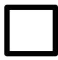


DISTRICT ENROLLMENT FORM

FOR OFFICE USE ONLY

Barack Obama Elementary School	Asbury Park Middle School
Bradley Elementary School	Asbury Park High School
Thurgood Marshall Elementary School	

PLEASE PRINT

Student's Name: ____

Parent/Guardian: ____

Address: ____

City/State/Zip Code: ____

Home Phone: ____

Emergency Phone: ______________________ Ethnicity: ______________________

Date of Birth: ______________________ Age: ______________________

Place of Birth: ____

U.S. Entry Date (if applicable) ____________ First Entry to U.S. Schools ______________________

Last School Attended: ______________________ Last Grade Completed: ______________________

Name of Father: ____

U.S. Citizen: Yes__________ No___________ Occupation: ______________________

Employer's Address: ______________________ Work Telephone: ______________________

Name of Mother: ____

U.S. Citizen: Yes__________ No___________ Occupation: ______________________

Employer's Address: ______________________ Work Telephone: ______________________

Does either parent work in a government institution? Yes____________________ No____________________

IN CASE OF EMERGENCY CONTACT:

Name: ______________________ Phone: ______________________

Address: ____

LIST OTHER PUBLIC OR PRIVATE SCHOOLS ATTENDED BY THIS STUDENT:

School/District: ______________________ Address: ______________________

School/District: ______________________ Address: ______________________

School/District: ______________________ Address: ______________________

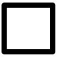
CENSUS INFORMATION – LIST OTHER CHILDREN IN FAMILY (OLDEST FIRST)

Name: ______________________ Date of Birth: ______________________

Name: ______________________ Date of Birth: ______________________

Name: ______________________ Date of Birth: ______________________

Name: ______________________ Date of Birth: ______________________



Temporary Address

Is your current address a temporary living arrangement: YES( ) NO( )

Did you move in with a relative or friend: YES( ) NO( )

Are you currently living in one of the following:

( ) Relative
Please explain:_________________________________

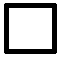
( ) With more than one family in a house or apartment

( ) Motel

( ) Shelter

( ) A place where you can't stay for an extended period of time

( ) A car or other place not usually designated for sleeping



Authorization for Release of Records

Student's Name ___________________________________ Date of Birth __________________

Current Grade ___________________________________

Records to be released (check appropriate items)

____________ Cumulative Record Folder

____________ Test Scores

____________ Transcript of Grades

____________ Health Records

____________ Attendance and Discipline Information

____________ Child Study Team Records (Educational, Psychological, and Social History Eval)

____________ NJ State ID Number

____________ Other: **NJ HSPA Score & ISR**

The Record(s) indicated above is/are to be released to:

___ **Barack H. Obama Elementary**
1300 Bangs Avenue
Asbury Park, NJ 07712
ATTN: Felecia Smith

___ **Bradley Elementary**
1100 Third Avenue
Asbury Park, NJ 07712
ATTN: Nancy Aumack

___ **Thurgood Marshall Elementary**
600 Monroe Avenue
Asbury Park, NJ 07712
ATTN: Yassanah Farrakhan

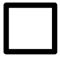
___ **Asbury Park Middle School**
1200 Bangs Avenue
Asbury Park, NJ 07712
ATTN: Yvose Damour

___ **Asbury Park High School**
1001 Sunset Avenue
Asbury Park, NJ 07712
ATTN: Diana Ervin

I hereby grant permission for the release of the above record(s):

___________________________________ ______________ ___________________________________

Parent/Guardian Signature **Date** **Student Signature (18 years or older)**



Academic History

In order to provide a highly educational instructional program, please answer the following questions:

I. ENGLISH AS A SECOND LANGUAGE/BILINGUAL

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 parent/guardian at home?

   ____

4. What language does your child use most often when speaking to brother or 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?

   ____

II. PROGRAM INFORMATION

Please check any of the following programs in which your child has participated:

PROGRAM	GRADE LEVEL
_____ ESL, Bilingual	______________
_____ Talented and Gifted	______________
_____ Special Education Services	______________
_____ 504	______________
_____ Homeless	______________
_____ None of the above	______________

III. ADDITIONAL INFORMATION

Please provide the date that your child entered the country:________________________________

<u>SOCIAL HISTORY</u>: Please write any information about your child which you think the teacher should have in order to understand and help your child:

____

____

____

____

☐

ASBURY PARK SCHOOL DISTRICT

IEP & 504 Plan

Student's Name:_________________________________ Date of Birth___________________

Current Grade:_____________________

Last School Attended:________________________ Phone Number of School:____________________

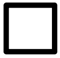
Please call the previous school to confirm the following information:

Does this student have an: IEP ( ) 504 Plan ( )

Staff Name:________________________________ __________________________________

Print Name Signature

Date:_______________________________



Health Services Information

In order to provide the best possible health services for your child, the school nurse needs to know your child's history and current health status. Please indicate below if your child has had any of the following:

____ Asthma or breathing problems

____ Allergies/ (to what) ____________________ Type of reaction____________________Epi Pen ________

____ Recent Hospitalization/Reason

____ Seizure Disorder, (type) ____________________________ Medication _____________________________

____ Frequent ear infections ____

____ Daily Medications - Name of medication ____

Dose __________________________________ Frequency ____

____ Diabetes & Treatment ____

____ Any other health condition ____

____

Doctor's Name ________________________________ Telephone Number _______________________________

Name of Health Insurance __________________________Identification Number ________________________

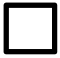
I give permission to the school to share information concerning my child's health to those faculty/staff members who may need to know. I recognize that sharing the information is important to my child's well-being and safety while attending school.

I give permission to the school nurse to contact my child's health providers to obtain necessary information to provide care to my child. This includes, but is not limited to Immunization Records and Medications Health Information, but also includes information from Mental Health care providers

Child's Name ____

___________________________________ _____________________

Parent's Signature **Date**



School Based Nurse Practitioner Health Services Program

Dear Parent/ Guardian:

The School Based Nurse Practitioner Health Services Program (Health Services Program) provides Comprehensive preventative, medical, and health education services for students in our Schools. The Health Services Program is operated by the Visiting Nurse Association of Central New Jersey at no cost to the students.

The Health Services Program offers primary health care services provided by a Nurse Practitioner (or advanced Practice Nurse). A Nurse Practitioner, in collaboration with a physician, is licensed to diagnose and treat individuals within the school setting. These services will include examination and evaluation of health complaints or problems.

You will be informed of the findings, and treatment will be offered or recommendations made that your child see his/her own health care provider. At your request and consent, treatment will be provided and follow up visit scheduled. Your primary health care provider will be informed of any treatment offered at the health office via fax and phone in order to maintain professional comprehensive care for your child. Kindly provide the following necessary information.

Please complete the consent form below:

- ☐ I give consent for my child______________________________________ to be examined and evaluated by a Nurse Practitioner in the case of illness or a health problem that may interfere with the child's progress in school. **Yes_____ No_____**

- ☐ **I do ____/do not___** want the Nurse Practitioner to administer basic care. Basic care may include giving Tylenol for high fevers

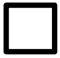
PLEASE NOTE: We are not an emergency room. If further care is needed, we will call 911. There is no cost to you for these services, whether your child is covered by a health insurance policy or not.

I hereby release this Asbury Park school, the Board of Education and the visiting Nurse Association of Central Jersey, and any other of their agents, elected officials or employees from any and all liability, claims, damages, costs and expenses, which result or may result from any action, accident, omission, or incident in condition in connection with or related to my child's use of the School- Based Nurse Practitioner Health Services Program.

I certify by signing that I am also releasing any claims for my child. As a condition and consideration for being able to use the School-Based Nurse Practitioner Health Services Program, I agree, to the fullest extent permitted by law, not to commence, encourage, facilitate or participate in any action or proceeding for damages, injunctive or any other type of relief, in any state, federal or local court or before any administrative agency on behalf of myself, my child or any other person relating to the School-Based Nurse Practitioner Health Services Program.

Parent /Guardian Signature ____________________________________ Date __________________________

Parent/ Guardian Print Name ___________________________________ Date _________________________



Medical Home Form

Student's Name ____ Date of Birth _____________________

Students Address ____

City ____________________________________ State __________________ Zip Code ______________________

School __________________________________ Grade _________________ Homeroom# __________________

Homeroom Teacher _____________________________Parent/ Guardian Name__________________________

Please Check/complete one of the following:

1. My primary care Physician or clinic (medical home) is____

   Address ____

   Phone Number ______________________________

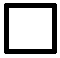
2. I **Do Not** have a Primary Care Physician

Check the lines below that apply to you:

_______ I do not have Medicaid
_______ I do not have NJ KidCare

____________________________________ _________________________

Parent Signature **Date**



Title I - Parent Involvement Survey

Dear Parent/Guardian,

Title I parents are to be involved in the decisions regarding how the 1% reserved funds will be used for parental involvement. Our school believes your input regarding school information and parental involvement activities is crucial. Please complete the following survey by checking the kinds of resources and services you would like to see made available in the district.

This survey will be used to develop our school's Parental Involvement Policy and Activities.

Please check all that apply:

Listed below are opportunities we would like to offer. Please check any/all of those that you would like to see and or be involved in:

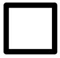
- ☐ District-wide Parent Enrichment Conference
- ☐ English as a second language
- ☐ Resume writing workshop
- ☐ Strategies for improving Student achievement in reading and writing
- ☐ Basic Computer Skills
- ☐ Resources for Grand Parents Raising Children
- ☐ Ensuring your child does well on the NJ ASK Test
- ☐ Understanding ADHD and doing something about it
- ☐ Helpful Hints for single Mothers raising boys
- ☐ Developing a Home Learning System
- ☐ Monitoring your child's us of technology
- ☐ Discovering your child's hidden Talent
- ☐ PTO (Parent Teacher Organization)
- ☐ Other
- ☐ Improving your child's self-image
- ☐ Drug and Gang Prevention workshops
- ☐ GED prep classes
- ☐ Chess Club
- ☐ Stress Management for Today's parent
- ☐ The 411 on HIB (Harassment, Intimidation and Bullying)
- ☐ Preparing Children for school
- ☐ Improving Communication with the Child's Teacher
- ☐ Finding Mentors for children
- ☐ Diagnosing Depression and other Mental health issues
- ☐ Navigating The American Education System (Spanish and Creole)
- ☐ Talking with youth about sex
- ☐ PAC (Parent Advisory Council)
- ☐ Other

Time of meetings *(Check one):* ____ AM ____PM /___Mon ___Tues ___Wed ___Thurs ___Fri ___Sat

Parent/Guardian Name: ______________________________

Best Contact Number: ______________________ Email Address: ______________________

Child's School: ______________________________ Grade: ______________________



School-Parent/Guardian Compact

The Asbury Park School District , and the parents of the students participating in activities, services, and programs funded by Title I, Part A of the Elementary and Secondary Education Act (ESEA) (participating children), agree that this compact outlines how the parents, all school staff, and the students will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children achieve the State's high standards.

This school-parent compact is in effect during school the current school year.

School Responsibilities

The Asbury Park School District will:

1. Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the State's student academic achievement standards.

2. Hold parent-teacher conferences during which this compact can be discussed as it relates to the individual child's achievement.

3. Provide parents with frequent reports on their children's progress. Specifically, the school will provide reports as follows.

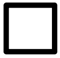
4. Provide parents reasonable access to staff. Specifically, staff will be available for consultation with parents upon request and on an as needed basis.

5. Provide parents opportunities to volunteer and participate in their child's class, and to observe classroom activities upon request and on an as needed basis.

Parent/Guardian Responsibilities

I (We), as parent(s), will support my child's learning in the following ways:

- Monitoring attendance.
- Making sure that homework is completed.
- Monitoring amount of television my child engages in.
- Volunteering in my child's classroom.
- Participating, as appropriate, in decisions relating to my child's education.
- Promoting positive use of my child's extracurricular time.
- Staying informed about my child's education and communicating with the school by promptly reading all notices from the school or the school district either received by my child or by mail and responding, as appropriate.
- Serving, to the extent possible on policy or advisory groups.



Student Responsibilities

I, as a student, will share the responsibility to improve my academic achievement and achieve the State's high standards. Specifically, I will:

- Do my homework every day and ask for help when I need to.
- Read at least 30 minutes every day outside of school time.
- Give to my parents or the adult who is responsible for my welfare all notices and information received by me from my school.

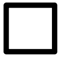
The Asbury Park School District will:

1. Involve parents in the planning, review, and improvement of the school's parental involvement policy, in an organized, ongoing, and timely way.
2. Involve parents in the joint development of any school-wide program plan, in an organized, ongoing, and timely way.
3. Hold an annual meeting to inform parents of the district's participation in Title I, Part A programs, and to explain the Title I, Part A requirements, and the right of parents to be involved in Title I, Part A programs. The district/schools will convene the meeting at a convenient time to parents, and will offer a flexible number of additional parental involvement meetings, such as in the morning or evening, so that as many parents as possible are able to attend. The district/schools will invite to this meeting all parents of children participating in Title I, Part A programs (participating students), and will encourage them to attend.
4. Provide information to parents of participating students in an understandable and uniform format, including alternative formats upon the request of parents with disabilities, and, to the extent practicable, in a language that parents can understand.
5. Provide to parents of participating children information in a timely manner about Title I, Part A programs that includes a description and explanation of the school's curriculum, the forms of academic assessment used to measure children's progress, and the proficiency levels students are expected to meet.
6. On the request of parents, provide opportunities for regular meetings for parents to formulate suggestions, and to participate, as appropriate, in decisions about the education of their children. The district/schools will respond to any such suggestions as soon as practicably possible.
7. Provide to each parent an individual student report about the performance of their child on the State assessment in at least math, language arts and reading.
8. Provide each parent timely notice when their child has been assigned or has been taught for four (4) or more consecutive weeks by a teacher who is not highly qualified within the meaning of the term in section 200.56 of the Title I Final Regulations (67 Fed. Reg. 71710, December 2, 2002).

Signature of District/School Representative ______________________ **Date**______________

Signature of Parent/Guardian ______________________ **Date** ______________

Signature of Student ______________________ **Date** ______________



Parental/Guardian Media Consent Form

Dear Parents/Guardians:

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personally identifiable information to be published by media outlets or used on the district and/or school's web site and/or social media.

As you are aware, there are potential dangers associated with the posting and sharing of personally identifiable information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as a parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, email address, phone numbers and locations and times of class trips. If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

Check ONE of the following choices:

☐ I /We GRANT permission for a photo/image/video that includes this student without any other personal identifiers to be published or used on the school and/or district's public Internet site.

☐ I /We GRANT permission for this student's photo/image/video and name to be published or used on the school and/or district's public Internet site.

☐ I /We GRANT permission for this student's photo/image/video and all other personal identifiers listed above to be published or used on the school and/or district's public Internet site.

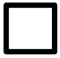
☐ I /We DO NOT GRANT permission for photo/image/video that includes this student to be published or used on the school and/or district's public Internet site.

Student's Name: (please print) ____

Print name of Parent/Guardian: (print) ______________________________________

Signature of Parent/Guardian: (sign) _______________________________________

Relationship to student: ________________ Student's Grade: ____________ Date: __________



Student Agreement for Internet Access Account

By signing this agreement, I/we are signifying that I /we have read the Asbury Park Acceptable Use Policy and agree to abide by its terms. I/we understand that the computers, networks and technologies are to be used solely for educational purposes and that there is no expectation of privacy with respect to the use of the same.

When this contract is complete, it must be returned to the principal's office. If there are any questions regarding this policy, please contact a sponsoring teacher, technology coordinator, or an administrator.

Last Name:______________________________ **First Name:** ______________________________

Home Address: ____

Home Phone: ____________________________________ **Age:** _____________________________

Expected Year of Graduation: ____________________

User Signature: _____________________________________ **Date**: ___/___/_______

Parent or Guardian (If the applicant is under the age of 18, a parent or guardian must also read and sign this agreement):

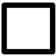
As the parent or guardian of this student I have read the policy in its entirety and agree to its terms on behalf of my child. I hereby give my permission to issue an account for my child and certify that the information contained in this application is correct.

Parent or Guardian's Name (please print): ____

Parent or Guardian Signature: ____

Date: ___/___/_______

Daytime Phone: ____________________________ **Evening Phone:** _______________________



SEMI Annual Notification Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).
The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.
In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent .

Is there a cost to you?
No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?
- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Asbury Park Board of Education
Ms. Melanie Pelosi
SEMI Coordinator
910 4th Avenue
Asbury Park, NJ 07712

PHONE 732-776-2606 x2957
FAX 732-869-9561
WEB SITE asburypark.k12.nj.us

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	

New Jersey Required Immunizations: School Age Children

Student Name: ___________________________________Birth Date:_______________

The Asbury Park School District, in compliance with New Jersey law, requires that a child receive the following immunizations prior to entering school. Please have your doctor record the dates below.

1. **Diphtheria, Tetanus, and Pertussis (DTaP)**:
Minimum four (4) doses with one dose given on or after the fourth birthday OR any (5) doses.

1.___________________
2.___________________
3.___________________
4.___________________
5.___________________

2. **Polio**:
Minimum three (3) doses with one dose given on or after the fourth birthday OR any (4) doses.

1.___________________
2.___________________
3.___________________
4.___________________

3. **Measles, Mumps, Rubella:**
Minimum two (2) doses of live measles-containing vaccine given on or after the first birthday.

1.___________________
2.___________________

4. **Hepatitis B:**
Minimum three doses hepatitis B vaccine.

1.___________________
2.___________________
3.___________________

5. **Varicella:**
Every pupil born after Jan. 1, 1998, shall have received one dose of Varicella before entering kindergarten.

1.___________________
2.___________________

6. Haemophilus Influenza B (HIB):
(Required for day/child care enrollees 2 months to 5th birthday only)
Age 2 – 11 months: 2 doses minimum
Age 12 – 59 months: 1 dose minimum given after the first birthday

1.___________________
2.___________________
3.___________________

7. Pneumococcal:
(Required for day/child care enrollees 2 months to 5th birthday only)
Age 2 – 11 months: 2 doses minimum
Age 12 – 59 months: 1 dose minimum given after the first birthday

1.___________________
2.___________________
3.___________________

8. A physical exam performed within the last 365 days is also required.
Please attach a copy of this exam.

If the pupil has had any other immunization, please provide the type and date:_________________________________

Place Physician's stamp below: Physician's Signature: ________________________Date:_______________________

Asbury Park School District Emergency Card

ID # ____

Last Name ________________________________ First ____________________ Initial _____ Date of Birth (MM/DD/YYYY) ____________
Address ____School ________________________________
City ____Zip _________________Grade ___________________________________
Home Phone (_____)______________________Teacher/H.R. __________________________ Email_____________________________

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.

Parent/Guardian 1: Name ____Relationship _______________________________
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

Parent/Guardian 1: Name ____Relationship _______________________________
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

List four neighbors or nearby relatives who will asume temporary care of your child (ren) if yu cannot be reached:

Neighbor/Relative 1 Name _________________________________ Address ____
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

Neighbor/Relative 2 Name _________________________________ Address ____
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

Neighbor/Relative 3 Name _________________________________ Address ____
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

Neighbor/Relative 4 Name _________________________________ Address ____
Phone Numbers: Home (_____)_____________ Cell (_____)____________ Work (______)_____________ Email ____________________

Please list other children attending New Jersey Public Schools (Name, Grade, School):

______________________________________ ____________________________ ________________________________
______________________________________ ____________________________ ________________________________
______________________________________ ____________________________ ________________________________

Please check this box if there has been a name change of parent/guardian, address or telephone number.

¿Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

NO. My child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about Health Insurance.

Signature: ________________________________ **Printed Name:** _____________________________**Date:** ________________

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit visite www.njfamilycare.org to apply online or call 1-800-701-0710.

YES. My child has health insurance.

List any medical/surgical care your child has received during the past year:____________ __________________________________
____

Dental Exam: Date:__________ Braces Yes No Eye Exam Date:__________ Glasses/Contacts Yes No
Allergy:_____________________ Medications Yes No Allergic Reaction:____
Immunizations/Tetanus: Date:____________ Type: ____________ Restrictions:____________________________________
Doctor ____ Phone ____
Dentist ____ Phone ____
Hospital (Hospital Name)____ Phone ___________________________________
Hospital (Address) ____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby aurhorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

____ _____________________

Signature of Parent(s)//Guardian(s) **Date**

Asbury Park School District

910 Fourth Avenue
Asbury Park, New Jersey 07712
Telephone; 732-776-2606 ext: 2415
Email: schetlick@asburypark.k12.nj.us

Parents & Guardians

The Asbury Park School District uses the Genesis Student Information System to store all student information from demographic information to attendance, grades and discipline and much more. One of the features of Genesis is the Genesis Parent Portal. This is used for parents to view his/her child's information via the Internet.

Through the Parent Portal, parents will be able to view his/her child's attendance, discipline, grading (report cards) and gradebooks. Parents can set preferences to have alerts sent to his/her email regarding absences, tardies, and gradebook updates. Information availability may vary between schools while systems are upgraded and precesses are streamlined. If there is something you cannot see, let you school administrator know.

To provide this service, parent registration is required. Please complete the attached form and return it to your school's main office secretary. Upon identification verification, the form will be sent for the setup to be completed.

You will receive your username, paswsword and a user guide via email within 10 days of verification.

Please be reminded, only verified Parents, Guardians and Students may have access to this information. If the requestor is not the student, the requestor MUST be in Genesis as a contact.

Asbury Park School District

910 Fourth Avenue
Asbury Park, New Jersey 07712
Telephone; 732-776-2606 ext: 2415
Email: schetlick@asburypark.k12.nj.us

Genesis Parent Access Registration Form

Please Print

Parent/Guardian Last Name		Parent/Guardian First Name		Role (ex.Parent/Guardian)	
Telephone		Cell Phone#		Email Adress	
Child's Name		School		Grade Level	
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	
6		6		6	
7		7		7	

______________________________ Requestor Signature

______________________________ Date

______________________________ Print Verifier Name

______________________________ Verifier Signature