

**DEMAREST PUBLIC SCHOOLS REGISTRATION FORM**

Grade \_\_\_\_\_

Date \_\_\_\_\_

Student Name \_\_\_\_\_

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

Mother's E-Mail \_\_\_\_\_ Father's E-Mail \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender M \_\_\_\_\_ F \_\_\_\_\_

Place of Birth \_\_\_\_\_ Birth Certificate Presented \_\_\_\_\_  
(City) (State) (Country^)

*^If student was NOT born in the USA please provide the DATE ENTERED INTO US SCHOOL SYSTEM:*

Parent Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_  
Home Business Cell

Address (if different from above) \_\_\_\_\_

Parent Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_  
Home Business Cell

Address (if different from above) \_\_\_\_\_

Home Language \_\_\_\_\_ Native Language of Parent/Guardian \_\_\_\_\_  
(Check here \_\_\_\_\_ if English is spoken and understood by the parent/Guardian/person enrolling student)

\*\*Racial Origin \_\_\_\_\_ \*\*Ethnicity \_\_\_\_\_  
(See back of form for explanation of racial origin and ethnicity)

Emergency Contact Name/  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Home Cell

Last School Attended \_\_\_\_\_  
Name Address Date Left

Grade Completed \_\_\_\_\_ or Current Grade Level \_\_\_\_\_ Proof of residence submitted \_\_\_\_\_

**\*\*\*List all children in family - in age order including student\*\*\***

NAME BIRTH DATE CURRENT GRADE LEVEL

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**\*\*Racial Origin:**

**American Indian or Alaska Native** - a person having origins in any of the original people of North and South America (including Central America) and who maintains a tribal affiliation or community attachment)

**Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

**Black or African American** – a person having origins in any of the black racial groups of Africa.

**Native Hawaiian or Other Pacific Islander** – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**White** – a person having origins of the original peoples of Europe, the Middle East or North Africa.

**\*Acceptable to identify with more than one racial origin.**

**\*\*Ethnicity:**

**H** - Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin regardless of race.

**N** - Non-Hispanic or Latino

**\*\*The above information will not be used to determine student's eligibility for enrollment. This information is needed to meet the requirements of the following State reports: NJ Smart and NJ Report Card.**

## Demarest Public Schools Emergency Information Card

Please Print All Information

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_  
Last First Birth Date \_\_\_\_\_  
Month/Day/Year  
Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Parent/Guardian: To serve your child in case of accident/ sudden illness, it is necessary that you give the following information for emergency calls:

Parent 1 Contact Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Email Address \_\_\_\_\_

Parent 2 Contact Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Email Address \_\_\_\_\_

Address of Non-custodial Parent if pertinent. Address \_\_\_\_\_

List 2 neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physicians named below and follow their instructions. In the event that it is impossible to contact the physician, school officials are hereby authorized to take whatever action is deemed necessary for the health of the aforesaid child. I will not hold the school district responsible for the emergency care and/or transportation for said child.

Local Physician's Name \_\_\_\_\_ Office # \_\_\_\_\_

Local Dentist's Name \_\_\_\_\_ Office # \_\_\_\_\_

**DEMAREST PUBLIC SCHOOL DISTRICT**

County Road School  
130 County Road  
Demarest, NJ 07627  
(201)768-6060 x51600

Luther Lee Emerson School  
15 Columbus Road  
Demarest, NJ 07627  
(201)768-6060x52600

Demarest Middle School  
568 Piermont Road  
Demarest, NJ 07627  
(201)768-6060x53600

**INFORMATION FORM FOR NEW STUDENTS**

The following information is provided to assist teachers in integrating the student into our school as quickly as possible.

NAME \_\_\_\_\_  
                                    First                                    Middle                                    Last

DATE OF BIRTH \_\_\_\_\_

LANGUAGE SPOKEN AT HOME \_\_\_\_\_

ENROLLING IN GRADE \_\_\_\_\_

LAST SCHOOL ATTENDED \_\_\_\_\_  
(Including Pre-School if applicable)

ADDRESS OF SCHOOL \_\_\_\_\_

WEARS GLASSES:                      YES \_\_\_\_\_                      NO \_\_\_\_\_

USES HEARING AID:                      YES \_\_\_\_\_                      NO \_\_\_\_\_

ALLERGIES:                                      YES \_\_\_\_\_                                      NO \_\_\_\_\_

IF YES, DESCRIPTION:  
\_\_\_\_\_  
\_\_\_\_\_

**DEMAREST PUBLIC SCHOOL DISTRICT**

**County Road School**  
130 County Road  
Demarest, NJ 07627  
(201)768-6060 x51600

**Luther Lee Emerson School**  
15 Columbus Road  
Demarest, NJ 0762  
(201)768-6060x52600

**Demarest Middle School**  
568 Piermont Road  
Demarest, NJ 07627  
(201)768-6060x53600

**Home Language Survey Form**

The home language survey is used solely to offer appropriated education services (U.S. ED EL). This survey is the first of three steps to identify whether a student is eligible to be identified as and English language learner (ELL).

**Student Information**

Student name: \_\_\_\_\_ Student birth date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Survey Questions**

**Question 1:** List all languages used in the student's home:

\_\_\_\_\_

**Question 2:** Was the first language used by the student a language other than English?

- No
- Yes

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

- No
- Yes

**Question 4:** When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English *most of the time*?

- No
- Yes

**Question 5:** When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English *most of the time*?

- No
- Yes

**Demarest Early Learners  
Demarest, New Jersey 07627**

Dear Parent/Guardian:

Welcome to the Demarest Public School System. Registering your son/daughter for *preschool* requires that the following information be included and submitted to the Health Services Department before the first day of class.

1. Record of **physical examination** within 1 year of the date of school entry.
2. **Immunization record** consisting of Primary Series and booster doses as listed below. (N.J.S.S.C. Chapter 14 requires immunizations must be complete and up-to-date or student may be excluded from school.)

**DTaP - (Diphtheria, Tetanus, Pertussis) must have 4 doses.**

**IPV - (Polio)- must have 3 doses.**

**MMR - (Measles- Mumps – Rubella) - must have 1 dose given after the 1<sup>st</sup> birthday.**

**HIB – (Haemophilus B) – must have 1 dose given after the 1<sup>st</sup> birthday.**

**Pneumococcal Conjugate – must have 1 dose after the 1<sup>st</sup> birthday.**

**Varicella – must have 1 dose of the varicella (chicken pox) vaccine after the 1<sup>st</sup> birthday.  
(A physician or parent's statement of previous varicella infection or documented laboratory evidence of immunity will also be acceptable.)**

**Influenza – must have yearly dose of influenza vaccine administered between August and December 31 of current school year.**

3. **Mantoux Tuberculin Test**- Documentation of an IGRA or Mantoux tuberculin skin test is required for students entering school for the first time that were born in a high TB incidence country as outlined by NJ Department of Health. Valid only if administered within the previous six months.

If records are not received within the stated time, the students will be excluded from school. **Your cooperation is essential!** If you have any questions, please contact the school health office at (201) 768-6060 extension 51534.

Very truly yours,  
Health Services

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I have read and understand the rules of registration concerning preschool health and immunization requirements

Student's Name \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**DEMAREST PUBLIC SCHOOLS , DEMAREST, NEW JERSEY  
PRESCHOOL PHYSICAL AND IMMUNIZATION RECORD**

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Parent's Name \_\_\_\_\_ Phone # \_\_\_\_\_

**PHYSICAL REPORT:** Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BP: \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_

Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Laboratory: Urinalysis \_\_\_\_\_ HGB/HCT \_\_\_\_\_ Other \_\_\_\_\_  
with/without glasses (Circle)

Respiratory \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_ Skin \_\_\_\_\_

Musculoskeletal \_\_\_\_\_ Neurological \_\_\_\_\_

RECOMMENDATIONS	NO	YES	Comments
1. Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.?			
2. Any condition limiting classroom activity? Any condition limiting physical education?			
3. Any significant allergies or asthma?			
4. Any condition which may result in classroom emergency?			
5. Any emotional, mental or physical condition requiring periodic medical observation?			
6. Any medication taken on a daily basis?			

VACCINE TYPE	DISEASE DATE	1 <sup>ST</sup> DOSE Mo/Day/Yr	2 <sup>ND</sup> Dose Mo/Day/Yr	3 <sup>RD</sup> Dose Mo./Day/Yr	4 <sup>TH</sup> Dose Mo/Day/Yr	5 <sup>TH</sup> Dose Mo/Day/Yr	Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS- DTP							
POLIO - IPV							
MEASLES, MUMPS, RUBELLA - MMR							
HAEMOPHILUS B - HIB							
PNEUMOCOCCAL CONJUGATE							
VARICELLA							
INFLUENZA							
HEPATITIS B							

Mantoux	Date Tested	Date Read	Result(mm)	CXR (date)	Normal	Abnormal	Meds. Prescribed (Date)

Date of examination: \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Physician's Address \_\_\_\_\_

Phone Number \_\_\_\_\_

# COUNTY ROAD SCHOOL

## DEMAREST PUBLIC SCHOOL DISTRICT

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130 COUNTY ROAD  
DEMAREST, NJ 07627  
201-768-6060

MR. FRANK J. MAZZINI  
PRINCIPAL

We are so happy to welcome your child into our educational community.

Our Preschool Team will be working diligently to help transition our preschoolers into their new learning environments. All of the classes will have scheduled visits to the bathroom where the students are taken to the bathroom multiple times during the mornings and afternoons.

Below you will find the Demarest Early Learners toileting expectations which were presented during the Preschool Open House. Please review these procedures below.

### TOILETING EXPECTATIONS

Please make certain that your child can complete the following bathroom tasks:

- No pull-ups are permitted
- Verbally express the need to use the bathroom to the teacher or aide.
- Turn the bathroom lights on and off.
- Pull garments (pants, underwear, etc.) up and down independently.
- Get on and off the toilet.
- Wipe themselves after both urination and bowel movement.
- Turn on the water, use soap, rinse hands and dry with paper towels.
- If students have a toileting accident, they need to be able to change their clothes independently.
- If your child has 1 accident, Nurse Kelly will assist your child and you will be notified via email.
- Upon your child's second accident and beyond, a phone call home will be made for each accident and you or your emergency contact will be expected to come to County Road School to change your child. Someone is expected to arrive to help your child within no more than 20-30 minutes as this is a sanitary issue.
- Please be sure that your emergency contact always has a change of clothes available in case you cannot come
- If your child has 6 accidents within 15 consecutive school days then a meeting will occur with Mr. Mazzini, the teacher and the nurse. A toileting plan will be implemented which will last for 10 consecutive school days and include 4 accidents as the threshold. If the child cannot meet the goal then the child will be removed from the program.



By signing on the portion below, you are signing off that you have read and received the toileting procedures and protocols for the Demarest Early Learner's Preschool Program. Please sign and return to Mrs. Rraci, County Road School Secretary, at your registration appointment.

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I have read and understood the toileting expectations of the Demarest Early Learner's Preschool Program. I will adhere to these protocols and guidelines.

Student Name \_\_\_\_\_ Grade:  
\_\_\_\_\_

Parent/Guardian Name (Print) \_\_\_\_\_ Date:  
\_\_\_\_\_

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