



BEDMINSTER TOWNSHIP PUBLIC SCHOOL DISTRICT

234 Somerville Road
Bedminster, NJ 07921
Telephone (908) 234-0768 Fax (908) 234-2318
www.bedminsterschool.org



Attached you will find the Bedminster School Registration Package. In addition to completing the attached package, in order to register your student, we will need the following documents presented:

PARENT / GUARDIAN ID:

- Passport
- Driver's License
- Military ID

ORIGINAL PROOF OF BIRTH (One of the following options):

- Passport
- Birth Certificate

ORIGINAL PROOF(S) OF RESIDENCY (One from each category):

Category A

- Real Estate Tax Bill
- Mortgage
- Lease

Category B

- Utility Bill
- Bank Statement

U.S. BASED PHYSICAL STAMPED BY A U.S. PHYSICIAN

UPDATED IMMUNIZATIONS FROM U.S. PHYSICIAN

Once the registrar has seen the originals, they will be copied and returned directly to you.

Please make an appointment to complete the registration process. To contact Karna Johnsen, School Registrar, via e-mail: kjohnsen@bedminsterschool.org. Or you may reach her by phone at 908-234-0768, Extension 202.



BEDMINSTER TOWNSHIP SCHOOL DISTRICT

KINDERGARTEN REGISTRATION

FAQ'S



Is Bedminster School a "one school district"?

Yes. We are a pre-K through 8 school district and a sending district to Bernards High School, Bernardsville, NJ in the Somerset Hills School District.

What are the school's hours?

School begins at 8:50 a.m. and ends at 3:20 p.m. No student should arrive prior to 8:40 a.m. unless enrolled in an activity that requires them to be here prior to the start of school, or unless they are enrolled in the before-care program. No student shall stay on premises after the close of school unless participating in one of our after-school activities or enrolled in the after-care program.

Do you have a before care and after care program?

Yes! It is on the premises of the school but run autonomously by the Somerset Hills YMCA. Information about this program may be found on our website listed above under the "Information" tab. Then click on "Child Care".

Will my child receive busing?

All students that reside in the Township of Bedminster will receive courtesy busing.

How does busing work with the grade differentials within the school?

Bedminster School prides itself in the management of our age differences. Along those lines, we assign seats on our buses, whereby the Kindergarteners are close to the front and the older children sit towards the back. We do not have monitors that ride the bus with the students, but we do have monitors that take attendance each day for our Kindergarten, Grade 1 and Grade 2 students, as well as enforce the seat assignments.

Does my child have to ride the bus?

No. We have options for after-care and parent pick up. You may set up a permanent arrangement for the year in writing with our reception desk, or occasionally change your child's destination on a one-time basis in writing by 2:00 p.m. Please refer to the arrival and dismissal procedures listed on our website under "Information" and the "Parent Verification Related Documents".

Does my child have to bring lunch every day?

No. We have a cafeteria with hot lunch and sandwiches that your child may utilize. You may either send them with money or set up an account for your child that can be reloaded throughout the school year.

What time will my child be eating lunch?

We have three lunch sessions as follows:

K, 1 & 2	-	11:07 a.m. – 11:37 a.m.
3, 5 & 6	-	11:50 a.m. – 12:20 p.m.
4, 7 & 8	-	12:33 p.m. – 1:03 p.m.

May we set up a tour of Bedminster School?

Tours during the year are not available. As a new student or Kindergartener registering during the summer, you and your child will be able to see the facility at orientation in September just prior to the start of the school year.

EMERGENCY CONTACT & SIBLING INFORMATION

Contact #1 NAME: _____ RELATIONSHIP: _____
 PHONE: _____ CELL: _____ WORK: _____

Contact #2 NAME: _____ RELATIONSHIP: _____
 PHONE: _____ CELL: _____ WORK: _____

Contact #3 NAME: _____ RELATIONSHIP: _____
 PHONE: _____ CELL: _____ WORK: _____

Contact #4 NAME: _____ RELATIONSHIP: _____
 PHONE: _____ CELL: _____ WORK: _____

SIBLING INFORMATION:

1) NAME: _____ AGE: _____
 2) NAME: _____ AGE: _____
 3) NAME: _____ AGE: _____
 4) NAME: _____ AGE: _____

OFFSITE PERMISSION

YES - My child has permission to go off school grounds on walking field trips throughout the school year. Students may go off school grounds throughout the year to practice school security drills and/or for curricular related activities such as nature walks, field day, etc.

SPECIAL PROGRAMS:

Has your child ever been in a Special Needs Program? NO YES Is your child currently in a Special Needs Program? NO YES

Does your child have a 504 Plan? NO YES

If yes to either of the above questions, please list which program: _____

Is your child receiving Speech Services? NO YES

Has your child ever been in or are they currently in a Limited English Proficiency/English as a Second Language (ESL) Program? NO YES

PLEASE BE SURE TO SIGN AND DATE

PARENT / GUARDIAN SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

Proof Of Residency: Lease (if so, expiration date) _____ Mortgage or Deed _____ Real Estate Tax Bill _____
 Utility Bill (indicate which utility) _____

Proof of Birth: Passport BC _____ Grade: _____ First Day: _____

Homeroom: _____ Student ID: _____



MCKINNEY-VENTO QUESTIONNAIRE FORM
(OPTIONAL & CONFIDENTIAL)
Bedminster Township School



Student Name: _____ Date of Birth: _____

School Name: _____ Grade: _____

Your child may be eligible for additional educational services through the McKinney-Vento Homeless Assistance Act. Eligibility can be determined by completing this questionnaire. **THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.** If eligible, students are to be immediately enrolled in accordance with the McKinney-Vento Assistance Act.

1. Do you/your student live in any of these following situations?

- In emergency or transitional shelter or program
- Sharing the housing of other persons due to:
 - Loss of housing, economic hardship or a similar reason (i.e. evicted)
 - Long term, cooperative living arrangement
 - Other (please specify): _____
- In a vehicle of any kind, park, public space, abandoned building, substandard housing, bus or train station or similar setting
- In a motel, hotel, campground or similar setting due to: (select one)
 - Lack of alternative adequate accommodations
 - A convenient living arrangement (i.e. waiting for apartment/home to be ready)
 - Other (please specify): _____
- None of the above

2. What is your/your student's living situation? Please check one box.

- Living with your legal parent guardian
- Living alone
- Living with an adult that is not a legal parent or guardian

 The undersigned certifies that the information provided is accurate:

PRINT NAME OF PERSON COMPLETING FORM: _____

SIGNATURE: _____

DATE: _____

ADDRESS OF CURRENT RESIDENCE: _____

PHONE NUMBER OR MESSAGE NUMBER: _____

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HOME LANGUAGE SURVEY FORM

Child's Name: _____ Birth Date: _____

Address: _____ Grade: _____

Home Phone: _____

Cell Phone: _____

Parent(s)/Guardian(s) Name: _____

1. What language do you use most often when speaking to your child? _____

2. What language did your child first use for communication? _____

3. What language does your child use most often when talking to brothers, sisters and other children at home? _____

4. What language does your child most often use when speaking with you or other adults in the home? _____

5. What language does your child use most often when speaking with friends or neighbors? _____

6. Has your child received ESL (English as a Second Language) services in a previous school district? What grade levels and where? _____



Please indicate other family members living in the home with you.

Other Adult Members of Family:	English	Other Language Spoken
_____	Yes ___ No ___	_____
_____	Yes ___ No ___	_____
_____	Yes ___ No ___	_____

Other Children in the Home:	English	Other Language Spoken
_____	Yes ___ No ___	_____
_____	Yes ___ No ___	_____

In which language do you wish to receive written communication? _____

Parent/Guardian Signature

Date

2-5th Grade Vaccine Requirements

Student: _____ DOB: _____

DTaP

Total of 3 doses

IPV

Total of 3 doses

MMR

2 Doses

Varicella

1 Dose

Hep B

3 Doses

Provisional Entrance

Vaccine: _____

Date next Vaccine Due by: _____

As the parent of this student, I understand that my child must be vaccinated with the above vaccines, prior to my child returning to school.

Initial

School Nurse

Parent

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> 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	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
- b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.

**Bedminster Township School
Health History**

Child's Full Name:

(Last) (First) (Middle) (Nickname)

(Date of Birth) (Country of Birth) Grade _____

Please complete the following health history. Give dates, if possible.

Has your child ever had the following? **If yes, please explain:**

1. Accident(s) _____
2. Allergic Reactions (Include bee stings, food or medications, etc.)
Yes _____ No _____ **If yes, explain** _____

Has your child ever needed medication or medical attention in the past for a reaction to a bee sting or food allergy? Yes _____ No _____ **If yes, please provide details:** _____

3. Asthma Attack: Yes _____ No _____ Other Respiratory Infections: Yes _____ No _____
Explain _____
4. Bone or Joint Disease or Injury: Yes _____ No _____ **If yes, explain** _____
5. Communicable Diseases (Specify): _____
6. Convulsion or Seizures: Yes _____ No _____ **If yes, explain** _____
7. Diabetes: _____
8. Dental Problems: Yes _____ No _____ **Explain** _____
9. Ear Infections: Yes _____ No _____ Ear Tubes: Yes _____ No _____ Date _____

Does your child have a hearing problem? Yes _____ No _____

Does your child wear a hearing aide? Yes _____ No _____

Does your child have a speech/language problem? Yes _____ No _____

10. Frequent throat infections: Yes _____ No _____
11. Frequent headaches: Yes _____ No _____
12. Kidney or Urinary Tract Problems: Yes _____ No _____ **Explain if yes** _____
13. Heart Problems/Murmurs/Rheumatic Fever: Yes _____ No _____ **Explain** _____
14. Does your child have any vision problems: Yes _____ No _____
15. Does your child wear glasses? Yes _____ (when) _____ No _____

16. Does your child have any neuromuscular problems or limitations? Yes _____ No _____

Explain if yes _____

17. Does your child have any developmental delays or been diagnosed with any syndromes?

Yes _____ No _____ **Explain if yes** _____

18. Has your child ever been hospitalized? Yes _____ No _____ **If yes, state when and reason:** _____

19. What medicine, if any, does your child take? _____

20. Does your child have any present physical limitations that may require program modifications or restrictions? _____

21. Please add any other problems or comments you would like to bring to the attention of the school nurse: _____

Note: No Medication can be given at school without a completed medication administration form signed by the parent and the prescribing physician. All medication must be in the original container with the pharmacy label intact. Medications should be hand delivered to the school nurse by the parent or guardian. Please see the school nurse or the school website for medication administration forms.

Parent's Signature _____ Date _____

Mother's Full Name _____ Employer _____

Home Address _____ Work Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Father's Full Name _____ Employer _____

Home Address _____ Work Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Home Situation:

_____ Parents reside together

_____ Parents separated

_____ Parents divorced

_____ Guardian cares for child

_____ Single parent home

_____ Father remarried

_____ Mother remarried

_____ Other _____

If parents are divorced or separated, who has legal (official) custody? _____

**Legal custody papers should be supplied to the Main Office and stored in child's Permanent Record Folder.

Child's Name: _____

Name and age of sibling(s): _____

Last school attended _____ address: _____

Describe child's last school experience:

Was child absent frequently? If so, explain _____

Personality and Emotional Development

Please check all that apply to your child:

_____ Happy

_____ Moody

_____ Withdrawn

_____ Sad

_____ Easily upset

_____ Overactive

_____ Friendly

_____ Quiet

Problems when separated from family? Yes _____ No _____ Explain: _____

Loss of family member? Yes _____ No _____ Explain: _____

Social Interactions

(Please check where appropriate)

Peers

Adults

_____ Good

_____ Good

_____ Fair

_____ Fair

_____ Poor

_____ Poor

Traumatic events? If so, please explain: Yes _____ No _____ explain: _____

Please list any concerns, questions or problems that the school personnel should know about

Please sign below if you would like **this page** shared with your child's teacher (if needed).

Parent's Signature _____

Bedminster Township School Emergency Medical Information (For Nurse)

ID# _____ (Office use)

Students Name _____ Print (last) _____ (first) _____ Sex _____ Date of Birth _____ / _____ / _____ Grade _____

Home Address _____ Home Phone _____ E-Mail _____

Mother's/Guardian's Name (First, Last): _____ Father's/Guardian's Name (First, Last) _____

Where can she be reached between 9AM-4:30PM? _____ Where can he be reached between 9AM-4:30PM? _____

Address _____ Address _____

Home Phone () _____ Home Phone () _____

Cell Phone () _____ Cell Phone () _____

Work () _____ Work () _____

Name and phone number(s) of emergency contact person(s) if parent cannot be reached. Please inform this/these person(s)

Name _____ Relationship _____ Phone () _____

Name _____ Relationship _____ Phone () _____

Name _____ Relationship _____ Phone () _____

List ALL medications that are currently being taken _____

Has your child been prescribed an: _____ 1) Epinephrine Auto-Injector Yes No 2) Inhaler Yes No

Physical disorders, considerations, or limitations: _____

Please complete all information accurately and update the school nurse with any changes. Reliable information is necessary should a sudden accident or illness occur while your child is at school. We will attempt to contact you if any type of medical attention is needed; however, in the event that treatment is necessary and we are unable to contact you, your signature below will authorize the school authorities, doctor, or hospital to use their best judgment in the interest of your child's health.

EMERGENCY TREATMENT PERMISSION

TO ANY DOCTOR OR HOSPITAL

Authorization is given to perform necessary emergency treatment of my child whose medical history is listed above.

(Signature of legal parent/guardian) _____ (Date) _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that medical information may be shared, when necessary, with appropriate professional staff involved in the care of my child. My consent is valid for the current school year and is intended to allow the staff to better serve the individual needs of my child.

(Signature of legal parent/guardian) _____ (Date) _____

COMPLETE REVERSE SIDE

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

Does child have Health Insurance?

Yes If Yes, name of insurance company _____

No NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.

For more information call 800-701-0710 or visit www.njfamilycare.org to apply online

You may release my home and address to the NJ FamilyCare Program to contact me about health insurance.

Policy Number: _____

Signature: _____

Printed Name: _____

Date: _____

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

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

Dental Exam	_____	_____	_____
Eye Exam	_____	date	braces
Allergy	_____	date	contacts
Allergic Reaction	_____	kind	medications
Immunizations/Tetanus	_____	date	medications
Restrictions	_____	date	type
		type	

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Hospital _____ Telephone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons 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 cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/Guardian(s) _____

Date _____