

**Plumsted Township School District**  
**New Egypt Primary School**  
**Kindergarten Registration**

Attention Parents: If your child will be five years of age on or before October 1, 2017, it is time to register for Kindergarten!

Kindergarten Registration packets are available to be picked up at the New Egypt Primary School from 8:00 AM to 4:00 PM starting February 24, 2017 to March 8, 2017. You can also access packets online at [www.newegypt.us](http://www.newegypt.us). **(If you print a packet online you must call the main office to schedule an appointment.)**

**At that time registration and screening appointments will be made. Appointments will be accommodated on a first come-first serve basis.**

Please feel free to call the Primary School at 609-758-6800-prompt 1-1-1 or visit [www.newegypt.us](http://www.newegypt.us) for more information.

# Plumsted Township School District

## New Egypt Primary School

131 Evergreen Road  
New Egypt, NJ 08533  
Telephone (609) 758-6800 Ext. 1-1-1  
Fax (609) 758-0912

Dear Parents/Guardians:

Welcome to the New Egypt Primary School!

When you return in March to register your child, please bring all of the following registration documents, which we require for your child to start school in September for the 2017 – 2018 school year. Please complete the necessary documents and check off that they have been filled out in their entirety before your scheduled appointment.

1.  Original Birth Certificate (**Raised Seal**)
2.  Immunization record signed by the doctor
3.  Physical form including vision & hearing test
4.  Health History form
5.  Registration Card

**(Incomplete registration cards will not be accepted. All information must be filled in completely with your signature at the bottom).**

You will also need to supply us with **2 PROOFS OF RESIDENCE:**

1.  2016 - 2017 tax bill, deed, or lease with Landlord's signature  
**(You must have one of the above Proof of Residence)**
2.  Bill (phone, electric, gas, etc.) or Driver's License (New Jersey driver's license with current address)

When you return with your child at the appointed time, he/she will meet with the reading and speech personnel. If you have any questions please call the main office at 609-758-6800 Prompt. 1-1-1.

Sincerely,



Richard P. DeMarco  
Principal

# Plumsted Township School District

## New Egypt Primary School

131 Evergreen Road  
New Egypt, NJ 08533  
Telephone (609) 758-6800 Ext. 1-1-1  
Fax (609) 758-0912

February 24, 2017

Dear Parents/Guardians:

Welcome to the New Egypt Primary School! If your child will be five years of age on or before October 1, 2017 then you are ready to register them as a Kindergartener!

Please review the materials in this packet very carefully. All of the information needs to be filled out in its entirety prior to your scheduled registration date. Your child may not be officially registered in the New Egypt Primary School or able to start school until all of the mandatory documents and information are provided.

Our registration process will be in two stages this year. **On March 14 – 16, 2017, only parents/guardians will be invited to the school to preregister your child into Kindergarten for the 2017-2018 school year.** Our school nurse will be on hand to collect information from you regarding your child's health history. Please take this time to discuss with her any health information that would help us to ensure the safety of your child while he/she is under our care. Information from the paperwork you provide will be placed into our student database system so that we can preregister your child into Kindergarten.

**The second phase of Kindergarten Registration will occur from May 23 – 25, 2017, when children will come to the school to spend some time with our literacy coach, teachers, Speech Therapist, and Occupational Therapist.** These educators will help us to get acquainted with your child so that we can best serve their needs in September. Please discuss this with your child ahead of time so that this will not come as a surprise for them. The entire process for this stage of the registration should not take more than 30 minutes. At your initial meeting with school officials in March, you will set the date and time for this aspect of Kindergarten Registration.

Please note that Kindergarten Orientation will be on Wednesday, August 23, 2017 starting at 9:00 a.m. More information on this event will be sent to you in the summer.

If you have any questions or concerns regarding any part of the registration process please feel free to contact us at 609-758-6800 ext. 1-1-1. Again, welcome to the New Egypt Primary School and we look forward to meeting you and your child!

Sincerely,



Richard P. DeMarco  
Principal

PLUMSTED TOWNSHIP SCHOOL DISTRICT

Student Name \_\_\_\_\_ State ID # \_\_\_\_\_  
(last) (first) (middle) (suffix)

Home Address \_\_\_\_\_ County \_\_\_\_\_ Home Phone \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Gr. \_\_\_ HR \_\_\_\_\_

Birth Information Date \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Language spoken at home \_\_\_\_\_ Student lives with: \_\_\_ Mother \_\_\_ Father \_\_\_ Guardian \_\_\_ Other \_\_\_  
(if not English)

Primary Physician \_\_\_\_\_ Physician Phone # \_\_\_\_\_

Ethnic: \_\_\_ American/Indian/Alaskan \_\_\_ Asian \_\_\_ Black \_\_\_ Hispanic  
\_\_\_ Pacific Islander/Hawaiian \_\_\_ White \_\_\_ Other \_\_\_\_\_

Email Address of Parent / Guardian: \_\_\_\_\_

Emergency Contacts: Only contacts listed on this emergency card will be permitted to pick your child up from school.

Mother's / Guardian's Name \_\_\_\_\_ Address \_\_\_\_\_  
(if different from student)

phone # \_\_\_\_\_ work phone # \_\_\_\_\_ cell phone # \_\_\_\_\_

Name of Mother's Employer: \_\_\_\_\_ Location of Employer: \_\_\_\_\_

Father's / Guardian's Name \_\_\_\_\_ Address \_\_\_\_\_  
(if different from student)

phone # \_\_\_\_\_ work phone # \_\_\_\_\_ cell phone # \_\_\_\_\_

Name of Father's Employer: \_\_\_\_\_ Location of Employer: \_\_\_\_\_

Name of friend, relative or child care provider permitted to pick up and care for child if parent / guardian can not be reached:  
(Additional contacts can be listed on back of card.)

- 1. name relationship phone # work phone # cell phone #
2. name relationship phone # work phone # cell phone #
3. name relationship phone # work phone # cell phone #

In case of accident or serious illness, all reasonable efforts will be made to contact the parent / guardian. If necessary, the primary physician and / or 911 will be called and the student sent to the nearest hospital. When a student becomes ill at school it is the policy of Plumsted Twp. Schools to send them home. On no occasion will a student be sent home if there is no one to provide care.

Physical Examinations \* School Nurse will provide services unless otherwise noted.

Students must receive routine medical exams upon entry into school. It is also recommended that students receive subsequent medical exams at least once during each developmental stage. Plumsted Twp. Schools requests physical exams for students in grades 4, 7 and 10. Student Medical Examinations must be given by the child's primary health care provider. Students who do not have a primary health care provider may receive an examination by the School Physician.

My child does not have a primary health care provider. Please call NJFamily care at 1-800-701-0710. If you need any assistance contact the nursing office.

\*Students are screened by the school nurse, for height, weight, vision, hearing and blood pressure.

\*The State of NJ requires that all children age 10-18 be screened for Scoliosis (curvature of the spine) every other year.

I want my child screened for Scoliosis at school. I wish to be present when my child is screened for Scoliosis.

My child will be screened for Scoliosis by our private physician. I will send a report of this exam to school.

Annual Medical History: \*All information will be shared with appropriate school personnel.\*

- 1. List any medications taken on a regular basis (prescription and over-the-counter):
2. List any allergies (food, environmental, be stings, medications):
3. Describe the symptoms your child has during an allergic reaction:
4. List any childhood diseases, serious illnesses, broken bones, hospitalizations or surgeries this past year:
5. List any disabilities (physical, emotional, learning, etc.) and / or physical restrictions:
6. Does your child have any of the following:
Anemia Seizures Heart Disease Diabetes Heart Murmur Menstrual Problems
Asthma Nose Bleeds Headaches Eye Problems Orthopedic Problems Digestive Disorders
Bowel / Bladder Disorder Speech Problems Neurological Disorder Glasses / Contacts

All checked items must be explained:

Please return this card to school as soon as possible. Notify the school immediately if there are changes in this information.

Signature of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Daniel E. Regenye, MHA  
Public Health Coordinator/Health Officer

Email: [Dregenye@ochd.org](mailto:Dregenye@ochd.org)



**Public Health**  
Prevent. Promote. Protect.

**OCEAN COUNTY HEALTH DEPARTMENT**

P.O. Box 2191  
Toms River, N.J. 08754-2191  
(732) 341-9700 ext. 7201  
Fax: (732) 831-6495  
[www.ochd.org](http://www.ochd.org)

Dear Parent,

The Ocean County Health Department is providing you with the enclosed information about the importance of vaccinations to your children's health, and to assist you in complying with New Jersey Regulations governing vaccinations required for children attending childcare, preschool, and elementary school.

Vaccinations are as much a part of protecting your children as are helping them cross a busy street and having them wear bike helmets and seat belts.

Vaccine-preventable diseases are occurring in children in Ocean County in increasing numbers. Flu season will be reaching us soon, and the Flu vaccination can prevent serious illness and death in children.

Due to the importance of disease protection for children in childcare and public/private school, New Jersey Regulations require certain vaccinations for entry into school. Attached is information regarding the importance of vaccinations and the required vaccinations for childcare and school attendance.

For more information about recommended vaccines, please speak to your healthcare provider. For questions about the attached information, please contact the Communicable Disease Unit of the Ocean County Health Department at 732-341-9700, ext. 7515.

Sincerely,

Daniel E. Regenye, MHA  
Public Health Coordinator/Health Officer



## Requirements for School Entry

For any child entering Kindergarten or 1<sup>st</sup> Grade in a public/private elementary school, he/she must have documentation for the following immunizations:

- Four (4) – DTaP shots - diphtheria, tetanus and pertussis (whooping cough) – Some children will have five (5) shots by the time they start school.
- Three (3) – Polio shots – Some children will have four (4) shots by school entry.
- One (1) – Varicella shot (chicken pox) – Unless your child had chickenpox disease.
- Two (2) – MMR shots - measles, mumps and rubella (German measles)
- Three (3) - Hepatitis B shots

For any child entering sixth (6<sup>th</sup>) grade (must be 11 years-old) and above, he/she needs proof of the vaccinations noted above as well as the following:

- One (1) – Tdap shot (tetanus, diphtheria, and pertussis) at 11 years old or older
- One (1) – Meningococcal shot

There are other **RECOMMENDED** vaccinations for children. Please discuss with your healthcare provider.

PLUMSTED TOWNSHIP SCHOOL DISTRICT  
KINDERGARTEN & FIRST GRADE PHYSICAL EXAMINATION

STUDENT \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF EXAMINATION \_\_\_\_\_ (Within 1 year of entry) HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

**DISEASE HISTORY: (PLEASE SPECIFY TYPE AND AGE AT ONSET)**

	YEAR		YEAR		YEAR		YEAR
ALLERGIES		CHICKEN POX		DRUG SENSITIVITIES		OTITIS MEDIA	
ASTHMA		HEART DISEASE		NEUROMUSC. DISEASE		CONVULSIVE DISORDER	
HEPATITIS		LYME DISEASE		RHEUMATIC FEVER		DRUG SENSITIVITIES	
DIABETES		MONONUCLEOSIS		STREP INFECTIONS		OTHER	

OPERATIONS/INJURIES: \_\_\_\_\_

CONGENITAL DEFECTS: \_\_\_\_\_

**BEE STING ALLERGY:**

- HAS THIS CHILD EVER BEEN STUNG BY A BEE? YES \_\_\_\_\_ NO \_\_\_\_\_
- IF YES, DID THIS CHILD REACT? YES \_\_\_\_\_ NO \_\_\_\_\_
- IF THIS CHILD REACTED, WAS IT LOCALIZED OR GENERALIZED? YES \_\_\_\_\_ NO \_\_\_\_\_
- PLEASE DESCRIBE THE REACTION \_\_\_\_\_
- DOES THIS CHILD REQUIRE MEDICATION: YES \_\_\_\_\_ NO \_\_\_\_\_ MEDICATION \_\_\_\_\_

**PHYSICAL EXAMINATION:**

EYES \_\_\_\_\_ SPEECH \_\_\_\_\_ ABDOMEN \_\_\_\_\_ ORTHOPEDIC \_\_\_\_\_ GENITO-URINARY \_\_\_\_\_  
 NOSE \_\_\_\_\_ THROAT \_\_\_\_\_ THYROID \_\_\_\_\_ STRUCTURE \_\_\_\_\_ EARS (OTOSCOPIC) \_\_\_\_\_  
 SKIN \_\_\_\_\_ HEART \_\_\_\_\_ NUTRITION \_\_\_\_\_ POSTURE \_\_\_\_\_ NERVOUS SYSTEM \_\_\_\_\_  
 LUNGS \_\_\_\_\_ HERNIA \_\_\_\_\_ TEETH/MOUTH \_\_\_\_\_ FEET \_\_\_\_\_ GENERAL APPEARANCE \_\_\_\_\_  
 LYMPH GLANDS \_\_\_\_\_

**VISION: DATE** \_\_\_\_\_

WITH GLASSES: RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_ BOTH \_\_\_\_\_ WITHOUT GLASSES: RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_ BOTH \_\_\_\_\_

MUSCLE BALANCE: \_\_\_\_\_ COLOR PERCEPTION RESULTS \_\_\_\_\_

**HEARING: DATE** \_\_\_\_\_

SWEEP CHECK: RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_ COMPLETE PURE TONE: RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

**IMMUNIZATION RECORD: (PLEASE GIVE FULL DATES - MONTH/DAY/ YEAR)**

	#1	#2	#3	Booster #1	Booster #2
DTP					
OPV					
MMR (MEASLES, MUMPS, RUBELLA)					
MEASLES (AFTER 1 <sup>ST</sup> BIRTHDAY)					
VARICELLA (CHICKEN POX VACCINE)					
HIB					
HEP B.					

**TB SCREENING (MANTOUX TEST)**

	DATE	DATE	DATE
TESTED	_____	_____	_____
READ	_____	_____	_____
RESULT (MM)	_____	_____	_____

RECOMMENDATIONS OR RESTRICTIONS (IF ANY): \_\_\_\_\_

I HAVE EXAMINED THIS CHILD AND FIND HIM/HER PHYSICALLY FIT TO PARTICIPATE IN SCHOOL ACTIVITIES.

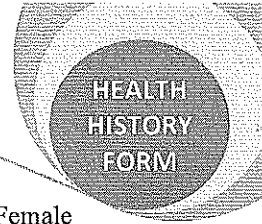
\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
ADDRESS OF PHYSICIAN

\_\_\_\_\_  
PRINTED NAME OF PHYSICIAN

\_\_\_\_\_  
TELEPHONE NUMBER

PLUMSTED TOWNSHIP SCHOOL DISTRICT/NEW EGYPT PRIMARY SCHOOL



This form should be filled out by parent/ guardian. Return the completed form to school nurse.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_ Sex: Male/Female

**PARENT/GUARDIAN INFORMATION**

Parent/Guardian #1: \_\_\_\_\_

Tel # (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_

Tel # (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**FAMILY**

Check all the people that the **child lives with**:

Mother  Father  Other: \_\_\_\_\_

Brothers (how many?) \_\_\_\_\_ Ages: \_\_\_\_\_  Sisters (how many?) \_\_\_\_\_ Ages: \_\_\_\_\_

How many members are there living in the child's household (counting child): \_\_\_\_\_

Does this child live with both parents?  Yes  No If not, with whom? \_\_\_\_\_

**MEDICAL HISTORY**

Does your child have any health concerns the nurse needs to be aware of?  Yes  No

If YES, please describe \_\_\_\_\_

Does your child have any **allergic reaction (bad effect)** from any of the following? (Check all that apply.)

Outside or Indoor allergies (for example: bees, grass, pollen, cats ...)

Food Allergies (for example: peanuts, milk, wheat ...)

Medicine or shots (immunization)

No, my child has no allergies that I know of

If YES, what is your child allergic to? \_\_\_\_\_

Has your child been prescribed an Epi Pen?  Yes  No Has your child ever used an Epi Pen?  Yes  No

Does your child currently take medications?  Yes  No If YES, what medicine? \_\_\_\_\_

Has your child ever been hospitalized or had surgery?  Yes  No If yes, please specify: \_\_\_\_\_

Does or has your child received medical care for any of the following (check all that apply):

- |   |  |                                  |
|---|--|----------------------------------|
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Concussion/Head injury | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Orthopedic    |                                  |

**MEDICAL PROVIDER INFORMATION**

Primary care provider: \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

**Child's Health insurance:**

Private Insurance/Employee sponsored \_\_\_\_\_ NJ Family Care \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_

**If you do not have a doctor or health insurance:**

Would you like assistance finding a health care provider?  Yes  No

Would you like assistance obtaining health care insurance?  Yes  No

Check here if you want to discuss confidential information with the school nurse.  Yes  No

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



**PLUMSTED TOWNSHIP SCHOOL DISTRICT**  
**HOME LANGUAGE SURVEY**

(Please Print)

1. Student's Last Name \_\_\_\_\_ Student's First Name \_\_\_\_\_
2. Gender: Male \_\_\_\_\_ Female \_\_\_\_\_      3. Date of Birth \_\_\_\_\_
4. Home Address \_\_\_\_\_
5. Home Telephone Number \_\_\_\_\_ 6. Grade Entering in 2017-2018 \_\_\_\_\_
7. Place of Birth \_\_\_\_\_ 8. Date of Student's Arrival in U.S.A. \_\_\_\_\_
9. Arrived From \_\_\_\_\_ 10. Student's Nationality \_\_\_\_\_

11. Please check one of the following:

\_\_\_\_\_ English is the **only** language spoken in our home.

\_\_\_\_\_ A language other than English is spoken in our home.

12. The other language(s) spoken in our home is/are: \_\_\_\_\_

13. Please list the dialect you speak, where applicable. For example, "Chinese" is not enough information. We need to know whether you speak Mandarin, Cantonese, etc. \_\_\_\_\_

14. What specific needs, if any, does your child have that the school district should be made aware of?  
\_\_\_\_\_

15. Has your child been referred for or received basic skills and/or special education services? \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

16. In which language do you wish to receive correspondence from the school? \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Gross Motor Skills

Child's name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Please answer the following questions as a screening tool to assess how your child is performing with regards to age appropriate gross motor skills.

Circle: YES, NO, or DON'T KNOW after each question.

If you have any concerns or comments, please write them at the bottom of the page.

Can your child:

- |   |     |    |            |
|---|-----|----|------------|
| 1. Stand on one foot for 5 seconds                | YES | NO | DON'T KNOW |
| 2. Hop on one foot 3 times                        | YES | NO | DON'T KNOW |
| 3. Walk downstairs alternating feet               | YES | NO | DON'T KNOW |
| 4. Catch a bounced playground ball                | YES | NO | DON'T KNOW |
| 5. Throw a small ball overhand                    | YES | NO | DON'T KNOW |
| 6. Run well, changing directions and speeds       | YES | NO | DON'T KNOW |
| 7. Ride a bike with/without training wheels       | YES | NO | DON'T KNOW |
| 8. Begin to skip                                  | YES | NO | DON'T KNOW |
| 9. Kick a rolled ball                             | YES | NO | DON'T KNOW |
| 10. Usually walk without slapping feet or on toes | YES | NO | DON'T KNOW |

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# PLUMSTED TOWNSHIP SCHOOL DISTRICT

## Student Information System (S.I.S) UPDATE

The New Jersey Department of Education is actively working to implement NJ SMART, a comprehensive data warehouse, student level data reporting, and unique statewide student identification (SID) system. Both Governor Christie and the Legislature have indicated that a statewide student database to support the tracking of student academic outcomes is a crucial need as well as a top priority for New Jersey. The steps required to develop this repository are taking place in several phases over the next twelve months. The New Jersey State Department of Education has mandated that school districts comply with their request in reporting student information.

We are requesting additional student information:

STUDENT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_

GENERATION SUFFIX \_\_\_\_\_ (i.e., jr., sr., II, III, etc.)  
(if any)

COUNTY OF RESIDENCE \_\_\_\_\_

CITY OF BIRTH \_\_\_\_\_ STATE OF BIRTH \_\_\_\_\_

COUNTRY OF BIRTH \_\_\_\_\_