Bedminster School
Registration Package

Attached you will find the Bedminster School Registration Package. Please print package **SINGLE-SIDED** and return via email to kjohnsen@bedminsterschool.org.

• FAQs	
• Registration Form (2 pages)	REQUIRED
• Release of Records	REQUIRED (Gr. 1 through 8)
• ***McKinney-Vento Questionnaire Form***	***OPTIONAL***
• Universal Child Health Record (2 pages)	REQUIRED
• Health History (3 pages)	REQUIRED
• Home Language Survey Form	REQUIRED

In addition to the attached package, the following documents are needed. You will be contacted to make an appointment to provide originals of these documents.

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

BEDMINSTER TOWNSHIP SCHOOL DISTRICT
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?
At this time, there is no before care. After care is running at the school and is provided by the Somerset Hills YMCA. Please go on to the website and click on "information" and "child care" to get more information about the program.

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 students in grades K through 4, 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.

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.

BEDMINSTER TOWNSHIP SCHOOL DISTRICT

STUDENT REGISTRATION FORM (Please print & complete ALL sections)

STUDENT INFORMATION:

Student Name: _____ **Date of Birth:** _____ **School Year / Grade:** _____
First *Middle* *Last*

City, State and Country of birth: _____
City *State* *Country*

Student Birth Name (if different from current name): _____

Student Home Phone Number: _____

Student Physical Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Student Mailing Address, City, State and Zip Code: _____
(If different from physical address) *Address* *City* *State / Zip Code*

Ethnicity (if multi-racial, please circle all that apply): *Hispanic* *African American* *White* *Asian*
Pacific Islander / Native Hawaiian *American Indian / Native Alaskan*

Gender (please circle one): *MALE* *FEMALE* **Student Birth Gender (if different from current gender):** *MALE* *FEMALE*

If country of birth is NOT the United States: Date of Entry into the United States: _____
Date of First Entry into U.S. School: _____

Primary language spoken at home: _____ **Native Language:** _____

Does student have health insurance? (*Please circle one*): NO YES **If yes, list insurance provider:** _____

Is student's parent/guardian on Active Military Duty, in the National Guard or the Reserve Component of the United States military services? NO YES

PARENT/GUARDIAN INFORMATION:

Circle Resident Parent/Guardian: Mother Father Both

Is custody of this child limited by court order or legal agreement? NO YES

IF YES - THE ORIGINAL LEGAL DOCUMENT DECLARING RESIDENTIAL CUSTODY MUST BE PROVIDED TO THE SCHOOL UPON REGISTRATION

MOTHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

FATHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

(OVER)

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: _____

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

Please circle all types of programs that apply: 504 I & RS IEP

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: _____

REVISED: 1/2021

BEDMINSTER TOWNSHIP PUBLIC SCHOOL DISTRICT
234 Somerville Road
Bedminster, New Jersey 07921
Telephone (908) 234-0768 Fax (908) 234-2318
www.bedminsterschool.org

REQUEST FOR STUDENT RECORDS

NAME & ADDRESS OF PREVIOUS SCHOOL

NAME: _____

ADDRESS: _____

_____

FAX #: _____

STUDENT NAME	GRADE	BIRTHDATE
_____	_____	_____
_____	_____	_____

(Please Print)

The above named pupil has recently enrolled in our school. **Please send all academic, health & CST records to:**

BEDMINSTER TOWNSHIP SCHOOL
234 SOMERVILLE ROAD
BEDMINSTER, NJ 07921
ATTENTION: SCHOOL SECRETARY

I do hereby authorize the release of academic/health/CST records regarding the above named pupil to the Bedminster Township School.

_____ _____

Parent/Guardian Signature Date

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

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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: _____

APPENDIX H

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	

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 heath 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)

_____ _____ Grade_____
(Date of Birth) (Country of Birth)

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

234 Somerville Road, Bedminster, NJ 07921
908-234-0768

Home Language Survey

Student name: _____ Student birth date: _____

Student address: _____

Student Phone number: _____

Question 1: What was the first language used by the student? _____

Question 2: At home, does the student hear or use a language other than English more than half of the time?

Circle one: Yes No

Question 3: Does the student understand a language other than English?

Circle one: Yes No

Question 4: When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

Circle one: Yes No

Question 5: When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

Circle one: Yes No

Question 6: Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

Circle one: Yes No

_____ _____

Parent/Guardian Signature Date