# CHERRY HILL PUBLIC SCHOOLS

**REGISTRATION DEPARTMENT**
**MALBERG ADMINISTRATION BUILDING**
**45 RANOLDO TERRACE**
**CHERRY HILL, NJ 08034-0391**

**REGISTRATIONS FOR ALL SCHOOLS TAKE PLACE AT THE MALBERG ADMINISTRATION BUILDING - PLEASE CALL FOR AN APPOINTMENT**
**(856) 429-5600 - EXTENSIONS 4430/4432/4436**
**FAX: (856) 429-3874**
**www.chclc.org**

## Welcome to Cherry Hill Public Schools
## Information and requirements for registering new students to our district are as follows:

1. **Person registering student(s):**
   Preferred Identification: Photo ID issued by a government, public body or authority (Ex., driver's license, military ID or passport), Employee ID or other appropriate form of identification. Other forms of identification are acceptable but may delay the registration process. We make our determination on eligibility to register upon the totality of information and documentation offered by the applicant.

2. **Parent/Guardian:**
   In accordance with New Jersey Administrative Code 6A:28-2.5 **Proof of eligibility**:
   A district board of education representative shall accept the following forms of current documentation from persons attempting to demonstrate a student's eligibility for enrollment in the Cherry Hill School District. **The documents must be originals that have been mailed to your address.**

   ● **If you own a house any TWO forms will be accepted**
   Property tax bill, mortgage statement, current utility bills (i.e., PSE&G, water, sewer, cell phone, cable), financial account information, employment documentation, or any other business record or document issued by a government entity (dated within the two months before registration).

   ● **If you rent you must have your Current Signed Lease (original) including student(s) name(s). PLUS ONE** current utility bill, (i.e. PSE&G, telephone, cell phone, cable), financial account information, employment documentation, or any other business record or document issued by a state or local government entity (dated within the two months before registration).

   ● **If you live with someone who owns a house in Cherry Hill:**
   Please call the registration office for a Landlord Affidavit **prior** to calling for an appointment. Owner and tenant must **each** provide two proofs of residency (dated within the two months before registration) and sign the affidavit in the presence of a Notary.

3. **Student(s):**
   An **Original** Birth Certificate **or** Passport. (If you do not have either of these, please contact the School District's Registration Department for further information)
   Evidence of completion of Required Immunizations
   Evidence of a recent Physical Examination - Must be submitted within 30 days of registration
   Most Recent Report Card
   Standardized Test Records
   Transfer Card from Previous School
   Address of Previous School
   IEP from a Child Study Team or 504 Plan (if applicable)

****MIDDLE AND HIGH SCHOOL STUDENTS SCHEDULING INFORMATION****
**After the registration process is complete, the guidance department will contact you to arrange a scheduling appointment. Any standardized tests should be brought to the appointment.**

# Cherry Hill Public Schools Student Master Control

**PLEASE PRINT**

**Today's Date: _____**

**Student Number:**

| **Student Full Legal Name (Last, First, Middle)** | **Home School** | **Grade** | **School Code** | **Forced/Requested** | **Classified** |
|---|---|---|---|---|---|
| | | | | | |

| **Preferred Name** | **Gender** Male / Female | **Birth Date** MM/DD/YYYY | **Birthplace City, State, Country** | **If not born in US, first date entered US** |
|---|---|---|---|---|
| | | | | |

| **Circle Ethnicity** | **Federal Ethnicity/Race (Circle as many as appropriate)** | **Native Language other than English spoken at Home** | **If not born in US, first date entered US school** |
|---|---|---|---|
| Hispanic/Latino OR Not Hispanic/Latino | American Indian or Alaska Native, Black or African American Asian, Native Hawaiian or Other Pacific Islander, White | | |

| **House #** | **Street Name** | **Apt.** | **City** | **State** | **Zip** | **Resident Telephone** |
|---|---|---|---|---|---|---|
| | | | | | | |

| **Parent/Guardian #1 Name (Last, First)** | **Contact Information** | **Does Parent/Guardian #1** |
|---|---|---|
| **Employer Info:** | **Home: ( )**<br>**Work: ( )**<br>**Cell: ( )**<br>**Email:** | _____ **Live with student?**<br>_____ **Have student custody?**<br>_____ **Get mail for student?**<br>_____ **Emergency contact?**<br>**What is your relationship to student?** |

| **Parent/Guardian #2 Name (Last, First)** | **Contact Information** | **Does Parent/Guardian #2** |
|---|---|---|
| **Employer Info:** | **Home: ( )**<br>**Work: ( )**<br>**Cell: ( )**<br>**Email:** | _____ **Live with student?**<br>_____ **Have student custody?**<br>_____ **Get mail for student?**<br>_____ **Emergency contact?**<br>**What is your relationship to student?** |

| **Additional Emergency Contact Name:** | **Home: ( )**<br>**Work: ( )**<br>**Cell: ( )** | **Relationship to student:** |
|---|---|---|

**Some students live in certain temporary situations (with friends, extended family, or in motels, etc.) due to eviction, house fire, domestic violence, etc. Check here if you need more information._____**

Applicant: Please turn to the back of this page to complete this form

**Below is for Office Use Only**

| Grade | School Year | Sch.Code | Entry Code | Start Date | Drop Code | Drop Date | Transferring to: |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Details: Generated by:

DG 4/2016

**Medical Alert: Does the child have any of these significant health problems?**

| Allergies | Convulsions | Diabetes | Heart | Epilepsy | Fractures | Hearing | Emotional |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Kidney Disorder | Orthopedic | Speech | Visual | Other (Please Explain) |
|---|---|---|---|---|
| | | | | |

**Permission to:** **Treat** ☐ **Call Doctor** ☐ **Call Ambulance** ☐

| Physician's Name: | Physician's Telephone #: |
|---|---|
| | |

| Name of last school attended: | Last Grade Attended |
|---|---|
| | |

| School Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Last HOME Address: | Apt. | City: | State: | Zip: |
|---|---|---|---|---|
| | | | | |

**Other children living at the same Cherry Hill residence**

| Last Name | First Name | School and Grade | M/F | Birth |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**May we forward your name and address to your school's PTA? Yes_____ or No_____**

This form becomes a district record; please be sure it is complete.

***For Registration Department Use Only:***

| *Registration* | *Time* | *Personal* | *Contacts* | *Enrollment* |
|---|---|---|---|---|
| | | ☐ | ☐ | ☐ |

# 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<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

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

# CHERRY HILL PUBLIC SCHOOLS

Student Name: _____

Dear Parent/Guardian:

The Cherry Hill Board of Education has policies and procedures related to ”Proof of Domicile” for students who attend our schools. The District shall only provide a free education to those students who are domiciled within the District or who otherwise qualify for a free education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 *et seq*. and N.J.A.C. 6A:22-1.1 *et seq*. A student shall be domiciled in the District “when he or she is living with a parent or legal guardian whose permanent home is located within the District.” N.J.A.C. 6A:22-3.1. The home is permanent if “the parent or guardian intends to return to it when absent and has no present intent of moving from it….” *Id*. If the District discovers that a student is attending school whose parents are not domiciled within the District and who is not otherwise eligible for a free education, the District may apply for the student’s removal and seek tuition reimbursement for the period of ineligible attendance in accordance with the provisions of N.J.S.A.18A:38-1(b) (2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense. N.J.S.A. 18A:38-1 (c). If the applicant is convicted of such an offense, the applicant may be fined up to $1,000.00 and/or be imprisoned for up to 6 months.

Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C:43-3. If convicted for such a crime, the applicant may be punished by a fine of $10,000.00 and/or be imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understood the contents of this notification.

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name of Parent or Guardian

# CHERRY HILL PUBLIC SCHOOLS

Date_____

Dear Parent/Guardian:

New Jersey Law mandates that every student entering a New Jersey Public School, regardless of the transferring locations, must present a physical exam signed by a licensed physician. The physical must have been completed within 365 days prior to the student's registration in Cherry Hill Public School District, and it is due in the nurse's office within 30 days of registration. Please make sure you provide the nurse with a written exam report as soon as possible. Your signature below indicates that you have been informed of this policy.

Thank you for you cooperation and attention to this matter.

Cherry Hill Public School District
Registration Office

Parent/Guardian
Signature_____

Cc: School Nurse

# CHERRY HILL PUBLIC SCHOOLS

## HOME LANGUAGE SURVEY

Student Name:_____ Birth Date:_____ Sex: M_____ F_____

Parent/Guardian Name:_____

Address:_____

Home Phone:_____ Cell:_____ Work:_____

School:_____ Grade:_____

IF ENGLISH HAS ALWAYS BEEN YOUR CHILD'S/FAMILY'S ONLY LANGUAGE SPOKEN OR HEARD AT HOME PLEASE STOP HERE AND SIGN AT BOTTOM.

1. What language is spoken by you and your family most of the time at home?_____
2. What language does your child most frequently speak at home?_____
3. What language does your child most frequently speak at home with family members?_____
4. What language do you most frequently speak to your child?
   Parent 1_____ Parent 2_____
5. If available, in what language would you prefer to receive communication from the school?
   _____
6. Is your child's first-learned language English? Yes_____ No_____

IF YOU RESPONDED "NO" TO QUESTION 6 ABOVE, PLEASE ANSWER THE FOLLOWING QUESTIONS.

7. What language did your child learn when he/she first began to talk?_____
8. What language does your child speak with friends?_____
9. If your child currently speaks English, at what age did he/she begin Speaking English?_____
10. Does your child write or read your home language? Yes_____ No_____

Parent/Guardian's Signature:_____ Date:_____

*School Office Use Only: Student ID#_____ Date Distributed_____ Date School Rec'd.*_____

# DIRECTIONS TO MALBERG ADMINISTRATION BUILDING
# 45 RANOLDO TERRACE
# CHERRY HILL, NJ 08034

## From Route 70: (Coming from East of Route 295)

- Travel west on Route 70, pass over NJ Turnpike and under Route 295.
- The first traffic light after 295 is Covered Bridge Road.
- Pass the Covered Bridge Road traffic light; pass the Manor Care Nursing Home; the next corner is Ranoldo Terrace (Penn Cardiology is on one corner. A gas station is on the other corner).
- Make a right onto Ranoldo Terrace, proceed .2 mile.
- Malberg Administration Building is on the right.

## From Kresson Road:

- Turn onto Covered Bridge Road. Follow Covered Bridge Road to Route 70.
- Turn left (west) onto Route 70. Follow directions from Covered Bridge Road above.

## From Kings Highway:

- Turn East on Chelten Parkway (first light south of Chapel Ave).
- Continue on Chelten Parkway to Howard Road.
- Make a left turn onto Howard Road.
- Make a right turn onto Ranoldo Terrace.
- Malberg Administration Building is on the left.

## From Route 295

- Exit at #34B (Route 70 West – Cherry Hill/Camden). Follow directions from Route 70 above.