Lebanon Borough School District

"Where great things are happening!"

6 Maple Street
Lebanon, New Jersey 08833
Telephone: (908) 236-2448
Facsimile: (908) 236-7670

Bruce Arcurio
Chief School Administrator
Tricia Duell
Business Administrator/Board Secretary

Dear Parents/Guardians,

Welcome to the Lebanon Borough School Family! We look forward to having your child join us.

The items listed below are required at the time of registration. Please complete and return to the school office prior to your child's first day at Lebanon Borough School. Registration forms can be downloaded or filled out online. All required documents can be submitted via email (rmuia@lebanonschool.org), fax, or mailed/dropped off to Lebanon Borough School. If your child is entering Preschool, the monthly fee is $250.00 which is due the first day of each month.

- **New Student Registration Form**
  (Kindergarten students must be age 5 on or before October 1st)
- **Release of Student Information** ***(Grades 1-6)***
- **Home Language Survey**
- **Student Health and Physical Exam Form** ***(less than a year old)***
- **Immunization Records**
  (Immunizations must be up to date before your child can begin school)
- **Authorization of Administration of Prescription Medication in School** ***(if applicable)***
- **Proof of Residency** ***(property tax bill, utility bill, deed, etc.)***
- **Student's original birth certificate with raised seal**
  (A copy will be made and original returned promptly)
- **Copy of most recent IEP, 504 Accommodation Plan, or Evaluation** ***(if applicable)***

If you have any questions, please feel free to contact the School Secretary at rmuia@lebanonschool.org. If your child requires additional health forms (i.e. EpiPen, Asthma etc.) please contact the School Nurse at lkosciolek@lebanonschool.org or the Main Office between 8:00 a.m. and 3:30 p.m.

Thank you.

BETTER TOGETHER!

NEW STUDENT REGISTRATION FORM: LEBANON BOROUGH SCHOOL

NEW STUDENT REGISTRATION FORM

Registration Date: ____________________

Grade Entering: ____________________

Student Name: ____
First Middle Last

Nickname: ______________________ **Child's Primary Language:** ______________________

Address: __________________________ **City:** ______________ **State:** _________ **Zip:** ________

Date of Birth: _________/_________/_________ **Male:** ___________ **Female:** ___________

Place of Birth: ______________________________ ___________/__________/__________
City State/Country Date of entry into the US if born outside of US

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1:	**Parent/Guardian 2:**
Name:	**Name:**
Relationship:	**Relationship:**
Home Address: **(if different)**	**Home Address:** **(if different)**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Email Address:	**Email Address:**
Employer:	**Employer:**
Occupation:	**Occupation:**
Work Phone:	**Work Phone:**

Ethnicity:____American Indian/Alaska Native ____Black/African American

____Native Hawaiian/Pacific Islander ____Asian

____Hispanic/Latino ____White/Caucasian

Military Connection:______Not Active Military Connected

______Active Military Connected

Marital status of parents: Married Divorced Separated Single Remarried Widowed

If parents are separated/divorced, name of person with legal custody: ________________

Does your child see the non-custodial parent:______________ How often: ____________

If there are other adults (i.e. guardian, relatives) that play an important role in your child's life, please list below:

Siblings: Name	Age	Grade	School

Child's Status in Family: _____Oldest _____Middle _____Youngest _____Multiple Birth

Are there any recent changes in family life (i.e. birth, death, divorce, separation, recent move, etc.): ______Yes ______No
If yes, please explain:

Does your child require any accommodation: ______Yes ______No
If yes, please explain:

Please attach a copy of your child's IEP, 504 Accommodation Plan, or any evaluations if applicable.

PREVIOUS SCHOOL INFORMATION

Did your child attend Preschool: ______Yes ______No
If yes, please complete the following:

Name of Preschool:______________________ Number of years attended:_______________

Days per week:_________________________ Dates of Attendance:____________________

Name of last school your child attended:____

Location:_____________________________________

Date of Entrance:______________________________

Reason for Leaving:____________________________

ADDITIONAL COMMENTS:

For Office Use:
Student Registration Form:_____________
Release of Student Information:_____________
Home Language Survey:_____________
Student Health and Physical Exam Form:_____________
Certificate of Immunization:_____________
Authorization of Prescription Medication:_____________
Proof of Residency:_____________
Birth Certificate:_____________
IEP/504 Plan/Evaluation:_____________
Student ID#:_____________
SID#:_____________

Lebanon Borough School District

6 Maple Street, Lebanon, NJ 08833
(908) 236-2448
Fax: (908) 236-7670

AUTHORIZATION FOR
RELEASE OF STUDENT INFORMATION

I/We, ____, parent(s)/guardian(s) of

____, DOB: ____________________,
(student name)
do, hereby, authorize the Lebanon Borough School District, Lebanon, NJ, to send information from their files, as it pertains to the above named student, to the following:

____
(School name)

____
(School address)

____

Telephone: ________________________________

Fax: ____________________________________

Signed: __________________________________
(Parent(s)/Guardian(s))

Date: ____________________________________

Please send requested records to the address below:

Bruce Arcurio, Chief School Administrator
Lebanon Borough School
6 Maple Street - Lebanon, NJ 08833
(908) 236-2448
FAX: (908) 236-7670

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Home Language Survey

(Parent/Guardian Language Questionnaire)

Name:____ Age: _____
[first] [middle] [last]

Date of School Entrance_____________________

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent

[ ] Guardian [ ] Other __________________

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English______ Other [specify]________________________________

2. What language does the family speak at home most of the time?

   English______ Other [specify]________________________________

3. What language does the parent [guardian] speak to the child most of the time?

   English______ Other [specify]________________________________

4. What language does the child speak to his/her parent [guardian] most of the time?

   English______ Other [specify]________________________________

5. What language does the child speak to her/her brothers and sisters most of the time?

   English______ Other [specify]________________________________

6. What language does the child speak to his/her friends most of the time?

   English______ Other [specify]________________________________

7. In which language do you wish to receive school communication?

   English______ Other [specify]________________________________

Signature:__________________________________ Date:______________
[person completing the survey]

*Adapted from the sample survey in A Manual for Community Representatives of the Title VI Steering Committee, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

BETTER TOGETHER!

LEBANON BOROUGH SCHOOL
NEW STUDENT HEALTH AND PHYSICAL EXAM FORM

Part A: HEALTH HISTORY-Completed by the parent/guardian and reviewed by examining licensed provider
Part B: PHYSICAL EXAMINATION-Completed by examining licensed provider

Student's Name: ______________________ Birth Date: ______________ Sex ____M ____F

Grade: ____________ Languages Spoken at home: ______________________

Parent / Guardian Name: ______________________

PART A: HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

____

Operations or Serious Hospitalizations:

____

Current Medications (Name, Dose, Frequency and Reason used):

____

Allergies: (Name, reaction to exposure)
Drug: ______________________
Food: ______________________
Environmental: ______________________

Any Other Additional comments or information that you would like to provide:

____

LEBANON BOROUGH SCHOOL

Student's Name: ______________________________ Exam Date: ______________

PART B: PHYSICAL EXAM
Completed by examining licensed provider

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

	Normal Exam	Abnormal Findings:
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

____

____

____

Any Limitation of Activity or other Recommendations? • No • Yes (Please define):

____

____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: ______________________________ Date: ______________
Name and Address Stamp:

LEBANON BOROUGH SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION IN SCHOOL

The following section is to be completed by the PARENT/GUARDIAN:

Student's Name:________________________________ Date of Birth:______________ Grade:__________

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

Parent/Guardian Name:____________________________________Telephone:____________________________

Signature: ____ Date:______________________________

RECOMMENDATIONS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: ____

Name of medication: ____

Dosage: ____

What time should the daily medication should be given? ____________________________________

If medicine is to be given "WHEN NEEDED", describe indications: ______________________________

How soon can PRN medicine be repeated? ____

List significant side effects: ____

Any restrictions or limitations: ____

PLEASE CHECK THE APPROPRIATE OPTION

** **RE: Class Trips** and/or **School Nurse is Unavailable** (when a parent is unable to attend class trip or administer the medication):

____________ **YES**, the prescribed dose can be withheld on the day of the class trip or if School Nurse is unavailable.

____________ **YES**, the time to be given can be adjusted with the parent/guardian.

____________ **NO**, this medication must be given to the child at the scheduled time.

I verify that this child is free from contagion and this medication is necessary for the student to fully participate in the school educational plan.

Physician's Name:____ Telephone:______________________

Address:____

Physician's Signature:____ Date:__________________

This form must be individually completed for **all prescribed medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.
It may not be possible to administer daily medication on half session days, early dismissal days or delayed opening days.
Parent/guardian will be notified if the daily medication could not be given to the student.

(rev. 2/2/12)