CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
TO THE PARENTS OF CHILDREN WHO WILL ENTER
THE DISTRICT IN SEPTEMBER 2020

To begin your child's registration, go to www.cwcboe.org/registration and complete the online pre-registration in the Genesis portal. If you do not have access to a computer please let us know.

You must present the following documents and information in person on the day of registration:

A. Proof of Age

Proof of Age: A child is eligible for entrance into Kindergarten who will have attained the age of five years on or before October 1 of the year in which entrance is sought.

You must provide your child's original birth certificate (with seal) or unexpired passport **plus one copy for our records** as evidence of your child's age.

B. Proof of Residency

You must be a resident of Caldwell or West Caldwell to register. All forms can be found within this packet.

1. **If you rent your residence** you must provide the following:
   - Domicile Statement
   - **Notarized** Landlord Statement
   - Copy of your current Lease Agreement
   - One copy/printout for our records of **two** of the following additional items featuring your name and current address:
     - Utility, Water or Cable bill
     - Telephone/mobile phone bill
     - Insurance bill
     - Bank statement
     - Recent pay stub
     - Valid NJ driver's license

2. **If you own your residence** you must provide the following:
   - Domicile Statement
   - Original plus one copy for our records of **one** of the following**:** Deed to the home, property tax bill or mortgage statement
   - One copy/printout for our records of **two** of the following additional items featuring your name and current address:
     - Deed to the home, property tax bill, mortgage statement
     - Utility, Water or Cable bill
     - Telephone/mobile phone bill

- Insurance bill
- Bank statement
- Recent pay stub
- Valid NJ driver's license

C. <u>Medical Requirements</u>

The following medical documentation must be presented at the time of registration:

1. **Official copy of the child's immunizations**
   The dates of your child's immunizations must include the month, day, and year your child received the vaccines.

   This information must be provided by the doctor and should be entered directly on the Physical Examination and Immunization Form included in this packet. A copy of the child's official immunization record from the permanent chart at the doctor's office will also be accepted. The doctor's name and address must appear on the Official Immunization Record.

2. **Official copy of the child's most recent physical examination**

3. **Health and medical history form completed by parent/guardian**

If you have any questions or need further information, please contact Kerry Ryan at keryan@cwcboe.org or 973-228-6979 ext. 3009.

CALDWELL-WEST CALDWELL

PUBLIC SCHOOLS

DOMICILE STATEMENT

This form may be used for more than one child living at the same address.

In addition to this form you will need to provide the proofs of residency as outlined in the District's residency requirements.

Student(s) Name(s): _____

Home address: _____

How long have you lived at this address? _____

Do you have any intention of moving from this address in the near future? _____

If yes, when and to where are you moving? _____

Do you maintain residences elsewhere? _____

If yes, where are they located/when do you reside there? _____

_____

Does the student reside with only one parent for the entire year? Yes No

If yes, with which parent, and at what address: _____

Are the student's parents domiciled in different districts? Yes No

If yes, regardless of which parent has legal custody, please answer the following:

1. Is there a court order or written agreement between the parents designating the district for school attendance? Yes No

2. If **yes**, where does it require the student attend school? _____

   Please provide a copy of this document.

Signature of parent/guardian: _____ **Date:** _____

CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
STATEMENT OF LANDLORD

To be completed by the landlord of parents/guardians who are providing proof of residency for a rental.

I,_____, am the lawful owner or legal representative of the residential property located at the following address:

_____

_____

This residential unit is currently under lease and occupied by – *please list occupants including parent(s)/legal guardian(s) and school-aged children:*

_____

_____

From (date) _____ to (date) _____.

The answers provided above are absolutely true and entitles the child/children of the above-named tenant to a tuition-free education in the Caldwell-West Caldwell Public Schools. I understand the above information is being relied upon by the Caldwell-West Caldwell Board of Education to determine a student's residency in Caldwell or West Caldwell. I fully understand that any false answers provided above are subject, if proven false, to punitive action.

*This document must be notarized by a Notary Public of the State of New Jersey. (See Below)

_____ _____

Landlord's Signature Print Name

_____ _____

Address Telephone Number

_____ _____

City State Cell Number

***Subscribed and sworn before me on_____20____.**

(date)

Notary Seal

_____

Notary Printed Name

_____

Notary Signature

My Commission Expires: _____

CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
PHYSICAL EXAMINATION AND IMMUNIZATION FORM

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN.

NAME:	☐ BOY ☐ GIRL	DATE OF BIRTH:

HEALTH HISTORY:

ALLERGIES: List all known allergies: Describe reaction and management of reaction.

Medication Allergies: Yes No _____ Food Allergies:

Yes No _____ _____

Insects/Animals: Yes No _____ _____

Environmental/ Pollens: Yes No _____ _____

MEDICATIONS: List all medications (prescription, over-the-counter, non-prescription) taken routinely.

Medication	Dosage/Frequency	Reason for medication

HEIGHT:	WEIGHT:	B/P:	HEART RATE:

	NORMAL	COMMENTS: (EXPLAIN ALL ABNORMAL FINDINGS)
APPEARANCE		
SKIN		
EYES/EARS/NOSE/THROAT		
LYMPH NODES		
HEART		
LUNGS		
ABDOMEN		
GENITOURINARY		
CNS		
NEUROMUSCULAR		
MUSCULO-SKELETAL		
EXTREMITIES		
SPINE		

SEIZURE DISORDER: ☐ NO ☐ YES TYPE:

SCOLIOSIS: ☐ NEGATIVE ☐ POSITIVE TREATMENT:

VISION: O.D. 20/ O.S. 20/ O.U. 20/

HEARING: RIGHT LEFT

KNOWN VISION OR HEARING PROBLEM:

DEVELOPMENT: **SPEECH:**

STUDENT MAY PARTICIPATE IN ALL PHYSICAL EDUCATION ACTIVITIES: ☐ YES ☐ NO

STUDENT MAY NOT PARTICIPATE IN THE FOLLOWING PHYSICAL ACTIVITY(IES):

PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT):	PHYSICIAN'S SIGNATURE:
TELEPHONE NUMBER:	DATE OF EXAMINATION:

Physical exam form must be completed in full. **05/2017**

CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
PHYSICAL EXAMINATION AND IMMUNIZATION FORM

NAME:	☐ BOY ☐ GIRL	DATE OF BIRTH:

IMMUNIZATIONS: A COPY OF THE IMMUNIZATION RECORD IS ATTACHED: ☐ YES ☐ NO

DPT/DT/DTaP: _____ _____ _____ _____ _____ _____ **TDAP:** _____	**OPV or IPV (circle):** _____ _____ _____ _____ _____	**MMR:** _____ _____	**HIB:** _____ _____ _____ _____ _____
HEPATITIS B: _____ _____ _____	**VARIVAX:** _____ _____ **DISEASE DATE:** _____	**PNEUMOCOCCAL:** _____ _____ _____ _____ _____	**MENINGITIS VACCINE:** _____
HEPATITIS A: _____ _____	**INFLUENZA VACCINE:** _____ _____ PLEASE LIST MOST RECENT.	**OTHER:** _____ _____ _____	**OTHER:** _____ _____ _____

MANTOUX:		**LEAD LEVEL:**
DATE GIVEN: _____	RESULTS: _____	RESULTS: _____
DATE READ: _____	TREATMENT: _____	DATE TESTED: _____

PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT): TELEPHONE NUMBER:	PHYSICIAN'S SIGNATURE:

CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
HEALTH AND MEDICAL HISTORY FORM

TO BE COMPLETED BY PARENT:

NAME:	☐ BOY ☐ GIRL	**DATE OF BIRTH**:
HEALTH INSURANCE: ☐ NO ☐ YES	**INSURANCE CARRIER:**	

HEALTH HISTORY (COMPLETED BY PARENT): If YES, please explain:

Chronic or recurring illness/condition	No	Yes	_____
Asthma	No	Yes	_____
Diabetes	No	Yes	_____
Epilepsy/Seizures/Blackouts	No	Yes	_____
Cardiac/Heart Disease	No	Yes	_____
Hypertension	No	Yes	_____
Bleeding Disorder	No	Yes	_____
Frequent Headaches	No	Yes	_____
Skin Disorder	No	Yes	_____
Gastrointestinal Disorders	No	Yes	_____
Neuromuscular Disorder	No	Yes	_____
Orthopedic Condition	No	Yes	_____
Respiratory Illness	No	Yes	_____
Mental/Emotional Issues	No	Yes	_____
Dental/Orthodontic Appliances	No	Yes	_____
Hearing Problems	No	Yes	_____
Vision Problems (glasses or contacts)	No	Yes	_____
Hospitalizations/Surgeries	No	Yes	_____
Recent injury, illness, infectious disease	No	Yes	_____
Other _____			_____
_____			_____

OTHER SIGNIFICANT MEDICAL INFORMATION THE SCHOOL SHOULD KNOW ABOUT:

Signature of Parent:_____ Date:_____

05/2017