STUDENT'S NAME:		
(Last)	(First)	(MI)

School______________________ Teacher______________________

Grade__________ Birth Date______________ Gender ____M ____F Bus #__________

Address____

Has your address changed since last year? ____Yes ____No Phone Numbers? ____Yes ____No

Mailing Address (if you have PO Box)______________________________

Name of Mother/Step-Mother/Guardian **(circle one)**______________________________

Home Phone #______________________ Cell Phone #______________________

Occupation______________________ Work Phone #______________________

Name of Father/Step-Father/Guardian **(circle one)**______________________________

Home Phone #______________________ Cell Phone #______________________

Occupation______________________ Work Phone #______________________

Student resides with: ____Both Parents ____Mother ____Father ____Parent & Step-Parent ____Guardian(s)

If student resides with Both Parents, they are: ____Married ____Single/Living Together

If student resides with One Parent, they are: ____Separated ____Divorced ____Single ____Widowed

If student resides with Guardian(s), indicate your relationship to student:______________________

****Are there custody or guardianship documents for this student? ____Yes ____No**

****Please Note:** If there are court documents regarding parental custody of this student and they are not on file with the school district, then this student may be released to either parent. Contact the school secretary with any questions.

Is this student covered by health insurance? Yes____ Insurance Company ______________________
No____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit *www.njfamilycare.org* to apply online. I hereby give permission for you to release my name and address to NJ FamilyCare Program or the State of N.J.
Signature ______________________ Date ______________

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b)

EMERGENCY CONTACTS: Please list persons who you authorize to receive phone calls or pick up this student in the event that you cannot be reached.

Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student

Parent/Guardian Email Address______________________________

Family Physician______________________ Phone #______________

In case of emergency, I hereby give permission for this student to be taken to the hospital for treatment, if necessary.

______________________ ______________
Signature of Parent/Guardian Date

Student Name____ Grade__________________

A) FOR NJSTATE REPORTS ONLY, WE NEED TO REQUEST THE FOLLOWING INFORMATION

1) Is the school registration name of this student the same as it is their birth certificate? ___Yes ___No
   If it is not, please indicate their legal name here :______________________________________
2) This student was born in __________________ ___________________ ________ __________
   (Town/City) (County) (State) (Country)
3) If this student was born in a country other than the United States, please indicate the date of first entry into a United States public school district ____________________________
4) Please indicate which ethnic background you consider this student to be:
   ____ White ____ Black ____ Hispanic ____ American Indian/Alaskan ____ Asian
   ____ Pacific Islander ____ Multi (If you have selected "Multi" please indicate all that apply)
5) Your native language is ____
6) The primary language spoken at home is ______________________________________
7) Does this student only speak English? ____Yes ____No
8) Is this student bilingual? ____Yes ____No

B) PLEASE COMPLETE THE FOLLOWING:

1) Does this student receive any type of special services? ____Yes ____No If Yes, indicate if it is:
   ___Speech Therapy ___Basic Skills ___504 Plan ___ Child Study Team Services ___Other
2) Does he/she have an Individualized Education Plan (IEP)? ____Yes ____No (IF YES, WE NEED A COPY)
3) This student will be transported to and from: ____ Home ____ Babysitter/Daycare Center
   _____ Student will be utilizing the Just Kids Before & After School Program _____ Not known at this time

**************************FOR OFFICE USE ONLY – DO NOT FILL IN THIS PART*******************************

Transfer_____ Report Card_____ Health Card/Shot Records_____ BC ______________________________

IEP_____ Classification______ RC_____ Self Contained_____ If classified, what type of service does student receive?____

Custody/Guardianship Papers ____

# of Children in Family______ This child's placement______ Siblings in School District_____________________

Proof of Residency ____

Physical requested _____Yes: Student is entering public school for the first time______ Student transferring from a private school _____ Student is transferring from a school from another state_____)

Student transferring from____

Documentation needed____

School ________ Grade _________ Teacher/Room # ____________________________________

Bus # ______ to school Pick Up Time _____________ @ _____________________________________

Bus # ______ from school Drop Off Time_____________ @ ___________________________________

Start Date ________________ Folder send to school ___________________

Other ____

____

____

____

____

TOWNSHIP OF FRANKLIN PUBLIC SCHOOLS
3228 COLES MILL ROAD
FRANKLINVILLE, NEW JERSEY 08322-3029

MEDICATION CONSENT FORM

If at all possible, parents are advised to give medication at home and on a schedule other than school hours. **IF IT IS NECESSARY** that a medication be given during school hours, these instructions must be followed:

1. Medication that is to be given by the school nurse must be brought to school by the parent, in the original container, with appropriate label intact. **MEDICATION MUST BE BROUGHT TO THE SCHOOL NURSE'S OFFICE AT THE BEGINNING OF THE SCHOOL DAY.**
2. Permission to dispense medication must be completed by the prescribing physician/dentist.
3. Permission to administer medication must be completed by the parent or the guardian.

Student's Name____________________________ **School**____________________

Grade__________ **D.O.B.**____________ **Teacher's Name**____________________

PART 1: TO BE COMPLETED BY PHYSICIAN/DENTIST

The school nurse may administer the following medication(s) to the above named student. This has been prescribed by me to treat:

ILLNESS/INJURY/CONDITION____

MEDICATION____

STRENGTH OF MEDICATION____

DOSE(S) TO BE GIVEN____

TIME(S) TO BE GIVEN____

LENGTH OF TIME MEDICATION TO BE ADMINISTERED______________________

POSSIBLE SIDE EFFECTS____

______________________________ ____________________
SIGNATURE OF PHYSICIAN/DENTIST DATE SIGNED

______________________________ ____________________
PRINTED NAME OF PHYSICIAN/DENTIST OFFICE PHONE #

PART 2: TO BE COMPLETED BY PARENT/GUARDIAN

The school nurse has my permission to administer the above medication to my child as prescribed by Doctor____________________, and has my permission to contact the physician/dentist, if necessary.

______________________________ ____________________
SIGNATURE OF PARENT/GUARDIAN DATE SIGNED

________________ ________________ ________________
HOME PHONE # CELL # WORK PHONE #

(Please see page 2 and complete if applicable to your child)

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MEDICATION CONSENT FORM

PART 3: TO BE COMPLETED BY PARENT/GUARDIAN AND PHYSICIAN, IF APPROPRIATE

I certify that ______________________________ is capable of self-administering the
Student's Name

above identified medication and grant my permission for such self-medication.

It is understood that the Township of Franklin Board of Education shall incur no liability as a result of the above self-medication.

______________________________ ______________________________
SIGNATURE OF PARENT/GUARDIAN DATE SIGNED

______________________________ ______________________________
SIGNATURE OF PHYSICIAN/DENTIST DATE SIGNED

Reg/dmc
Date: 6/14/94
Revised: 6/6/12