GREENWICH TOWNSHIP SCHOOL DISTRICT

Nehaunsey Middle School
415 Swedesboro Road
Gibbstown, NJ 08027
856-224-4920 ext 2140
Fax 856-224-5765
Dr. Jennifer Foley-Hindman, Principal

Broad Street School
255 West Broad Street
Gibbstown, NJ 08027
856-423-0490 ext 1131
Fax 856-423-7945
Alisa Whitcraft, Principal

Welcome to the Greenwich Township School District.
In order to enroll your student into our district, you will need to:

1. **Make an appointment with the appropriate school.**
2. **Download and complete the appropriate packet at www.greenwich.k12.nj.us**
3. **If you do not have the technology to duplicate the enrollment packet, please stop at either school for a hard copy.**
4. **Along with the enrollment packet you will need to provide the following documents:**
    1. **Transfer card from previous school district**
    2. **Copy of birth certificate**
    3. **Copy of immunization records**
    4. **Copy of physical examination records**
        - **All students enrolling in school for the first time must have documentation of a completed medical examination completed and signed by a physician within the 365 days prior to the first day of the student's attendance at school**
        - **All students coming from out of the state or country must provide proof of a completed physical examination within 30 days of school entry**
        - **All other NJ students must provide documentation of a school entry medical examination**
    5. **Proof of custodial parent**
    6. **Release of records form**
    7. **504 Plans and/or IEPs if applicable**
    8. **Residence Enrollment Questionnaire**
    9. **Proof of residency – MUST PROVIDE FOUR PROOFS**

       PROPERTY OWNERS – Tax bill, mortgage statement, or settlement statement and three other proofs – gas, electric, water, bank statement, etc.

       RENTERS – Current lease with names of all residents in the dwelling (a new lease must be presented when it is renewed) and three other proofs - gas, electric, water, bank statement, etc.

       LIVING WITH FAMILY MEMBER OR FRIEND – If you reside with a family member or friend, <u>you will also need a verification of residency form completed and notarized</u>. This form is located on the last two pages of this packet and needs to be renewed annually.

GREENWICH TOWNSHIP SCHOOL DISTRICT

GRADES PRE-K THROUGH 8TH

If Pre-K, please review the next page entitled

“Parents with Preschool Children” prior to completing the enrollment packet

If grades 5 through 8, please complete the laptop agreement form

Parents with Preschool Children

If you are a Greenwich Township resident and have a child between three and five years of age and suspect that he/she may be displaying a delay in any one of the following areas:

intellectual functioning
speech and language
social/emotional development
gross/fine motor skills

they are eligible for a **free screening** by the Child Study Team Staff.

The entire Broad Street registration packet **must** be completed **prior** to your calling for an appointment. After you have completed the registration packet, contact the Child Study Team Office to inquire about the schedule or to obtain additional information. Remember, the earlier you recognize your child's special needs and seek professional help, the greater the possibility that your child can be helped to overcome a problem. The Greenwich Township School District wants to find some very special Children!!

Call: Child Study Team at 224-4920, Ext. 2160

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RELEASE OF RECORDS PERMISSION

I hereby give permission for _____ to release all academic and health
(Name of School)

records on _____ to _____.
(Name of Student) (Name of School)

I also authorize the release of any Child Study Team evaluations, IEPs, or other relevant information for placement or evaluative purposes.

_____
Parent/Guardian Signature

Date: _____

Student current address:

_____

_____

Telephone Number:

_____

Student forwarding address:

_____

_____

Telephone Number:

_____

School that student is transferring to/from:

Name: _____

Address: _____

_____

Telephone Number: _____

County: _____

District: _____

GREENWICH TOWNSHIP SCHOOL DISTRICT
GIBBSTOWN, NJ 08027

STUDENT REGISTRATION

Please complete the following questions so that we may better know your child and be able to contact you in case of illness or emergency. Thank you for your cooperation.

Today's Date _____

Child's Name _____

Sex: ___M ___F

Racial/Ethnic (Check ALL that apply):

_____ American Indian _____ African American _____Asian

____ Caucasian _____ Hispanic _____ Pacific Islander

Date of Birth _____ City/State of Birth_____ Country of Birth_____

Student's Address_____

Father's Name _____

City of Birth _____

Father's Address_____

_____

Father's Cell # _____

Father's email: _____

Employer_____

Occupation_____

Work Address _____

Telephone # _____

Mother's Name_____

Mother's Maiden Name_____

City of Birth_____

Mother's Address_____

_____

Mother's Cell # _____

Mother's email: _____

Employer _____

Occupation_____

Work Address _____

Telephone # _____

Number of children in family: Female: _____ Ages:_____

Male: _____ Ages:_____

With whom does the child live? _____

If student does not live with parent/s, custody papers WILL be required. Information of person/s student lives with (other than mother/father):

Name:_____ Relation: _____

Address: _____

IN CASE OF EMERGENCY NOTIFY:

1. Name _____ Telephone Number_____

   Address _____ Relationship to Child _____

2. Name _____ Telephone Number_____

   Address _____ Relationship to Child _____

Is your native language English? Yes____ No ____ Specify_____

Has your child been under early intervention or Child Study Team/Basic Skills services?

Yes____No____

Specify_____

Has your child had any speech remediations? Yes____No____

Specify_____

Was your child on the free/reduced lunch program at his/her previous school?

_____ yes _____ no _____ free _____ reduced

Is there anything about your child's health, habits, or behavior that you would like to comment upon?_____

_____

_____

_____

FAMILY MEDICAL HISTORY: DATE: _____

Do any of child's immediate family members have the following; if yes, please state sibling, mother, father, grandmother, etc.

	YES	NO	Family Members
Heart Disease	___	___	_____
Diabetes	___	___	_____
Cancer	___	___	_____
Sickle Cell Anemia	___	___	_____
High Blood Pressure	___	___	_____
Allergies/Asthma	___	___	_____

Has your child had or currently have any of the following?

	YES	NO		YES	NO
1. High fevers	____	____	16. Anemia	____	____
2. Seizures	____	____	17. Diabetes	____	____
3. Head Injury	____	____	18. Ringworm	____	____
4. Sutures (Stitches)	____	____	19. Arthritis	____	____
5. Broken Bones	____	____	20. Epilepsy	____	____
6. Operations	____	____	21. Heart trouble	____	____
7. Hospitalizations	____	____	22. Kidney problems	____	____
8. Allergies	____	____	23. Frequent ear infections	____	____
9. Chicken Pox	____	____	24. Frequent headaches	____	____
10. Mumps	____	____	25. Eczema	____	____
11. Measles	____	____	26. Asthma	____	____
12. German Measles	____	____	27. High Blood Pressure	____	____
13. Scarlet Fever	____	____	28. Lyme Disease	____	____
14. Rheumatic Fever	____	____	29. Hepatitis	____	____
15. Fifth Disease	____	____			

**IF YES, PLEASE DESCRIBE

_____

_____

Does your child have any hearing difficulties? Yes ____ No ____ Specify _____

Does your child wear glasses? Yes ____ No ____ Specify _____

Does your child take medication that would be necessary during school hours? Yes ____ No ____
Names of Medications _____

Has your child had routine dental checkups? Yes ____ No ____

Does your child have health insurance? If so, name of company _____

Date of your child's last medical exam: _____

Date of your child's last lead blood test and results: _____

Date of first Polio immunization: _____

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.

GREENWICH TOWNSHIP SCHOOL DISTRICT

ENROLLMENT RESIDENCY QUESTIONNAIRE

Parent/Guardian Name: _____ Date: _____

Please list all children living with you up to age 21. Please include children of all ages and if they are attending an educational program.

Name	Date of Birth	School Attending and Grade (or High School Graduate)

Phone Numbers: _____

Current Address: _____

Previous Address: _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

Section A: Current Living Situation

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this section. Please check all that apply:

_____ Sharing housing with relatives or other due to lack of housing

_____ Living in a shelter or transitional living program

_____ Living in a motel, hotel, park or campground due to lack of adequate housing

_____ Living in a car or RV or in a public place

_____ Living in substandard housing

_____ Awaiting foster care placement

_____ Parents are migrant workers

_____ Moving from place to place

_____ None of the above

School/Schools of origin (school attended when last permanently housed):

_____

_____

I, _____, have been consulted about the school placement

that I prefer for my child (check or mark next to appropriate box)

_____ to attend school in the district of last attendance

_____ to attend the district in which we are currently residing

I certify that the information provided here is true and correct. I understand that the Greenwich Township Public School Homeless Liaison has the right to determine who is eligible.

Signed: Date:

_____ _____

Section B - To be completed by Homeless Liaison:

_____ Homeless

_____ Not Homeless

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Greenwich Township Homeless Liaison Signature: Date:

_____ _____

Notes/Comments:

_____

_____

_____

_____

Medicaid Annual Notification
Regarding Parental Consent

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
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- 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 your school district's Special Education department 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 meeting ____ Hand Delivered

Greenwich Township School District
415 Swedesboro Road
Gibbstown, NJ 08027

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Please sign and return this form to the address listed above

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act,34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

Child's Name:_____

Child's Date of Birth: _____/_____/_____

Parent:_____ Date:____/_____/_____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting the administrator at your child's school.

GREENWICH TOWNSHIP SCHOOL DISTRICT
Gibbstown, NJ 08027

AFFIDAVIT OF RESIDENCE BY PARENT
PURSUANT TO N.J.S.A. 18A:38-1(b)

I, _____, of full age, being duly sworn according to law on oath deposes and says:

1. My natural child, _____, and I are currently residing at _____ with _____ in the School District of Greenwich Township, New Jersey.
2. I am aware that I am making an Affidavit (sworn statement) and that I may be subject to penalty for false swearing in the event any of the aforesaid is willfully false or fraudulent. I am further aware that I may be subject to pay tuition or other school charges of the Greenwich Township School District if the facts stated above are not true. This affidavit is given pursuant to the requirements of N.J.S.A. 18A:38-1 (b).

_____ _____

PARENT/GUARDIAN PARENT/GUARDIAN

Sworn and Subscribed
before me on this _____
day of _____, 20_____

_____
A Notary Public of the State of New Jersey.
My commission expires:

_____

** Completion of this form does not guarantee approval. This must be renewed annually **

GREENWICH TOWNSHIP SCHOOL DISTRICT
Gibbstown, NJ 08027

AFFIDAVIT OF RESIDENCE BY GREENWICH TOWNSHIP RESIDENT PURSUANT TO N.J.S.A. 18A:38-1(b)

I, _____, of full age, being duly sworn according to law on my oath deposes and says:

1. I am an adult residing and domiciled within the School District of Greenwich Township, New Jersey, and live at the following address: _____.
2. I am seeking admission to Greenwich Township School District for a minor child who resides with me with his/her parent/guardian.

   NAME OF MINOR: _____

   NAME OF PARENT/GUARDIAN: _____

3. The minor child and parent/guardian aforesaid have resided with me since _____, and will continue to reside with me until _____.
4. I am making this Affidavit (sworn statement) to induce the Greenwich Township School District to admit _____ as a student without charge since the aforesaid child and parent/guardian are residing with me.
5. I will inform the Superintendent of Schools if there is any change in the above-stated statement.
6. I am aware that I am making an Affidavit (sworn statement) and that I may be subject to penalty for false swearing in the event any of the aforesaid is willfully false or fraudulent. I am further aware that I may be subject to pay tuition or other school charges of the Greenwich Township School District if the facts stated above are not true. This Affidavit is given pursuant to the requirements of N.J.S.A 18A:38-1 (b).

_____ _____

PARENT/GUARDIAN PARENT/GUARDIAN

Sworn and Subscribed
before me on this _____
day of _____, 20_____

_____
A Notary Public of the State of New Jersey.
My commission expires:

_____

** Completion of this form does not guarantee approval. This must be renewed annually **