ENROLLMENT PACKET CHECK LIST
NEW STUDENTS GRADES 7-12

Welcome to Kittatinny! Below you will find a check list of all the information that is recommended for your child(ren) to begin their school experience at Kittatinny.

- ☐ Copy of Birth Certificate
- ☐ Student Data Form (Both Sides)
- ☐ Residency Documentation (Copy Of):
  - ☐ Tax Bill, Deed or Rental Agreement
  - ☐ 2 Current Bills
    OR
  - ☐ 1 Current Bill and Guardian's Driver's License
- ☐ If Applicable (Copy Of):
  - ☐ Custody Agreement and/or Proof of Guardianship
  - ☐ IEP
  - ☐ 504 Plan
- ☐ Health Office Packet/Immunization Record
- ☐ Bus Transportation Form
- ☐ Signed School Records Release Form (Yellow Form)
- ☐ Copy of Most Recent Report Card/Unofficial Transcript
- ☐ Standardized Test Scores

Please call the guidance office at (973) 383-1800, ext. 1200 to setup a residency/pre-enrollment meeting. Please bring all recommended documentation as noted on the checklist.

KITTATINNY REGIONAL HIGH SCHOOL
Student Data Form

Student's Full Name: _____ Incoming Grade: _____
(As shown on birth certificate)

Sending School: _____ Fredon _____ Hampton Other: _____
_____ Sandyston-Walpack _____ Stillwater _____

STUDENT EDUCATIONAL PLAN:

Circle All That Apply: Regular Education / Choice School / Special Education Services / 504 Accommodations
If Special Education or 504 student, please attach latest plan

STUDENT PROFILE:

_____ _____ _____ _____
Present Grade Student's Full Name (Including Middle Initial) Nickname Gender

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Date of Birth Birthplace Primary Language

ETHNICITY/RACE:

Ethnicity *(Choose One)*: ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino**
Race *(Choose All That Apply)*:
☐ **American Indian/Alaskan** ☐ **Asian** ☐ **Black** ☐ **Pacific Islander/Hawaiian** ☐ **White**

RESIDENCY:

Where is the student currently living? *(Please check **one** box)* ☐ In rental property
☐ In permanent housing ☐ In a shelter ☐ In a hotel/motel ☐ In a car, park bus, train or campsite
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up")
☐ Other temporary living situation (Please describe): _____

Please attach the following items as proof of residency:

- *Tax bill, deed or rental agreement **AND***
- *Copy of 2 bills **OR** Copy of 1 Bill and Copy of Parent/Guardian Driver's License*

All information must list the parent/guardian's name and address.

NOTE: **We do not accept PO Box addresses** Please list the street address of the home or rental. This information is required for transportation and emergency purposes.

PARENT INFORMATION:

Status: (Circle One) Divorced Married Widow Separated Never Married

☐ **Not Military Connected** ☐ **Currently on Active Duty** ☐ **Currently in National Guard/Reserve**

Relationship: Mother	**Relationship: Father**
Mothers Name:	**Fathers Name:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Township:	**Township:**
Home Phone:	**Home Phone:**
Day Phone:	**Day Phone:**
Cell Phone:	**Cell Phone:**
Mother Email:	**Father Email:**

Please complete the information on the reverse side

CUSTODY INFORMATION:

If divorced, please confirm your information and attach a copy of your latest custody agreement. This is required for residency, pick-up and financial responsibility purposes.

Custodial Parent: _____ Mother _____ Father _____ Joint

Designated Physical Custody: _____ Mother _____ Father _____ Guardian

Student primarily resides with: _____ Mother _____ Father _____ Guardian

List any stipulations the school should be aware of that is supported by a court order or your custody agreement: _____

_____

_____

OTHER PARENT OR GUARDIAN INFORMATION: *(Example: Stepparent or Guardian)*

OP/G1 Relationship:	**OP/G2 Relationship:**
OP/G1 Name:	**OP/G2 Name:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Home Phone:	**Home Phone:**
Day Phone:	**Day Phone:**
Cell Phone:	**Cell Phone:**

EMERGENCY CONTACT INFORMATION *(if parent or guardian are not available)*

Name	Phone 1	Phone 2	Phone 3	Relationship	Permitted to Pick-Up
#1					YES / NO
#2					YES / NO
#3					YES / NO

ATTENDANCE VERIFICATION CONTACTS:

For attendance calls, please list 1st and 2nd contact numbers (custodial parent/guardian only)	
1st Contact #: **Circle: cell home work**	**2nd Contact #:** **Circle: cell home work**
Mother / Father / Legal Guardian Name:	**Mother / Father / Legal Guardian Name:**

Please contact the Guidance Office to update any changes during the school year. Emergency contact numbers can be updated through the Parent Portal.

I attest that all of the information provided on this form is true and correct. ***Both signatures are required.***

_____

(Mother/Guardian Signature) (Date)

_____

(Father/Guardian Signature) (Date)

KITTATINNY REGIONAL HIGH SCHOOL
BUS TRANSPORTATION FORM

PLEASE PRINT **DATE:**_____

_____ ( )M ( )F _____ _____
Student Name Present Grade Date of Birth

Name of Parent/Guardian_____

Home Phone_____ Work or Cell Phone_____

Mailing Address_____

Street Name ***VERY IMPORTANT***_____

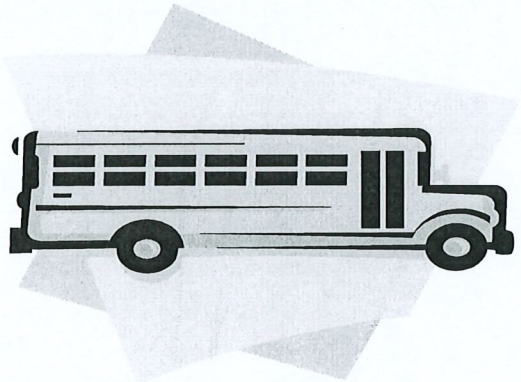
Nearest Intersection_____

Township in which you reside_____

Please circle if applicable: Part-Time Tech Full-Time Tech

Signature of Parent/Guardian_____

FOR OFFICE USE ONLY: _____ *Student ID* _____ *State ID*
Bus Stop: *Route:*



Kittatinny Regional Board of Education

"Imparting Knowledge That Works for Our Children"

77 Halsey Road • Newton, NJ 07860

Phone: (973) 383-1800 • Fax: (973) 383-0085

Date_____

CONFIDENTIAL

KITTATINNY REGIONAL HIGH SCHOOL
77 Halsey Road
Newton, New Jersey 07860
Phone: (973) 383-1800
Fax: (973) 383-0085

AUTHORIZATION FOR RELEASE OF RECORDS FROM PREVIOUS SCHOOL

I hereby authorize _____

_____

_____

_____

Phone #_____

to release cumulative records including SID, discipline, health, and Child Study Team records for

my child _____ D.O.B._____

Last day student attended school:_____ Grade_____

These records are to be sent to:

KITTATINNY REGIONAL HIGH SCHOOL
77 Halsey Road
Newton, New Jersey 07860

Attention: Guidance Office

_____
Parent/Guardian Signature

_____
Address

_____
City/Zip

_____
Home Phone Work Phone

Kittatinny Regional High School

77 Halsey Road • Newton, New Jersey 07860
Phone (973) 383-1800 • Fax (973) 383-0085
Web site: www.krhs.net

Dear Parent/Guardian and Student:

Welcome to your new school. Allow me to provide you with information concerning some of the services of the health office.

Health Services

The health office provides basic first aid for injuries and illness which occur during the school day. Routine health screenings (height, weight and blood pressure) are conducted yearly on all students. Vision and hearing screenings are performed on various grade levels. All students age 10-18 will be screened biannually for scoliosis (curvature of the spine) as required by New Jersey law. Please see attached permission form for the scoliosis screenings. It is also recommended that a more thorough comprehensive examination by a physician be done annually during adolescence.

Injuries

Any student that sustains an injury in school should report it immediately to the faculty member in charge or the school nurse. This also applies to after school sponsored activities. An accident report will be completed for insurance purposes. The school's insurance is an excess plan to your own health insurance.

Medication Policy

All prescription and over the counter medications require a physician's written order and the parent/guardians written consent before the medication can be administered by the school nurse. The medication must be in a current pharmacy labeled container. Over the counter medications must be in a new unopened container. All medications must be brought to the nurse by a parent/guardian. For the safety of all our pupils, students are not permitted to carry any medication in school except physician approved medication for life threatening illnesses such as diabetes, asthma and allergic reactions. Medication forms can be obtained from the school nurse.

Health Insurance

New Jersey law mandates that all children age 18 and under have health insurance. New Jersey Family Care 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 on line.

Please notify me throughout the school year of any changes in your child's medical condition. Should you have any questions or concerns at any time you can reach me at (973) 383-1800 Ext. 1460.

Sincerely,

Mary Ellen Leppert, RN

School Nurse

KITTATINNY REGIONAL HIGH SCHOOL
COMPREHENSIVE HEALTH RECORD - NURSE'S OFFICE
EMERGENCY INFORMATION AND AUTHORIZATION

NAME: _____ SEX:_____ DATE OF BIRTH: _____
ADDRESS: _____ TELEPHONE #: _____
FATHER: _____ PLACE OF EMPLOYMENT: _____ TEL.#: _____
MOTHER: _____ PLACE OF EMPLOYMENT: _____ TEL.#: _____
IF PARENT NOT AVAILABLE, CONTACT: _____ TEL.#: _____
FAMILY PHYSICIAN: _____ TELEPHONE #: _____
FAMILY DENTIST: _____ TELEPHONE #: _____
SPECIALIST: _____ TELEPHONE #: _____
KNOWN ALLERGIES (BE SPECIFIC): _____
TYPE OF REACTION (BE SPECIFIC): _____
ALL MEDICATIONS IN USE AT PRESENT (REASON, NAME, AND AMOUNT): _____
_____
ANY MEDICAL CONDITION THE SCHOOL SHOULD BE AWARE OF: _____
_____
OTHER CONDITIONS/COMMENTS: _____
_____

If any of the above information changes during enrollment at Kittatinny, please send a WRITTEN STATEMENT to the Nurse's Office.

DISPENSING OF MEDICATIONS	EMERGENCY MEDICAL TREATMENT
Non-prescription drugs are not dispensed routinely at KRHS. In the event of minor medical emergencies, however, the following may be dispensed. These medications are given at the discretion of the School Nurse and have been approved under written standing orders of our School Physician(s). Acetaminophen (Tylenol) 1-2 tab. for pain Medicoff lozenge for cough or sore throat The above medications may ( ), may not ( ), be given to my child. _____ _____ Date Parent/Guardian Signature	To the Board of Education, Superintendent, Principal, Designated Teacher in Charge, and School Nurse: In the event that I am unable to be reached and my child, in your opinion, needs EMERGENCY MEDICAL TREATMENT during any time he/she is at Kittatinny Regional High School, you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interests in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of the doctors' actions and I assume and agree to pay for any professional medical services incurred if my child does not have or is not fully covered by school insurance. _____ _____ Date Parent/Guardian Signature

Emergency Medical Treatment will be effective throughout the student's enrollment at KRHS. Permission for the dispensing of medications will need to be renewed yearly via the student's health update form.

KITTATINNY REGIONAL HIGH SCHOOL
COMPREHENSIVE HEALTH RECORD - NURSE

ROUTINE PARENTAL AUTHORIZATION

STUDENT'S NAME: _____ PRESENT GRADE: _____

THIS PERMISSION WILL REMAIN IN EFFECT THROUGHOUT ENROLLMENT
UNLESS NOTIFIED IN WRITING

Please check the desired response to the left of each statement

SCOLIOSIS SCREENING PROGRAM

The purpose of this program is to recognize curvature of the spine at its earliest stages so that the need for treatment can be determined. The earlier the condition is discovered, the easier it is for the doctor to treat. If left untreated, some forms of scoliosis can produce serious deformities; severe cases may even affect the heart and lungs.

( )Yes ( )No This student may be screened for scoliosis.

( )Yes ( )No This student is currently under active treatment for a spinal problem.

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____

Students will be examined by the school nurse or by trained physical education instructors. Boys and girls are screened separately. Boys must take off their shirts. Girls may wear halter tops, swimsuit tops, or bras and are screened by the school nurse.

KITTATINNY REGIONAL HIGH SCHOOL
COMPREHENSIVE HEALTH RECORD - NURSE'S OFFICE

STUDENT/FAMILY HISTORY

DATE: _____

GENERAL INFORMATION

STUDENT'S NAME: _____ SEX: _____ DATE OF BIRTH ____/____/____

FATHER'S NAME: _____ MOTHER'S NAME: _____

NAMES AND AGES OF SIBLINGS:

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HEALTH (NOTE CHRONIC ILLNESS, MENTAL ILLNESS, ETC. OR CAUSE OF DEATH)
This section is optional yet we have found that the information, when available in the child's personal folder, is helpful in assisting us to further individualize student care. Thank you!

RELATION	*YEAR OF BIRTH*	*STATE OF HEALTH*	*OCCUPATION*
Father			
Mother			
Sister(s):			
Brother(s):			

HAS ANY RELATION HAD:

			RELATION
1. Significant Allergy	( ) No	( ) Yes	_____
2. Rheumatic Fever	( ) No	( ) Yes	_____
3. Heart Disease	( ) No	( ) Yes	_____
4. Diabetes	( ) No	( ) Yes	_____
5. Tuberculosis	( ) No	( ) Yes	_____
6. Convulsive Disorders	( ) No	( ) Yes	_____
7. Mental Illness	( ) No	( ) Yes	_____
8. Cancer	( ) No	( ) Yes	_____

ADDITIONAL INFORMATION/COMMENTS: _____

_____

_____

_____

STUDENT HISTORY (Please be sure to check ALL categories and include dates. A section for comments is provided below.)

	YES	NO	DATE
Trouble with Hearing	( )	( )	_____
Hearing Aid	( )	( )	_____
Trouble with Speech	( )	( )	_____
Speech Therapy	( )	( )	_____
Trouble with Vision	( )	( )	_____
Wears Glasses	( )	( )	_____
Wears Contacts	( )	( )	_____
Measles	( )	( )	_____
German Measles	( )	( )	_____
Mumps	( )	( )	_____
Chicken Pox	( )	( )	_____
Poliomyelitis	( )	( )	_____
Pertussis	( )	( )	_____
Strep Infections	( )	( )	_____
Rheumatic Fever	( )	( )	_____
Otitis Media	( )	( )	_____
Frequent Ear Infections	( )	( )	_____
Pneumonia/Bronchitis	( )	( )	_____
Frequent Sore Throats	( )	( )	_____
Tends to Bleed Easily	( )	( )	_____
Frequent Vomiting or Diarrhea	( )	( )	_____

	YES	NO	DATE
Convulsive Disorder	( )	( )	_____
Eczema or Hives (specify cause)	( )	( )	_____
Wheezing or Asthma (specify cause)	( )	( )	_____
Allergies (be specific)	( )	( )	_____
Undergoing hyposensitization by allergist	( )	( )	_____
Nail-Biting	( )	( )	_____
Bed-Wetting	( )	( )	_____
Nightmares	( )	( )	_____
Trouble Sleeping	( )	( )	_____
Sleep Walking	( )	( )	_____
Unusual Nervousness	( )	( )	_____
Emotional Problem(s)	( )	( )	_____
Unusual Irritability	( )	( )	_____
Many Absences from School	( )	( )	_____
Previous Child Study Team Referral	( )	( )	_____

Other(s)

_____

_____

_____

COMMENTS

_____

_____

_____

_____

OPERATIONS/INJURIES/HOSPITALIZATIONS

_____

_____

_____

Is the student taking any medications on a regular basis? ( )Yes ( )No If Yes, please specify for what condition the medication is being used, how often they are administered, and the dosage strength: _____

_____

_____

Will it be necessary to have any medications during school hours? ( )Yes ( )No

Is there any reason at present for exclusion from Physical Education classes or any limitations of physical activity? ( )Yes ( )No If Yes, please clarify: _____

_____

_____

Are there any problems or special considerations you feel the school should be aware of in working with your child? ( )Yes ( )No If Yes, please comment: _____

_____

_____