? _____
5. What language does your child use most often when speaking to other relatives? _____
6. What language does your child use most often when speaking to friends at home? _____

Parent/Guardian Signature

Date

Dear Parent or Guardian:

As required by State and Federal Law (State Bilingual Education Act of 1975, Federal Lau vs. Nicholas Supreme Court ruling of 1974), all parents must be surveyed as to the home language of their public school children.

We request the above information in order to provide a good instructional program for your child. The completion of this survey is mandatory. Thank you for your cooperation.

Silvia Abbato
Silvia Abbato
Superintendent of Schools

For office use only:

LAU: _____

ETH: _____

Grade: _____



Union City Board Of Education
Central Registration Office



PERMISSION FOR MEDICAL SCREENING

Students Name: _____ Date of Birth: ____/____/____
(Month) (Day) (Year)

The following services will be given to all new entrants and only in those grades recommended *by the State Department of Education.*

- Record of Child's Health History
- Immunization Evaluation & Completion
- Heights and Weights
- Blood Pressure Screening (Athletes)
- Tuberculin Testing
- Vision Screening
- Hearing Screening
- Scoliosis

Physical Examinations for boys and girls will be done throughout the school year. Boys and girls will be examined separately. In the absence of a parent, a nurse and the teacher will be present when the School Doctor examines a student. Parents are encouraged to attend, if possible.

If you wish to obtain the results of the physical screening, please contact the school nurse. In the event that further examination and/or treatment are necessary, the nurse will be available to inform you.

Please select only one and provide your signature below with the date.

_____ I **GRANT** do grant permission to the Union City Board of Education, Medical Department to screen my child.

 Signature of Parent/Guardian _____
 Date

_____ I do **NOT** grant permission. I will be responsible to obtain these services by my private Doctor and provide the school nurse with the results.

 Signature of Parent/Guardian _____
 Date

Our sincere appreciation for your cooperation in helping us provide the best services for your child.

SUPERINTENDENT OF SCHOOLS

FOR OFFICE USE ONLY

School: _____ **Home Room:** _____



New Jersey Department of Health
MUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL INTERNET 2015/16
NOTICE TO PARENTS
Regarding Immunization Deficiencies

Student Name: _____

HR: _____

Your child's health record shows that immunization requirements for school attendance are incomplete. The boxes circled below indicate the immunizations that are missing.

Name of Child (Last, First, M.I.)		Date of Birth (Mo/Day/Yr)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
PARENT OR GUARDIAN	NAME	TELEPHONE NO.			
	ADDRESS				

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)					
Tdap					
POLIO - INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

If you have records that show that these immunizations have been received, please bring proof to the school nurse and have the information transcribed to the school health record. (Approximate dates of immunization are needed).

The immunization regulation permits for a provisional or temporary attendance at school upon filing a request for provisional admittance. If your child requires more than one doctor visit to complete these requirements, have your private medical doctor or the local health department complete the attached form. Failure to comply with the States Immunization Requirements will prevent your child from attending school.

 School Nurse Phone Number Date

Check if you need either of these forms: Medical Contraindication Religious Exemption

PROVISIONAL ADMITTANCE REQUEST

Name of Child: _____ HR: _____

I, _____ request to have my child provisionally admitted to school pending the completion of the minimum immunization requirements and I affirm that the immunization(s) required would be completed in a timely manner in accordance with the appointment scheduled provided by my private medical doctor or local health department.

 Parent/Guardian Phone Number Date

The above pupil's immunization series has been initiated and he/she is in the process of complying with all the requirements. I have scheduled a doctor's appointment to complete the immunizations and I agreed to provide the school with an updated record. All immunizations must be met by _____.

Expiration of Provisional Admittance (May not exceed one year)

Signature of Physician or Health officer	Address	Medical Seal Required
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Union City Public Schools
 Department of Special Services
 3912 Bergen Turnpike



Special Education Medicaid Initiative (SEMI) Parental Consent Form

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, 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 insurance to pay for special education or related services under Part 300 (services under the IDEA).

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.

Name of Child: _____

Date of Birth of Child: ____/____/____

State ID: _____ Local ID: _____

Parent/Guardian: _____ Date: ____/____/____

I give my consent to bill for SEMI ____ Yes ____ No

This consent can be revoked at any time by contacting the administrator at your child's school.

Union City Board of Education
3912 Bergen Turnpike
Union City, NJ 07087
(201) 348-5770

STUDENT DATA COLLECTION

Please fill out this data collective survey. Your cooperation is very much appreciated. This survey is required/mandated by the New Jersey State Department of Education and must be completed by all Union City students. This survey may affect future school funding.

Student's Information:

Last Name: _____

First Name: _____

City and State of Birth: _____

Country of Birth: _____

Ethnicity: (Please circle) Hispanic/Latino: Yes or No

Answer **YES** if student is a Cuban, Puerto Rican, South or Central American, or other Spanish Culture/origin, regardless of race. Answer **NO** if not Hispanic or Latino.

Race: Check all that may apply

- American Indian or Alaskan Native
- Asian
- Black/African American
- Native Hawaiian or Pacific Islander
- White/Caucasian

Military Status: (Circle One)

- Not Military Connected
- Active Duty (Army, Navy, Air Force, Marine Corps or Coast Guard)
- National Guard or Reserve (Army, Navy, Air Force, Marine Corps or Coast Guard)
- Unknown

Health Information:

Last Medical Exam: _____

Last Lead Level: _____

First Polio Immunization: _____

Does student have health insurance? Yes or No

If **YES**, name of Health Insurance Provider: _____

