

## 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](mailto: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](mailto: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** \_\_\_\_\_ **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

**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<br>(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**

<b>Billingsport Early Childhood Center</b> _____	<b>Loudenslager School</b> _____	<b>Paulsboro Jr. High School</b> _____	<b>Paulsboro Sr. High School</b> _____
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 \_\_\_\_\_

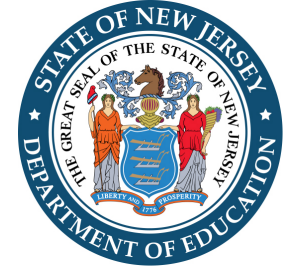
Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

# New Jersey Department of Education

## Household Information Survey 2024 – 2025



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–\$18,954	5. \$32,319–\$36,482	9. \$45,992–\$52,364	13. \$65,010–\$65,728
2. \$18,955–\$25,636	6. \$36,483–\$39,000	10. \$52,365–\$55,500	14. \$65,729–\$74,518
3. \$25,637–\$26,973	7. \$39,001–\$45,682	11. \$55,501–\$59,046	15. \$74,519–\$84,027
4. \$26,974–\$32,318	8. \$45,683–\$45,991	12. \$59,047–\$65,009	16. \$84,028–\$93,536
			17. \$93,537+

**\*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.

<b>Frequency of payment</b>	<b>Annual Income Conversion Amount</b>
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).

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### 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)



ONLY FOR PRESCHOOL PARENTS

Early Screening Inventory-Revised<sup>™</sup> Meisels et al.

Parent Questionnaire

Date \_\_\_\_\_



CHILD INFORMATION

CHILD'S NAME \_\_\_\_\_  Male  Female

HOME ADDRESS Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Who is completing this Name \_\_\_\_\_  
Parent Questionnaire?

Relationship to child \_\_\_\_\_

FAMILY

With whom has the child lived for most of the past year? \_\_\_\_\_  
\_\_\_\_\_

Other children in the family – How many older? \_\_\_\_\_ How many younger? \_\_\_\_\_

Other people living in the household \_\_\_\_\_

What language(s) are spoken at home?  English  Other (specify) \_\_\_\_\_

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before?  Yes  No

If yes, for how long?  6 months  1 year  2 years  more than 2 years

Name of child's present or most recent school \_\_\_\_\_

PEARSON

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Pearson Executive Office 5601 Green Valley Drive Bloomington, MN 55437  
800.627.7271 www.PsychCorp.com

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## MEDICAL HISTORY

### Birth

Were there any significant problems during pregnancy?  Yes  No

If yes, please explain:

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Was your child more than 3 weeks premature?  Yes  No

If yes, how many weeks premature? \_\_\_\_\_

Baby's birth weight \_\_\_\_\_

Did the baby stay in the hospital longer than the mother?  Yes  No

If yes, please explain:

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At the time of birth, did the baby — have seizures  Yes  No

turn blue?  Yes  No

### Child's Health Since Birth

**EYES** Has your child ever had trouble seeing?  Yes  No

Does your child hold books and objects close to his or her face?  Yes  No

Have your child's eyes ever looked crossed?  Yes  No

Have you ever suspected that your child has vision problems?  Yes  No

If yes, please explain:

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**EARS** Has your child had frequent ear infections?  Yes  No

Has your child ever had trouble hearing?  Yes  No

Have you ever suspected that your child has hearing problems?  Yes  No

If yes, please explain:

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**COORDINATION** Has your child ever had trouble walking, climbing, reaching, holding on to things?  Yes  No

If yes, please explain:

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**MEDICAL HISTORY** (continued)

**Child's Health**

**Since Birth** continued

Has your child ever had any significant injuries or hospitalizations?

Yes  No

If yes, please explain:

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Does your child have allergies?

Yes  No

If yes, please explain:

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Is your child presently on any medications?

Yes  No

If yes, please explain:

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Please describe any other health concerns:

Yes  No

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**SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS**

Can your child – feed him or herself using a spoon and/or a fork?

Yes  No

wash and dry his or her own hands?

Yes  No

help with dressing or dress with little assistance?

Yes

stay with a babysitter?

Yes  No

speak so that he or she can be understood by others?

Yes  No

express his or her thoughts and needs easily?

Yes  No

Do you have any concerns about your child's appetite or willingness to try different foods?

Yes  No

If yes, please explain:

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**CHILD'S DEVELOPMENT** (continued)

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)?  Yes  No

If yes, please explain:

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Is your child — highly active?  Yes  No

very quiet?  Yes  No

Is your child — toilet trained during the day?  Yes  No

in need of help with toileting?  Yes  No

Does your child — play with blocks, boxes, cups, or other construction toys without help?  Yes  No

use crayons and/or markers to scribble or draw?  Yes  No

listen to stories being read?  Yes  No

turn pages of a book and look at pictures?  Yes  No

recall stories or events?  Yes  No

enjoy playing alone or with imaginary friends?  Yes  No

talk with your friends/relatives who come to visit?  Yes  No

follow simple, age-appropriate directions?  Yes  No

What are your child's favorite activities?

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Does your child have opportunities to play with other children?  Yes  No

How many hours a day does your child spend watching TV?

Does he or she sit very close to the TV?  Yes  No

Does he or she turn up the volume very high?  Yes  No

Are there other things you would like to tell us about your child?

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**Paulsboro High School**  
**Genesis Parent Portal Access Form**

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

<b>Parent / Guardian Information</b>
<small>(Please Print)</small> Parent/Guardian First Name: _____ Last Name: _____ Telephone # (daytime): (_____) _____ - _____ Email Address (required): _____ Signature _____ Date: _____
<b>Student Information</b>
<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).