

Paulsboro Public Schools Registration

1. All registrations begin with the parent/guardian visiting our website <http://www.paulsboro.k12.nj.us> and pre-registering their child(ren) **online** (under information for registration button).
2. Registrar will contact the parent/guardian via phone, email, etc., to review procedures and documentation needed to process registration.
3. A Registration Packet will be sent via email for the parent/guardian to complete **OR** parents may download the fillable forms from our web site, <http://www.paulsboro.k12.nj.us> , fill them out, save to your device, attach them to an email and return with the other necessary documentation (below) to tcroce@paulsboro.k12.nj.us .
DO NOT Email PICTURES (scanned or Microsoft documents only)
4. Upon completion of the Registration Packet, the parent/guardian must **CALL TO MAKE A APPOINTMENT (856-423-5515 x1236)** to return all forms to the Paulsboro Public School Administration Building **along with copies of:**
 - a. Proof of Residency:
 - **Owners:**
Copy of property tax bill/water sewer bill *from Borough Hall* **AND** an OFFICIAL mail item with their name and address (electric bill, phone bill, etc.) or a copy of their mortgage statement.
 - **Renters:**
Original, up to date, *signed lease with ALL persons living in home listed & copy of the Certificate of Occupancy from Borough Hall with ALL persons listed* – **NO EXCEPTIONS**
 - b. Shot Records - **UP TO DATE**
 - c. Original Birth Certificate - **(a copy with raised seal visible)** -original see below
 - d. Custody or Court papers stating you have residential custody of this above student.
 - e. **(Grades K-12)** Copy of transcripts and or last report card
 - f. Transfer Card from last school of attendance (NJ residents)
 - g. **(Grades 7-12 ONLY)** NJSIAA Transfer Form
 - h. **(Grades 9-12 ONLY) Greenwich Twp. residents** must first register in Greenwich Twp. prior to coming in to Paulsboro Jr. / Sr. High School for transportation.
 - i. **(PRESCHOOL ONLY)** Copy of any documents if receiving service from State of New Jersey (SSI, TANF, SNAP, county benefits/assistance, etc.) **AND** copies of last two pay stubs or copy of last income tax returns.
 - j. copy of drivers license of person registering student

This documentation can be mailed to:

Paulsboro Public Schools
662 North Delaware Street
Paulsboro, NJ 08066
Attn: Terry Croce, Registrar

OR Email: tcroce@paulsboro.k12.nj.us

An appointment must be made for: Monday – Friday between the hours of 8:00 a.m. – 3:00 p.m. at the Administration Building for review of all documentation by the Registrar. After that time students will be enrolled and students will be placed into our student database (Genesis) .

Since, regulations require the district to view original documents of certain items to complete registration, (birth certificate, driver's License, custody/court papers, transfer card(s), etc.), **an appointment must be made with the Registrar to show the original documents listed above to finalize the enrollment process.**

Questions - Terry Croce: (856)-423-5515x1236

ALL REGISTRATION IS PROVISIONAL UNTIL ALL DOCUMENTS ARE OBTAINED AND VIEWED BY REGISTRAR

PAULSBORO PUBLIC SCHOOLS
Paulsboro, New Jersey 08066
REGISTRATION FORM

Name of Student _____

Male _____ Female _____ Date of Birth _____ Place of Birth _____

School to Attend _____ Grade _____ Registration Date _____

Address: _____ Phone No. _____

Email: _____ Cell No. _____

Residing With: Father _____ Mother _____ Both _____ Guardian (please attach proof of guardianship) _____

**Guardian(s) email address: _____

Father _____ Employer _____ Work Phone _____

Mother _____ Employer _____ Work Phone _____

Guardian _____ Employer _____ Work Phone _____

Emergency Contact/Address 1. _____ Phone No. _____

2. _____

Ethnicity: White _____ Black _____ Hispanic _____ American Indian/Alaskan _____ Asian _____ Hawaiian native
 _____ Pacific islander _____

*****LIST ALL CHILDREN IN FAMILY - PLEASE NOTE THE SCHOOL THE CHILDREN ARE ATTENDING:**

NAME	DATE OF BIRTH	SCHOOL PRESENTLY ATTENDING

Last School Attended _____ Address _____

Was student enrolled in a **special education** class in the previous district? YES _____ NO _____

Has the student ever attended Paulsboro Public Schools? YES _____ (School: _____) NO _____

Signature of Parent / Guardian _____

Date _____

FOR OFFICE USE ONLY

_____ Home Language Survey Attached _____ Transfer Card
 _____ Medical Information Attached _____ Birth Certificate Attached _____ Other _____

PLACE OF RESIDENCE (CHECK ONE):

(Parent **MUST** show registering official one of the following and attach copy to this form)

_____ Student lives with his/her family in their own house or apartment

Proof attached: (current) _____ Tax Bill and/or Water Bill _____ Lease _____

_____ Student domiciled with another family

Proof attached: _____ Affidavit of Support of Minor and _____ Statement of Parent/Guardian

_____ Student was placed in Paulsboro by an agency or court order

Proof attached: _____ Letter from Agency or _____ Court Order

_____ Student living with his/her family, but in someone else's house or apartment

(Please see the *Residency Questionnaire* for additional information)

_____ McKinney Act _____ Letter from Homeowner _____ Letter from Landlord

Signature of Registrar _____

Date _____

Principal _____

Date _____

Signature of School Nurse _____

Date _____

PAULSBORO PUBLIC SCHOOLS
PAULSBORO, NEW JERSEY 08066

HOME LANGUAGE SURVEY

HOME INFORMATION

Student's Name _____ Telephone _____

Student's Address _____

Date of Birth _____

Place of Birth _____

Parent/Guardian's Name _____

LANGUAGE INFORMATION

1. What language did your child speak first? English _____ Spanish _____ Other _____
2. What language do you speak most often to your child at home? English _____ Spanish _____ Other _____
3. What language does your child most often use when speaking to you at home? English _____ Spanish _____ Other _____
4. What language does your child most often use when speaking to brothers and sisters? English _____ Spanish _____ Other _____
5. What language does your child speak most often with other family members? English _____ Spanish _____ Other _____

In which language do you wish the school to send you communications? _____
Indicate Language

Parent/Guardian Signature

Date

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

ENROLLMENT RESIDENCY CHECKLIST

To be completed by district enrollment clerk

In accordance with New Jersey State Law (N.J.S.A. 18A:38-1 and 18A: 7B-12), it is necessary to determine the residence of students entering the school district by answering the following question:

1. Does the student reside in any of the following facilities? (Please check where applicable.)

Home the parent/guardian owns or is renting (*Skip remaining registration procedures.*)

Domestic Violence Shelter

Living with family or friend's home out of necessity.
(* grandparent, aunt, uncle, brother, sister, cousin, etc.)

Home For Adolescent School-Age Mothers

Hotel/Motel/Apartment

Migrant Family Dwelling

Runaway Youth Shelter

Shelter (other - identify): _____

Transitional Housing Facility

Other (identify): _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Parent's Name _____ Date _____

School District Staff: Forward this completed checklist and the Declaration of Residency Form to the Paulsboro School District's Homeless Liaison within two days.

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

DECLARATION OF RESIDENCY FORM

To be completed at time of enrollment by parent/guardian

This is to inform the Paulsboro Board of Education that my child(ren)

and I _____ (Parent/Guardian)

are ___ temporarily or ___ permanently residing at the following address:

We are living with _____ Telephone # _____

Complete all sections that apply to your current situation:

I am currently in a homeless situation and living out of necessity with the person(s) listed above.

I am not actively pursuing housing and permanently residing with the person listed above.

I have found permanent housing and no longer wish to be considered homeless.

My last district of permanent residence was _____

My last address was _____

My child(ren) attended _____ School.

The causes of my becoming homeless are:

I request to register my child(ren) in the Paulsboro School District.

I prefer for my child(ren) to attend school in the former school district.

Name of former district _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

PARENT/GUARDIAN AFFIDAVIT

To be completed and returned to the school by the parent/guardian

I, _____, of full age, being duly sworn upon my oath, depose, and say:

1. I am domiciled at the following address:

2. I affirm that my child(ren) _____ is/are temporarily residing in the residence of relatives or friends named here:

_____ because my family lacks a regular or permanent residence of our own in accordance with N.J.A.C. 6A:17-2.3(A)(3).

3. I certify that I am not capable of supporting or providing care to my child/children due to family or economic hardship, and my child(ren) is/are not residing with relatives or friends solely to receive a free and/or better education per N.J.A.C. 6A:28-2.4(A)(2)(I)(2).
4. I understand that my child(ren)'s eligibility may be subject to re-evaluation, and that tuition may be sought in the event that my child/children are determined not to be eligible as a result of fraud or untruthful information.
5. I have been consulted and understand that the district of residence will make the decision regarding the educational placement of my child/children, and if I disagree with that decision, I have the right to appeal to the County Superintendent of Schools.
6. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-I and N.J.A.C. 6A;17.
7. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

Parent/Guardian Signature

Sworn and subscribed to before me the _____ day of _____.

Signature of Registrar

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

RESIDENT AFFIDAVIT

To be completed and returned to the school by the homeowner

I, _____, of full age, being duly sworn upon my oath, depose and say:

1. I am domiciled at the following address within Paulsboro:

2. I affirm that the school aged child(ren):

is(are) residing in my residence temporarily out of necessity because the child(ren)'s family lacks a regular or permanent residence of their own in accordance with N.J.A.C. 6A:17-2.3(a)(3).

3. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-I and N.J.A.C. 6A:17.
4. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

Signature of homeowner

Sworn and subscribed to before me this _____ day of _____, 20__.

Signature of Notary Public

PARENT CONSULTATION

I, the parent/guardian of the above named child(ren) understand that the district of residence will make the decision for his/her/their educational placement based upon the best interests of the child(ren) after consulting with me. If I disagree with that decision, I know that I may appeal to the county Superintendent of Schools.

Parent/Guardian agrees with placement: Yes: _____ No: _____

Parent/Guardian Signature: _____ Date: _____

**PAULSBORO PUBLIC SCHOOLS
RESIDENCY INFORMATION FORM**

To be completed by the person registering the child for school.

Name of Student(s): _____

Name of Parent/Guardian: _____

Address of the Parent _____

Phone Number _____ Cell _____

Name of person registering the student(s) if other than the parent: _____

Relationship to student(s): _____

Address of person registering the student(s): _____

Phone Number _____ Cell _____

Address where the students(s) will reside: _____

Type of residence: Rental Yes No
 Purchase/Own Yes No
 Temporary Yes No

If temporary, please explain: _____

Other (please explain): _____

The Paulsboro Public School will investigate all new registrants in order to verify legal residency for the purposes of students attending schools.

Signature of the person registering the student(s): _____
(I attest the above statements and information are true.)

Date

PAULSBORO PUBLIC SCHOOLS

Billingsport Early Childhood Center _____
Phone: 856-423-2226
Fax: 856-423-8912

Loudenslager School _____
Phone: 856-423-2228
Fax: 856-423-8914

Paulsboro Jr. High School _____
Phone: 856-423-2225
Fax: 856-423-2443

Paulsboro Sr. High School _____
Phone: 856-423-2222
Fax: 856-423-2443

HEALTH HISTORY

PLEASE RETURN THIS FORM WITHIN 30 DAYS OF YOUR CHILD'S FIRST DAY OF SCHOOL. If not returned, your child will be excluded from school.

Child's name _____ Date of Birth _____

Address _____ Phone & Cell _____

Parents' / Guardians' Names _____

PERINATAL

- | | | |
|---|--------------|--------------|
| 1. Child's Birth | Weight _____ | Height _____ |
| 2. Complications of Pregnancy or Delivery | _____ | _____ |
| 3. Gestation / Prematurity | _____ | _____ |
| 4. Breathing Problems | _____ | _____ |
| 5. Feeding Problems | _____ | _____ |
| 6. Congenital Defects | _____ | _____ |
| 7. | _____ | _____ |

DEVELOPMENTAL

- | | | |
|---|------------|------------|
| 1. At what age did the child | Walk _____ | Talk _____ |
| 2. At what age was child toilet trained | _____ | _____ |
| 3. Hand preference | _____ | _____ |

MEDICAL HISTORY - (DO NOT LEAVE ANY AREA BLANK, PLACE "N/A" IF NOT APPLICABLE).

- | | <u>Type</u> | <u>Date</u> |
|---|-------------|-------------|
| 1. Allergies (seasonal/food and non-food) | _____ | _____ |
| 2. Drug Sensitivities | _____ | _____ |
| 3. Hepatitis | _____ | _____ |
| 4. Neuromuscular Diseases | _____ | _____ |
| 5. Asthma(indicate if student will have medication in school) | _____ | _____ |
| 6. Chicken Pox | _____ | _____ |
| 7. Seizures (Date of most recent seizure) | _____ | _____ |
| 8. Diabetes | _____ | _____ |
| 9. Heart Disease | _____ | _____ |
| 10. Middle Ear Infections(chronic/frequent) | _____ | _____ |
| 11. Rheumatic Fever | _____ | _____ |
| 12. Strep Infections(chronic/frequent) | _____ | _____ |
| 13. Operations or Injuries
(please explain) | _____ | _____ |
| 14. Present Medications | _____ | _____ |
| 15. Limitations of activities | _____ | _____ |
| 16. Foods restrictions | _____ | _____ |
| 17. Other | _____ | _____ |

FAMILY

Recent changes in family life _____

Chronic diseases in family history _____

Parent / Guardian Signature

Date

MUST BE RETURNED TO SCHOOL NURSE WITHIN 30 DAYS

PAULSBORO PUBLIC SCHOOLS

Billingsport Early Childhood Center _____	Loudenslager School _____	Paulsboro Jr. High School _____	Paulsboro Sr. High School _____
Phone: 856-423-2226	Phone: 856-423-2228	Phone: 856-423-2225	Phone: 856-423-2222
Fax: 856-423-8912	Fax: 856-423-8914	Fax: 856-423-2443	Fax: 856-423-2443

PHYSICAL EXAM

THIS FORM SHOULD BE COMPLETED BY THE CHILD'S DOCTOR AND RETURNED TO THE SCHOOL WITHIN 30 DAYS OF YOUR CHILD'S FIRST DAY OF SCHOOL. If not returned, your child will be excluded from school.

Child's name _____ Date of Birth _____

Grade _____ Age _____

Parents' / Guardians' Names _____

Address _____

Height _____	Heart _____
Weight _____	Lungs _____
Blood Pressure _____	Abdomen _____
Vision Acuity: _____	Hernia _____
OD _____	Genito-Urinary _____
OS _____	Orthopedic: _____
Hearing: _____	Structural _____
Right _____	Posture _____
Left _____	Feet _____
Ears (otoscopic) _____	Skin _____
Eyes _____	Nutrition _____
Lymph Glands _____	Nervous System _____
Thyroid _____	Speech _____
Nose _____	Other _____
Throat _____	General Appearance _____
Teeth-Mouth _____	

Please explain below any deficiencies / recommendations: _____

Physician Name _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____

**PAULSBORO PUBLIC SCHOOLS
Screening**

PK and K only

Developmental History

Date: _____

Child's Name: _____ M _____ F _____

Date of Birth: _____ Age: _____ y _____ m - in Sept.

Place of Birth: City _____ State: _____

Code: _____ (1= Am Indian/Alaskian 2 = Asian 3= black 4= Hispanic 5 = White
6=Native Hawaiian/Pac Isl)

Language Spoken at Home _____

Child Care Experience

1. Is the child or has the child been in any other early childhood program?

2. Any difficulties? _____

Speech / Language

1. Does the child speak in words? _____

2. Does the child speak in sentences? _____

3. Is the child's speech clear? _____

4. Do you have any concerns with your child's speech and language skills?

5. Does the child ask questions (who, what, when, where, why)? _____

6. Does your child understand questions asked of him/her? _____

7. Can the child name objects in pictures? _____.
8. Can the child name actions in pictures? _____.

Social / Emotional

1. Does the child separate easily from parent or guardian? _____.
2. Has the child had experiences playing with other children? _____.
3. Is the child friendly? _____ Aggressive? _____ Shy? _____.
4. Does the child enjoy playing with others? _____ Alone? _____.
5. Does the child share? _____.
6. Does the child demand a lot of attention from adults? _____.
7. How does the child handle discipline? _____.
8. Can the child follow simple rules (walk, stop, look, etc.)? _____.
9. How long can the child sit for an activity? _____.

Self-Help

1. Is the child toilet trained? _____.
2. Can the child take care of bathroom needs independently? _____.
3. Can the child feed him or herself independently? _____.
4. Can the child pick up after him or herself? _____.
5. Can the child dress him or herself? _____ Zip? _____ Button? _____.

Motor Development

1. Can the child maintain his or her balance on tiptoes? _____.
2. Can the child balance on one foot? _____.
3. Can the child run smoothly? _____.
4. Can the child hop? _____.

5. Can the child throw and catch a ball? _____.
6. Can the child kick a ball? _____.
7. Can the child pedal a bicycle or tricycle? _____.
8. Can the child climb steps independently? _____.
9. Can the child hold a pencil/crayon properly? _____.
10. Can the child scribble? _____.
11. Can the child draw simple shapes? _____.
12. Can the child use scissors properly? _____.

Cognitive Development

1. Does the child know his or her name? _____ Age? _____.
2. Does the child enjoy listening to stories? _____.
3. Can the child match colors? _____.
4. Name colors? _____.
5. Can the child match shapes? _____.
6. Names shapes? _____.
7. Does the child understand positional concepts?

Over? _____	Big? _____
Under? _____	Little? _____
On Top? _____	Long? _____
Next To? _____	Short? _____
More? _____	Less? _____
8. Can the child rote count? _____.
9. Can the child count objects? _____.

10. Does the child enjoy being read to? _____.

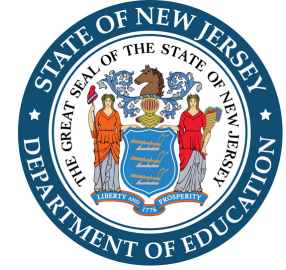
11. Can he or she answer simple questions about stories? _____.

Please add any other pertinent information that will help us know your child better.

Screener's Observations:

New Jersey Department of Education

Household Information Survey 2022 – 2023



County:

District:

School:

Please complete, sign, and return this form to your child's school.

Part A. Household Members

Fill in the information for every person living in your household (adults & children). For help determining who should be included in the household, see instructions on the third page.

List all who live in the household: Names (<i>Last Name, First Name</i>)	Date of Birth XX-XX-XXXX	Name of School the Student Attends (if applicable)	Grade Level	Student Information (mark as applicable)			
				Migrant	Homeless	Foster	In Head Start
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

* If household size is greater than 8, list additional household members on a separate paper, and follow special instructions in Part C.

Part B. Benefits Received (if applicable)

- 1) If anyone in the household receives FDPIR, TANF, or SNAP, check the appropriate box(es): FDPIR TANF SNAP
- 2) If you checked a box, write the full name (Last, First) and 10-digit case number of any one person receiving the benefit and skip to Part D.

Name:

Case #:

Part C. Household Size and Gross Income (before deductions)

For help determining your annual income, see page 3 of the survey.

- Households with 8 or fewer people: Check the box below for the Annual Income range that reflects your total annual household income.
- If Household Size is greater than 8, do **not** check an income range, but follow the special instructions below ("Special instructions for households with more than 8 people").

Annual Household Income Ranges*

1. \$0–\$17,667	5. \$29,940–\$33,874	9. \$42,607–\$48,347	13. \$60,071–\$60,619
2. \$17,668–\$23,803	6. \$33,875–\$36,075	10. \$48,348–\$51,338	14. \$60,620–\$68,802
3. \$23,804–\$25,142	7. \$36,076–\$42,211	11. \$51,339–\$54,483	15. \$68,803–\$77,534
4. \$25,143–\$29,939	8. \$42,212–\$42,606	12. \$54,484–\$60,070	16. \$77,535–\$86,266
			17. \$86,267+

***Special Instructions for households with more than 8 people:** Do **not** check the boxes above. Instead, fill in items below:

Household size (# people):

Total annual income: \$

Part D: Certification

The head of household or adult designee who completed this form must complete this certification section.

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

Sign Here: **X**

Print Name:

Date:

Last Four (4) Digits of Social Security Number (Optional): XXX-XX-

(may be used to verify the accuracy of the information provided)

Address:

City:

Zip:

Home Phone:

Work Phone:

Email (optional):

Do not fill out this section. This is for school use only.

Status: F: R: N:

Reason for ineligibility:

Determining Official's Signature:

Date:

Confirming Official's Signature:

Date:

New Jersey Department of Education
Household Information Survey Instructions

This survey is used to determine eligibility for state benefits for which your child(ren)'s school may qualify. Please complete, sign, and return this form to your child's school.

Part A: Who should I include in “Household”?

You must include yourself and all people living in your household, related or not (for example, children, grandparents, other relatives, or friends) who share income and expenses. If you live with other people who are economically independent (they do not share income with you/your children and they pay a share of the expenses), do not include them.

Part B: What are benefits received?

- **TANF:** NJ's Temporary Assistance for Needy Families (WorkFirst NJ)
- **SNAP:** Supplemental Nutrition Assistance Program (formerly food stamps)
- **FDPIR:** Food Distribution Program on Indian Reservations

Part C: What is included in “Annual Household Income”?

Annual Household Income includes the following:

- **Gross earnings from work:** Use your gross income, not your take-home pay. Gross income is the amount earned before taxes and other deductions. This information can be found on your pay stub or, if you are unsure, your supervisor can provide this information. Net income should only be reported for self-owned business, farm, or rental income.
- **Welfare, Child Support, Alimony:** Include the total amount everyone in your household receives from these sources. Do **not** include SNAP or FDPIR payments.
- **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits), and disability benefits:** Include the amount everyone in your household receives from these sources.
- **All Other Income:** Include for everyone in the household: worker’s compensation, unemployment or strike benefits, rental income, interest and dividends, regular contributions received from others who do not live in your household, and any other income received. Do **not** include income from WIC, federal education benefits and foster payments received by your household.
- **Military Housing Allowances and Combat Pay:** Include off-base housing allowances, and food or clothing allowances. Do **not** include Military Privatized Housing Initiative or combat pay.
- **Overtime Pay:** Include overtime pay **only** if it is received on a regular basis.

How do I calculate total household income received from multiple sources and/or on a weekly, every two weeks, twice a month, or monthly basis?

- 1) Annualize pay for each source of income based on the above definitions for every household member.
 - a. Use the table below to convert your pay to an Annual Income amount.

Frequency of payment	Annual Income Conversion Amount
Weekly	= 52 × weekly gross (not take-home) income
Bi-Weekly (every two weeks)	= 26 × bi-weekly gross (not take-home) income
Twice per Month	= 24 × gross (not take-home) amount received twice per month
Monthly	= 12 × monthly gross (not take-home) income

- 2) Add together the annualized pay from every person in the household for the total annual household income for Part C.
- 3) If your household has 8 or fewer people, check the box that shows the range for your total income. If your household has more than 8 people, do not check a box; instead, write household size and total annual household income in the space provided.

If your income fluctuates, include the wages/salary that you regularly receive. For example, if you normally make \$1,000 each month, but you missed some work last month and made \$900, use \$1,000/month as the basis for your annual income. If you have lost your job or had your hours or wages reduced, enter zero or your current reduced income.

Additional information about this survey is available on the [CEP Information webpage: http://www.state.nj.us/education/finance/cep/](http://www.state.nj.us/education/finance/cep/).

PAULSBORO SCHOOL DISTRICT

CHILD STUDY TEAM
662 North Delaware Street
Paulsboro, NJ 08066

Telephone: (856) 423-5515, Ext.1245

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI) PARENTAL CONSENT FORM

Dear Parent / Guardian:

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).

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

Please fill in the information below, sign the form, and return it to the address indicated

Child's Name: _____
(First) (Middle Initial) (Last)

Child's Date of Birth: _____
(Month) (Day) (Year)

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.

As a parent / guardian of the child named above, I voluntarily give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Educational Plan (IEP).

My authorization is good for as long as my child receives special education services, unless I decide to withdraw from the program.

Signature: _____ Date _____
(Parent or person in parental relationship) (Month/Day/Year)

Paulsboro High School
Genesis Parent Portal Access Form

Please complete the following form and return to your child's school.

Parent / Guardian Information
<small>(Please Print)</small> Parent/Guardian First Name: _____ Last Name: _____ Telephone # (daytime): (_____) _____ - _____ Email Address (required): _____ Signature _____ Date: _____
Student Information
<small>(Please Print)</small> Student Grade Level: _____ First Name: _____ Last Name: _____ Enter the Student's date of birth: ____ / ____ / ____
<small>(Please Print)</small> Student Grade Level: _____ First Name: _____ Last Name: _____ Enter the Student's date of birth: ____ / ____ / ____
<small>(Please Print)</small> Student Grade Level: _____ First Name: _____ Last Name: _____ Enter the Student's date of birth: ____ / ____ / ____
<small>(Please Print)</small> Student Grade Level: _____ First Name: _____ Last Name: _____ Enter the Student's date of birth: ____ / ____ / ____

Thank you for signing up for the Genesis Parent Portal On-Line Services. You will receive an email when your ID has been assigned to access information on your student(s).