HAMBURG SCHOOL

30 Linwood Ave., Hamburg, NJ 07419
973-827-7570 (phone) - 973-827-3624 (fax)

STUDENT PROFILE /REGISTRATION FORM

Start Date: _____

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	TODAY'S DATE

STREET ADDRESS	HOME PHONE	CELL PHONE
MAILING ADDRESS	GRADE	TEACHER
PRIMARY EMAIL ADRESS: (1)	GENDER BOY GIRL	

NAME (CIRCLE ONE) MOTHER, STEPMOTHER, GUARDIAN	CELL #	BUS. PHONE :
NAME (CIRCLE ONE) FATHER, STEPFATHER, GUARDIAN	CELL # :	BUS. PHONE :
EMERGENCY CONTACT #1 **(OTHER THAN PARENT) ***** ☐	PHONE: CELL #:	RELATIONSHIP
EMERGENCY CONTACT #2 **(OTHER THAN PARENT) ***** ☐	PHONE: CELL # :	RELATIONSHIP

CHILD'S DOCTOR & PHONE #

I, the undersigned, do hereby authorize officials of NJ Public Schools to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.
In the event that physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

X _____
Signature Printed Name

RACE: WHITE AFRICAN AMERICAN HISPANIC ASIAN AMERICAN INDIAN PACIFIC ISLANDER

PRIMARY LANGUAGE SPOKEN AT HOME-

Student resides with:
____ Both Parents ____ Mother ____ Father ____ Guardian

LAST SCHOOL ATTENDED:

OTHER CHILDREN IN FAMILY ATTENDING NJ PUBLIC SCHOOLS (LIST BELOW)

NAME/AGE	GRADE	SCHOOL	NAME/AGE	GRADE	SCHOOL

AS WRITTEN ON BIRTH CERTIFICATE:

Child's country of birth _____

Child's state of birth _____

Child's city of birth _____

☐

PLEASE CHECK ALL THAT APPLY:

____ I am the natural parent ____ I have sole legal custody ____ I have joint legal custody ___ I am a stepparent
____ I am a legal guardian ____ I am the adult the child is living with now

_____ **I give my permission to release my child's photo and/or name for school-related activities and yearbook**

_____ **I DO NOT give my permission to release my child's photo and/or name to the media for school-related activities.**

_____**I understand my child will be screened as per age/grade level appropriate health screenings.**

X _____ _____
Signature - Relationship to child **Date**

☐

☐ ***Please check this box if there has been a name change of parent/guardian, address or telephone #'s.***

***** MUST BE SOMEONE AUTHORIZED TO TRANSPORT/CARE FOR YOUR CHILD**

Please complete the reverse side. →

CHILD'S NAME	DATE OF BIRTH

☐ *Please check this box if there has been NO CHANGE in your child's medical history since the last school yeat.*

MEDICAL HISTORY**

1. Please explain any history of chronic health problems, communicable diseases or behavioral concerns: _____

_____

2. Does your child have any allergies? _____ Allergic to: _____

ALLERGIC REACTIONS:_____ TREATMENT:_____

3. **IS YOUR CHILD TAKING ANY MEDICATION?** Yes or No **DAILY?** Yes or No **CURRENT MEDICATION:**_____
(circle) (circle)

4. Does your child have any history of heart murmur/heart related condition/chest pain, fatigue or shortness of breath?

_____

5. Please check any of the following conditions your child has had and indicate the year and date whenever possible:

_____ Emotional Concerns	_____ Earaches	_____ ADD/ADHD
_____ Infectious Mononucleosis	_____ Frequent sties	_____ Bowel problems
_____ Rheumatic/Scarlet Fever	_____ Leg or joint pain	_____ Burns - severe
_____ Convulsions/seizures	_____ Diabetes	_____Frequent upper respiratory inf.
_____ Frequent urination	_____Skin Problem	_____ Frequent abdominal pain
_____ Appendix removed	_____ Speech problem	Explain _____
_____ Frequent nosebleeds	_____ Hearing loss	Explain _____ Dental Exam:
_____ Tonsils removed	_____ Vision problem →	Explain _____ Eye Exam:
_____ Chicken Pox	_____ Bleeding Disorder →	**OTHER:** _____

Please list any childhood/communicable diseases your child has had and indicate the year and date: _____

_____

Please list any conditions or habits that school personnel should be aware of: _____

_____

** This information may be shared with school staff on a "need to know" basis for my child's safety.

PLEASE GIVE DETAILS ON ANY OF THE ABOVE ANSWERS: _____

_____

Please notify the school if your child will be attending day-care before or after school and the provider's name and location.
Please notify the school if your child will be taking the bus to and or from school.

Does your child have Health Insurance?
Yes _____ If Yes, name of insurance **company** _____
No_____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

X Signature:_____ Printed Name:_____ Date: _____
Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).

X _____ _____
Name of person completing this form (PLEASE PRINT) Signature of person completing this form Date

"All information that is provided will be managed under the guidelines established by the Family Education Rights and Privacy Act (FERPA)."

OFFICE USE: _____ (2) Proofs of Residency _____ Birth Certificate _____ Immunization Record