



MONTAGUE SCHOOL

2016 – 2017

**1st – 8th Grade
Registration Packet**

MONTAGUE TOWNSHIP SCHOOL DISTRICT

475 Route 206

Montague, NJ 07827

V: 973 293 7131 / F: 973 293 3391

www.montagueschool.org

Robert Walker

Chief School Administrator/Principal

Donna Pinzone

Administrative Assistant

Tina Palecek

Business Administrator/Bd. Secretary

Christopher Gregory

Assistant Principal

RESIDENCY REQUIREMENTS

In order to have your son/daughter educated by the Montague Township School District, they and you as a parent or legal guardian must be full-time residents.

So as not to delay the registration process we are accepting the information you are supplying at the time of registration. This information may or may not be sufficient for us to satisfy our residency requirements. This form, along with your registration form, will be forwarded to my office and given to an administrator for further research and verification, if necessary.

By signing this form you are declaring that to the best of your knowledge the address you are supplying is within the Montague Township boundaries and you and the student you are registering are full-time residents at that address. If our verification reveals that the address you supplied is not within our boundaries, or you are not living full-time within this District, you understand that you will be notified, the student will be removed in an appropriate manner, and you will be directed to the proper school district, if known.

If, for any reason, you choose not to sign this form, your son/ daughter will not be registered.

Thank you and welcome to the Montague Township School District.

Robert Walker

Chief School Administrator/Principal

Signed: _____
Parent/Guardian

Address: _____

Date: _____



Montague Township School District
Montague School
STUDENT REGISTRATION FORM
Home of the Black Bears



Child's Information

Last Name _____
First Name _____ Middle Name _____
PO Box _____ Physical Address _____
City _____ State _____
Zip Code _____ Home Phone _____
Date of Birth _____ Gender Male _____ Female _____
City, State & Country of Birth _____
Race: American Indian ___ Asian ___ Black ___ Hispanic ___ White ___
Language spoken at home _____

Parent/Guardian Information

Last Name _____ First Name _____
Relationship to child _____
Does child live with you? Yes _____ No _____
If no, Physical Address _____
Mailing Address _____
City, State & Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Last Name _____ First Name _____
Relationship to child _____
Does child live with you? Yes _____ No _____
If no, Physical Address _____
Mailing Address _____
City, State & Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Mail Information to each parent/guardian? Yes _____ No _____

Is there a court ordered:

Temporary Restraining Order? Yes _____ No _____ Dated: _____

Permanent Restraining Order? Yes _____ No _____ Dated: _____

Child Custody Order? Yes _____ No _____ Dated: _____

Guardianship? Yes _____ No _____ Dated: _____

If **yes**, a copy **must** be attached to this form.





Montague Township School District
 Montague School
 STUDENT REGISTRATION FORM
Home of the Black Bears



Does this child have any siblings in this school? Yes ____ No ____ If Yes, please complete below.

Last Name	First Name	Grade/Class

Emergency Contact/Closing Information (other than parent)
Please notify your emergency contacts that they may be contacted by the school.

1st Contact Name _____
 Relationship to child _____
 Phone _____ Cell Phone _____
 Work Phone _____ Does this person live with student? Yes ____ No ____

2nd Contact Name _____
 Relationship to child _____
 Phone _____ Cell Phone _____
 Work Phone _____ Does this person live with student? Yes ____ No ____

Children will be sent home on their daily/regular bus, **unless a parent/guardian** calls and notifies the school of different arrangements for **that** day due to the emergency closing. Due to the critical nature of an early closing, please do not request bus changes in these situations.

All after school programs will be cancelled!

Children that have brought in bus notes to stay after school for an activity will be sent home on their regular buses, unless the school is notified otherwise by a parent/guardian. **YMCA after school care will be notified of emergency dismissals. They will make calls to parents as well. YMCA children will be sent home on their regular bus (unless the school is notified otherwise by a parent/guardian).**

In an emergency closing:
 My child(ren) has permission to go directly home on his/her **regular** bus.
 Please hold my child(ren) at school (parent/guardian must arrange pick up).

Please list all persons to whom the child(ren) may be released:

Name: _____ Phone: _____ Relationship: _____
 Name: _____ Phone: _____ Relationship: _____
 Name: _____ Phone: _____ Relationship: _____

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September 2016

TO: Parents/Guardians of Montague Students
SUBJECT: Afternoon Bus Stops

REMINDER:

Students will be dropped off at their assigned bus stop only if:

1. The student is met by a parent or legal guardian.

OR:

2. A written request designating a responsible person to meet the student at the stop has been submitted and approved by the transportation office.

If there is not a parent or approved designated person to meet the student, the student will be returned to the school by the bus driver. At stops directly in front of a house, a long driveway, etc, there must be a visual contact of the parent or designated person by the bus driver or the student will be returned to the school.

Thank you for your cooperation.

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Roster Card



Name: _____

Home () _____

Cell () _____

Office () _____

Other () _____

Please fill in and return. By returning this card, you give permission to receive calls.

Please Note:

Only fill out one Roster Card per family.

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Former School Name _____
Address _____
Phone and Fax Number _____

Re: Student's Name _____ Date of Birth _____

Please forward all mandated records for the above-named student who has enrolled in the _____ grade of the Montague Township School, including the student's State I.D. Number.

In addition, we would appreciate receiving copies of all permitted records, as per parent release below. Please include Federal Lunch Program Application or verification of eligibility, if applicable.

Thank you for your prompt attention to this matter.



Robert Walker
Chief School Administrator

I authorize the release of all permitted records of the above-named student; this includes all CST, IEP's, Speech, health and birth certificates.

Signature of Parent/Guardian

Relationship to Student

Address

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Grades PreK-8 Acceptable Use Policy

Student Name: _____ Date: _____

I understand that, as an Internet user, I am responsible for acting considerately and appropriately in accordance with the following rules when using the Montague School technology resources:

- I will not send, show, or download inappropriate messages or pictures.
- I will not use bad language.
- I will not insult, annoy, or hurt others.
- I will not damage computers, networks, or other technology equipment.
- I will obey all copyright laws.
- I will not use other users' passwords.
- I will not go into other users' work or files.
- I will not intentionally waste resources like paper, power, or ink.
- I will not access any instant messaging programs like AIM© or Yahoo© instant messenger.
- I will not access any social networking sites like MySpace© or Facebook©.

I understand that any or all of the following could be imposed if I violate any of the policies and procedures regarding the use of Montague School technology resources, including the Internet.

1. Loss of access.
2. Additional disciplinary action taken by the elementary teacher and administration in line with existing district policy.
3. Legal action, when applicable.

My child has my permission to access the Internet under the supervision of a certificated member of the Montague School faculty.

Parent Name: _____ Parent Signature: _____

Student Signature (Grades 2-8 only): _____

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The Parents/Guardians of _____ class _____

PERMISSION TO PUBLISH

****Publishing Student's Name**

I understand that my child's name may be published in newsletters, newspapers or magazines or on the school website.

Parent/Guardian's Full Name (please print) _____

Parent/Guardian's Signature _____ Date _____

****Publishing Student Work**

I understand that my child's artwork or writing may be published in newspapers or magazines or on the World Wide Web, a part of the Internet, as part of classwork. I understand that copyright and ownership of the work or writing remain my child's property. I grant permission for this publishing as described. A copy of all such publishing will be printed out and brought home for me to see upon request.

Parent/Guardian's Full Name (please print) _____

Parent/Guardian's Signature _____ Date _____

****Publishing Student Image**

I understand that my child's image may be published in newspapers or magazines or on the World Wide Web, a part of the Internet, as part of classwork. No last name, home address, telephone number or email address will appear with such images.

Parent/Guardian's Full Name (please print) _____

Parent/Guardian's Signature _____ Date _____

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From the School Nurse:

No child may begin school without documentation of immunizations and a current physical within the last six months. The school nurse clears all students to begin school. Please call the school nurse at 973.293.7131 ext 214, to schedule an appointment to review immunization documents and health records.

Absence:

Your child is expected to be on time and in school every day that school is in session. If your child is sick and cannot attend school you must call the school nurse at 973.293.7131 ext 214, and report the child's name, grade, teacher, and reason for absence. When the child returns to school, a written reason of absence is needed. Please have doctor's notes given to the school.

Attendance:

Consistent attendance at school is a strong predictor of student achievement and success.

1. Children are expected to be in attendance every day school is in session.
2. Every absence from school will be documented and recorded.
3. If a child is in school less than four hours, the day is considered an absence.
4. Parents/guardians will be notified of their child's absences approximately every fifth day's absence.
5. Upon notification, parents/guardians will work to correct the absence pattern and may be required to meet with the Assistant Principal regarding attendance.
6. Parents/guardians of each absent child must call the nurse to explain the reason, or the school will call.
7. Two days after an absence a note must be brought to school explaining the cause, with a note from the doctor if that applies.
8. Any student absence without an acceptable note or at the accumulation of ten days will be considered truant. State mandates regarding truancy issues will be followed.
9. All absences are cumulative regardless of parent or physician notes.

10. If a child is ill and will be home longer than two days, parent may request the child's teacher prepare missed work after two day's absence.
11. After an absence of twenty days, retention is possible.
12. If school is required to close for extended periods, the legally required attendance of 180 days may lead to an extension of the school year, including attending on Saturdays or scheduled holidays.

Medication Policy:

It is the policy of the school board that all children's medication be administered by the parent whenever possible, If a child is required to take medication during school hours, the school nurse will administer the medication in compliance with the regulations that follow:

1. A prescription written by a physician stating child's name, diagnosis, name of medication, dosage, and time to be given.
2. This policy includes prescription and over-the-counter medications (i.e. Tylenol, Motrin, etc.)
3. Medication must be in a prescription labeled bottle.
4. Written permission signed by the parent.
5. The PARENT must deliver the medication to the school nurse.

NO medication will be dispensed without the physician and parent written authorizations.

MONTAGUE SCHOOL

Growth and Development

Registration _____

Date

Child's Last Name

First Name

Middle Name

Date of Birth

Address (Number, Street, Town)

Phone Number

Mailing Address (if different than street address)

Father's Name

Mother's Name

Last School Attended

Is your child subject to: (Please circle Yes or No) Has your child had:

Frequent Colds	Yes	No	Poor eating habits	Yes	No
Bronchitis	Yes	No	Eye Disease	Yes	No
Frequent sore throats	Yes	No	Head Injury	Yes	No
Speech Difficulties	Yes	No	A severe fall	Yes	No
Ear Aches	Yes	No	Difficulty sleeping	Yes	No
Development:			Eye Injury	Yes	No
Age Walked _____			Eyeglasses Prescribed	Yes	No
Age Talked _____			Hearing Loss	Yes	No

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

Allergy:	Hernia	
Medication _____	High Fever	
Other _____	Hospitalization	
Chicken Pox	Mononucleosis	Operations:
Enuresis (bed wetting)	Pneumonia	Appendectomy: _____
Epilepsy	Tonsillitis	Hernia Repair _____
Heart Disease	Tuberculosis	Tonsillectomy _____
Hepatitis	Whooping Cough	Ear Surgery _____
		Other _____

Please list any childhood diseases, accidents or problems: _____

Medication: Please list medications your child takes both at home and in school. If your child must take prescription or over-the-counter medication (i.e. Tylenol, Motrin, etc) in school, a medical authorization form must be completed and signed by the parent/guardian and physician.

Please list my child and his/her health concern on your confidential list to be distributed to teachers and cafeteria staff. ___ Yes ___ No

Parent/Guardian Signature

Date

MONTAGUE SCHOOL

School Year: 2016-2017

MEDICAL HEALTH HISTORY AND EMERGENCY CONTACT FORM

Student Name _____ Grade & Teacher _____ DOB _____

Mailing Address _____ PO Box _____

Name

Address

Telephone

Mother/Guardian _____ Home _____ Home _____

Work _____ Work _____

Cell _____

Father _____ Home _____ Home _____

Work _____ Work _____

Cell _____

Parent Email Address _____

Emergency Contact #1 _____ Phone _____

#2 _____ Phone _____

Does your child have health insurance?

Yes _____ Name of Insurance Company or NJ FamilyCare Insurance Provider: _____

No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more info 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 _____ Date _____

MEDICAL HISTORY

(Most recent)

Allergies: _____ Plants _____ Animals _____ Food _____ Mold _____ Drugs _____ Bees _____ Date of reaction _____

Life Threatening? _____ Yes _____ No

There should be a meeting with the School Nurse to discuss medication or treatment orders.

Please describe the reaction & treatment _____

Documented Medical Condition & Restrictions if any: _____ Date _____

Daily Medications & Dosages: _____ Date _____

If your child needs to take medication at school, please download and print the form from the school website and have the doctor complete it. This form must be completed prior to the administration of any medication at school. The school nurse cannot give OTC (over the counter) medications without a doctor's note. An adult must bring to school any medication, including OTC meds to be given by the school nurse.

Recent Surgeries or Injuries _____ Date _____

Physical Exam Date _____ Doctor & Phone _____

Dental Exam Date _____ Dentist & Phone _____

Eye Examination Date _____

*****REMINDER*****

Please be advised that physicians recommend that a child have a **physical examination** at least once during each of the student’s developmental stages: early childhood (preschool-grade 3), pre-adolescence (grades 4-6), and adolescence (grades 7-12). When your child receives a physical examination, please **submit a copy** of the report to the School Nurse so that your child’s health history can be updated.

I am aware that my child will participate in the following School Health Services where applicable:

- 1. Vision & hearing screening
- 2. Scoliosis screening every 2 yrs starting at age 10
- 3. Height, weight & blood pressure
- 4. Periodic head lice checks

Have you ever been told by a physician or health care professional that your child has:

- _____ Asthma
- _____ Seizure Disorder
- _____ Bleeding Disorder
- _____ ADD/ADHD
- _____ Diabetes
- _____ Bone/Muscle Disorder
- _____ Skin Condition
- _____ Heart Condition
- _____ Mental Health Condition (i.e. depression, anxiety, eating disorder)
- _____ Learning Disability

Does your child experience any of the following:

- _____ Nose Bleeds
- _____ Frequent Earaches
- _____ Overweight for Age
- _____ Underweight for age
- _____ Physical Disability
- _____ Poor Appetite
- _____ Frequent Stomachaches
- _____ Frequent Headaches
- _____ Fainting Spells
- _____ Tires Easily
- _____ Emotional concerns

Do any of the above condition(s) limit/effect your child at school? Yes _____ No _____

Describe _____

Hearing: Does your child wear hearing aids? _____ Yes _____ No

Vision: Does your child wear glasses or contacts? _____ Yes _____ Distance
_____ Reading

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ **Date** _____

Immunizations required to begin Kindergarten:

- DPT **Diphtheria, Pertussis and Tetanus**: 4 vaccines with the 4th one being after the 4th birthday or any 5 vaccines
- IVP **Polio**: 3 vaccines with the 3rd one being after the 4th birthday or any 4 vaccines
- HPT **Hepatitis**: 3 vaccines (one usually at birth, the second vaccine one month later and the third one 5 months after the second one)
- MMR **Measles, Mumps and Rubella**: 2 vaccines (first one after the First birthday and the second one after the 4th birthday)
- Varicella **Chicken Pox**: 1 vaccine after the first birthday
- Hib **Influenza**: 4 vaccines before 18 months of age

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MEDICAL AUTHORIZATION

TO BE COMPLETED BY PHYSICIAN

Students Name _____ Age _____ Grade _____

Diagnosis _____

Medication _____

Dosage _____

Time of Administration _____

Possible Side Effects _____

Restrictions on Activities _____

Physicians Name (Printed)

Date

Physicians Signature

TO BE COMPLETED BY PARENT

I request that my child _____ receive the medication prescribed by his/her physician. The medication is to be provided by me as required by School Board Policy. I understand that the district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse, or substitute school nurse, will administer the medication.

NOTE: All medication, prescribed and over-the-counter, must be brought to the school by the parent, in the original, labeled bottle or container.

Parent/Guardian Signature

Date

School Year: 2016-2017
 PHYSICAL EXAMINATION – To be completed by a medical doctor

Name _____ DOB _____ Grade _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Significant Medical History: _____

Allergies: Insects Food Environmental _____

Vision Screening _____ **Hearing Screening** _____

Examination Findings

Ears _____	Abdomen _____
Eyes _____	Hernia _____
Nose _____	Scoliosis _____
Throat _____	Skin _____
Heart _____	General Appearance _____
Lungs _____	Neurological _____
Other _____	

Summary of Findings

Immunization History: M/D/YY (OR PLEASE ATTACH IMMUN. RECORD)

DPT _____	Trivalent Polio _____	Measles _____
_____	_____	MMR _____
_____	_____	_____
_____	_____	_____
Booster _____	Booster _____	Hepatitis B _____
Varicella _____	H.I.B. _____	_____
_____	_____	_____
_____	_____	_____

Physician Signature

Date of Exam

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HOME LANGUAGE SURVEY*

Date: _____

School District: _____

School: _____ Grade: _____

Student's Name: _____

1. What was the student's first language? _____

2. Does the student speak a language other than English? ___ Yes ___ No

If yes, specify language: _____

3. What language(s) is/are spoken in your home? _____

4. Has the student ever received English as a second language (ESL) services?

___ Yes ___ No If yes, when? _____ and

from what school district? _____

5. Has your family ever received migrant services? ___ Yes ___ No

If yes, please list the dates service was received: _____

6. Do either of the parents/guardians work in any field pertaining to agriculture?

___ Yes ___ No If yes, please specify where: _____

Person completing this form, if other than parent/guardian: _____

Parent/Guardian Signature

- * The school district/charter school has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school has the right to ask for the information it needs to identify English Language Learners (ELLs). AS part of the responsibility to locate and identify the ELL's, the school district/charter school may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enrolled in the school district/charter school in the future.

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CHILD CUSTODY INFORMATION FORM

(Please complete only if applicable)

The parent with whom the child resides will be considered the custodial parent; however the non-custodial parent has many rights in the absence of an explicit Court Order that limits those rights. It is the responsibility of the custodial parent to provide the school with a copy of any Court Order that limits the custodial rights of the non-custodial parent. Unless specified in the Court Order, the child may be released from school to the non-custodial. It is also expected that the custodial parent will provide the non custodial parent with academic progress information such as report cards or other academic information.

Child's Full Name _____

School child will be attending _____

Name of custodial parent with whom child resides _____

Do you, as the custodial parent, have legal custody through a Court Order?
 Yes No Pending*

*Date finalization is expected: _____
(If pending, please inform the school when finalized)

If there is a Court Order, does it limit the non-custodial parent's access to school records? Yes* No

*If Yes, a copy of the order must be given to the school office.

Please provide any additional information regarding custody of which the school should be aware: _____

Date

Signature of Custodial Parent

****In summary, this form allows us to bill Medicaid for Speech, OT, PT, Counseling, School Nursing services, Transportation (if this applies) and IEP services. It DOES NOT give consent to speak to your physicians or outside services. It DOES NOT affect your benefits or cost to you at all. It DOES NOT sign you up for any type of insurance or Medicaid. It allows the school to get reimbursed for services, helping to generate income for the school system.

Medicaid Annual Notification Regarding Parental Consent

Dear Montague Parents:

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
- Psychological Counseling
- Speech Therapy
- Audiology
- Occupational Therapy
- Nursing
- Physical Therapy
- 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 Michele Hordyszynski, SEMI Coordinator at 973-293-7131 ext. 220 with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) Mailed to parent(s) Emailed to parent(s) IEP meet Hand Delivered

