

# Ridgefield Park Public Schools

## Registration Packet

All materials must be returned to the

Ridgefield Park Public Schools Registration Office  
at Ridgefield Park Junior Senior High School

1 Ozzie Nelson Drive

Ridgefield Park, NJ 07660

Office Hours:

8:00 AM-4:00 PM

**Please print clearly!**

Ridgefield Park Public Schools  
Ridgefield Park, New Jersey 07660

**REQUIREMENTS FOR REGISTRATION OF CHILDREN GRADES 1-12**

Child's Name \_\_\_\_\_, \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last Name First Name

Child's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone# \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address \_\_\_\_\_  
No. Street Apt. No. Town State Zip Code

The following evidence must be presented and approved before the child may be registered and permitted to attend school:

**PROOF OF RESIDENCY:**

\_\_\_\_ **OWNER OF DWELLING:** Mortgage or Deed, Property Tax Record, any Utility Bill, and a valid New Jersey Driver's License with Photo Identification or NJ State MVC-photo ID...indicating the Ridgefield Park address

\_\_\_\_ **RENTER OF DWELLING:** Current original lease verifying names and status/duration of lease. Lease must also show landlord's name, address, and phone number. Present a valid New Jersey Driver's License with Photo Identification or NJ State MVC-photo ID...indicating the Ridgefield Park address

\_\_\_\_ **HEALTH RECORDS:**

- Two doses of Measles, Mumps and Rubella vaccine, given after 1<sup>st</sup> Birthday
- Four doses of DPT or DTaP, with one dose given on or after the 4<sup>th</sup> birthday or any 5 doses
- Three doses of polio vaccine, with one dose given after the 4<sup>th</sup> birthday or any 4 doses.
- TB Mantoux test with results
- History of all contagious diseases, allergies and illnesses must also be supplied.
- An Up-to-Date Physical Examination

No student can be admitted to the Ridgefield Park School District until health records are approved by a school district nurse.

\_\_\_\_ **PROOF OF AGE:** Original birth certificate with raised seal.

If original birth certificate is not available, a current passport is acceptable.

\_\_\_\_ **ADDITIONAL AFFIDAVITS:** Other court orders/agency placement orders may be required.

**LITTLE FERRY STUDENTS ENTERING RPJRSRHS GRADE 9**

At the time of the registration of a Little Ferry student entering Grade 9, a Certificate of Registration from the Little Ferry Board of Education, 130 Liberty St. (201-641-6186 Ext.1403) must be presented to the Registrar at the time of registration.

Ridgefield Park Public Schools  
Ridgefield Park, New Jersey 07660

**REGISTRATION LEGITIMACY**

Child's Name \_\_\_\_\_, Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last name First name

I, \_\_\_\_\_, affirm that I am the  
Parent/Guardian Name – Please print

Check one:

\_\_\_\_\_ Natural Parent

\_\_\_\_\_ Legal Guardian

\_\_\_\_\_ Affidavit Host

...of the child listed above.

I further affirm that this form and all the documentation I have completed/provided constitute true and accurate proof that the child listed above resides with me in the school district and will continue to do so for the next eleven (11) months.

If the child listed above ceases living with me, or if I move my residence within or outside of Ridgefield Park, I will promptly notify the Ridgefield Park Board of Education in writing...addressed to: Office of the Registrar, Ridgefield Park Public Schools, 1 Ozzie Nelson Drive, Ridgefield Park, NJ 07660 (201-807-2655).

I certify that all the information I have provided is true. I am aware that if any of the information I have provided is false, I may be subject to legal/punitive action.

My signature acknowledges that I have read and understand this document.

Signed \_\_\_\_\_ Relationship to child \_\_\_\_\_

Date: \_\_\_\_\_ Witness \_\_\_\_\_

Ridgefield Park Public Schools  
Ridgefield Park, New Jersey 07660

Today's Date: \_\_\_/\_\_\_/\_\_\_  
M D Y

**FAMILY BACKGROUND SHEET**

**STUDENT INFORMATION: (PLEASE PRINT)**

Student's Name: \_\_\_\_\_ Gender: Male Female  
Last name First name (Circle one)

Address: \_\_\_\_\_  
No. Street Apt. No. Town State Zip Code

Age: \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_  
M D Y City State Country

**Student Living With (Circle all that apply):**

Father & Mother Mother Only Father Only Guardian Stepfather Stepmother

**Race:**

White Hispanic Black Asian Pacific Islander Native American

**Language Survey**

\*Native language is the language first acquired by your child, or the language spoken most often by your child, or the language most often spoken in your home. When entering a language, please be specific. For example, do not simply enter Indian...enter Gujarati, Hindi, etc. Do not enter simply Chinese...enter Cantonese, Mandarin, etc.

Child's \*Native Language \_\_\_\_\_ Major Language spoken in your home \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION: (PLEASE PRINT)**

Do you: OWN RENT  
(Circle one)

Parent/Guardian \_\_\_\_\_  
(Living with student) Last Name First Name Relationship  
Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
(Living with student) Last Name First Name Relationship  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
(Not living with student) Last Name First Name Relationship  
Address: \_\_\_\_\_  
No. Street Apt. No. Town State Zip Code  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Student's Previous**

Address: \_\_\_\_\_  
No. Street Apt. No. Town State Zip Code

**OTHER CHILDREN IN THE FAMILY: (PLEASE PRINT)**

Name	Age	Grade	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STUDENT'S NAME \_\_\_\_\_

**PREVIOUS SCHOOL INFORMATION**

School Attended \_\_\_\_\_

School Address \_\_\_\_\_  
No. Street Town State Zip Code

School's Phone Number \_\_\_\_\_ School's Fax # \_\_\_\_\_

Was your child enrolled in any special program (s)? Yes \_\_\_\_\_ No \_\_\_\_\_

Please circle the program(s) the student was enrolled in (circle all that apply).

Honors      ESL/ELL      Special Education      Basic Skills Improvement      Vocational      Satellite

Parent/Guardian Signature: \_\_\_\_\_

**OFFICE USE ONLY**

N.J. State ID \_\_\_\_\_

Country of Birth Code \_\_\_\_\_ If other than the US: Date of Entry     /     /      
M D Y

County Code Resident:    Bergen -03    Other \_\_\_\_\_

District Code of Resident    RP-4380    LF-2710    Other: \_\_\_\_\_

School Code of Resident:    HS -050    Grant - 060    Lincoln - 070    Roosevelt -080

District Entry Date:                /     /      
M D Y

County Code Attending    Bergen -03    Other: \_\_\_\_\_

District Code Attending:    4380

School Code Attending:    HS -050    Grant -060    Lincoln -070    Roosevelt -080

School Entry Date:                /     /      
M D Y

Grade Level: \_\_\_\_\_

Program Type: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

**HEALTH INFORMATION:**

Health Insurance: Yes or No    If yes, Health insurance provider: \_\_\_\_\_

Date of last Lead Test:                /     /          Lead Level: \_\_\_\_\_  
M D Y

Ridgefield Park Public Schools  
Ridgefield Park, New Jersey 07660

**REQUEST FOR SCHOOL RECORDS**

Grant School  
104 Henry St.  
201-641-0441

Lincoln School  
712 Lincoln Ave  
201-994-1830

Roosevelt School  
508 Teaneck Rd.  
201-440-0808

RPJRSRHS  
1 Ozzie Nelson Drive  
201-440-1440

Date \_\_\_\_\_

The child named below has enrolled in one of our schools. The parent/guardian has given permission (see below) for academic, attendance, health, and disciplinary records to be sent to the school circled above as soon as possible.

Full name of previous school \_\_\_\_\_

School Street Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

School Telephone # (\_\_\_\_\_) - \_\_\_\_\_ School Fax # (\_\_\_\_\_) - \_\_\_\_\_  
(Area Code) (Area Code)

Thank you for your cooperation.

Thank you.

Sincerely,

Mr. Bill Morton, Registrar-Ridgefield Park Public Schools  
(201) 807-2655

I hereby give permission to release all academic, attendance, health, and disciplinary school records to the school circled above for:

Child's Name \_\_\_\_\_ Present Grade \_\_\_\_\_  
Last Name, First Name

Parent/Guardian Name (print) \_\_\_\_\_

Parent/Guardian  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Medication

Child's Name \_\_\_\_\_, \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last Name First Name

Child's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

**A child must not bring to school  
any prescribed or over-the-counter medication...not one single dose!  
Any such products must be brought to the school nurse by a parent/guardian  
with directions for use from a physician.  
Only a school nurse may administer the medication.**

By my signature, I certify that my child does not need to take any prescribed or over-the-counter medication during the school day.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

There are few exceptions to this rule.

Permission may be granted to your child for self-administration of medication for asthma or other potentially life threatening conditions if the school receives written permission from a parent/guardian and authorization by a physician. Even in this case, we may require that the medication be self-administered in the presence of the school nurse.

By my signature below I give permission for my child to self-administer the medication indicated by the physician. I understand that Ridgefield Park Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and I shall indemnify and hold harmless the Ridgefield Park Board of Education and its employees and agent against any claims arising as a result of the self-administration of medication by my child.

The following section must be completed by a physician:

Diagnosis for which the medication has been prescribed: _____	
Name of medication: _____	
Form of medication: _____	
Dose: _____	
Time: _____	
How soon the dose can be repeated: _____	
List of significant side effects: _____	
Length of time this treatment is recommended: _____	
	<b>Physician's Signature and STAMP</b>
	Date: _____
	Physician's Name _____
	Address _____
	Telephone Number _____

The above mentioned child has asthma and/or other life threatening condition and has been instructed in and is capable of self-administering the medication noted above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Ridgefield Park Public Schools  
Ridgefield Park, New Jersey 07660

## ALLERGIES/REACTIONS

Child's Name \_\_\_\_\_, \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last name First name

Child's Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone #: \_\_\_\_\_  
M D Y

If your child has no allergies/reactions please check here \_\_\_ and sign below.

Item	Yes	No	Type of reaction experienced	Medication taken	Actions to be taken
Dairy Products					
Eggs					
Peanuts					
Other foods: Specify _____					
Bees					
Other Animals: Specify _____					
Penicillin					
Erythromycin					
Other Meds: Specify _____					
Seasonal Allergies Season _____					
Other Allergies: Specify _____					

Comments/Additional Information: \_\_\_\_\_  
 \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to child \_\_\_\_\_



**EXPECTATIONS FOR STUDENT BEHAVIOR**

**All students have the right to a safe as well as a thorough and efficient education!**

1. **In CLASSROOMS** students are expected to:
  - Demonstrate respect toward the teacher or substitute teacher at all times.
  - Demonstrate respect toward all other students at all times.
  - Complete all assignments as required by the teacher.
  - Use appropriate language.
  - Participate positively in all class activities.
  - Use restrooms in the same manner of positive conduct as required elsewhere in school.
  - Do their own work and not cheat.
  - Stand during the Pledge of Allegiance.
2. **In ASSEMBLIES** students are expected to:
  - Conduct themselves as directed.
  - Give full attention and respect to presenters.
  - Enter and exit in a safe and orderly manner as directed.
3. **In HALLWAYS & STAIRWELLS** students are expected to:
  - Keep to the right.
  - Walk at all times.
  - Remain quiet, and refrain from using any profane language.
  - Not show any overt displays of affection.
4. **In the LUNCHROOM** students are expected to:
  - Use the same manner of positive conduct as required elsewhere in school.
  - Walk at all times.
  - Join the end of food service lines.
  - Use their own lunch identification (envelope) or money.
  - Clear the space of their table seat and floor.
  - Enter and exit in a safe and orderly manner as directed.
5. **On SCHOOL GROUNDS & SCHOOL TRIPS-At SCHOOL & COMMUNITY EVENTS/ACTIVITIES**
  - All school rules extend and apply to these places or activities.
6. There is **ZERO TOLERANCE** for any degree of the following behaviors:

<ul style="list-style-type: none"><li>• Harassment</li><li>• Forgery-presenting the signature of someone else</li><li>• Using cell phones</li><li>• Gambling</li><li>• Possession, sale, distribution or use of explosives, fireworks, smoke/stink bombs, weapons of any kind, alcohol, other drugs, or any illegal substances</li></ul>	<ul style="list-style-type: none"><li>• Stealing</li><li>• Smoking in school or on school grounds</li><li>• Criminal acts of any kind.</li><li>• Leaving school with authorized permission</li><li>• Fighting</li><li>• Snow ball throwing</li><li>• Disruptive or disorderly conduct</li></ul>
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7. All students are expected to come to school everyday-on time and to attend all assigned classes on time.
8. All students are expected to adhere to the school dress code.
9. All students are expected to respect the property of all personal, private, and school property.
10. All students are expected to respect property in the community on their way to school or way home from school.

**We have read these expectations for student behavior and fully understand them. We also understand that failure of a student to abide by them will likely result in consequences to be determined by school administrators.**

(Print) Student Name \_\_\_\_\_ Student's Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT RELEASE FROM SCHOOL FORM**

There may be one or more times when someone other than you, the parent/guardian, may need to sign your child out of school during the school day. Therefore, please complete the information below. Note that the people you are giving permission to pick up your child (during the school day) must be at least 18 years old and will be able to present photo identification upon request.

Child's Name: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Phone numbers where you may be reached during the school day:

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

**THE FOLLOWING PEOPLE HAVE MY PERMISSION TO SIGN MY CHILD  
OUT OF SCHOOL AND MAY BE ASKED TO PRESENT PHOTO ID:**

Name _____	Relationship _____
Address _____	
Home Phone # _____	Cell Phone # _____

Name _____	Relationship _____
Address _____	
Home Phone # _____	Cell Phone # _____

Name _____	Relationship _____
Address _____	
Home Phone # _____	Cell Phone # _____

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_



**BERGEN COUNTY MEDICAL SOCIETY**  
**APPROVED SCHOOL AND ATHLETIC EXAMINATION FORM**  
 Lower Grades (K through 4)

Entering Grades K-4

GRADE \_\_\_\_\_

NAME (last) \_\_\_\_\_ (first) \_\_\_\_\_ ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

BIRTH DATE \_\_\_\_\_ PARENT'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

**PHYSICAL REPORT:**

Grade \_\_\_\_\_ Age \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ BP \_\_\_\_\_

Eyes \_\_\_\_\_ R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_; Ears \_\_\_\_\_ Hearing R \_\_\_\_\_; L \_\_\_\_\_

Respiratory \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_

Musculoskeletal \_\_\_\_\_ Skin \_\_\_\_\_

Neurological \_\_\_\_\_

LABORATORY: Urinalysis \_\_\_\_\_ HGB/HT \_\_\_\_\_ Other \_\_\_\_\_

**COMMENTS:**

**RECOMMENDATIONS:**

Yes No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Any conditions limiting<br>- Classroom activity?<br>- Physical education?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any significant allergies?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Any condition which may result in a classroom emergency   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Any emotional, mental or physical condition requiring periodic medical observation?                   | <input type="checkbox"/> | <input type="checkbox"/> |

**COMMENTS:**

**IMMUNIZATIONS**

(Insert dates)

Complete for new students. Otherwise only those since last report.

DPT	DPT	DPT
DPT	DT	DT
TET	TET	
OPV	OPV	OPV
OPV	OPV #1	OPV #2
MEASLES (LIVE)	/ /	/ /
MUMPS	/ /	/ /
RUBELLA	/ /	/ /
TB PPD	MANTOUX	RESULTS
Hepatitis B	1st	2nd 3rd

Phone \_\_\_\_\_

M.D.

# BERGEN COUNTY MEDICAL SOCIETY

## APPROVED SCHOOL AND ATHLETIC EXAMINATION FORM

(GRADES 5-12)

GRADE \_\_\_\_\_

NAME (last) \_\_\_\_\_ (first) \_\_\_\_\_ ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ PARENT'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

**History** — (must be completed and signed by student and parents before exam.)

- |   |  | Yes | No |
|---|--|-----|----|
| 1. Were you ever medically advised not to play any sport? Include date and reason below. (12) .....                                 |  |     |    |
| 2. Are you under physician's care now or had recent hospitalization? Describe below. (12) .....                                     |  |     |    |
| 3. Have you ever experienced loss of consciousness after exercise or after injury? .....  |  |     |    |
| 4. Have you ever had: a seizure (convulsion)? .....   |  |     |    |
| a fracture, dislocation or other orthopedic injury? .....   |  |     |    |
| any surgery? .....  |  |     |    |
| any bleeding disorder? .....  |  |     |    |
| loss of function of one kidney or testicle? .....   |  |     |    |
| 5. Do you take any medication on a regular basis? Include name of medicine and reason taken below. (12)                             |  |     |    |
| 6. Do you have any allergies, including drug allergies, hives, asthma, stinging insect bites? .....                                 |  |     |    |
| 7. Have you had any heart problems, high blood pressure, recurring chest pains, palpitations, rapid or irregular heart beats? ..... |  |     |    |
| 8. Do you have a recent history of fatigue or undue tiredness? .....  |  |     |    |
| 9. Do you have a history of vision difficulties, wear glasses or contact lenses? .....  |  |     |    |
| 10. Is there a history of sudden death in the family? .....   |  |     |    |
| 11. Do you have any worries etc.? .....   |  |     |    |
| 12. Describe the details of any item checked "yes": _____   |  |     |    |

I wish to participate in \_\_\_\_\_ Sport or activity \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Parent or Legal Guardian

**IMMUNIZATIONS (Insert dates)**

DTP	DTP	DTP
DTP	DT	DT
TET	TET	
OPV	OPV	OPV
OPV	OPV	OPV

	#1	#2
MEASLES (live)		
MUMPS		
RUBELLA		
TB Mantoux		
Hepatitis B		
	1st	2nd
	3rd	

HGT \_\_\_\_\_ WGT \_\_\_\_\_ BP \_\_\_\_\_ Pulse, Resting \_\_\_\_\_ After Exercise (10 Sit Ups) \_\_\_\_\_  
 Vision \_\_\_\_\_ wwith correction R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Hearing: Rt \_\_\_\_\_ Lt \_\_\_\_\_  
 \_\_\_\_\_ without  
 Urine \_\_\_\_\_ HGB/HCT \_\_\_\_\_ TB Test (Mantoux) \_\_\_\_\_

	Normal	Abnormal	DESCRIPTION
Appearance, Nutrition			
Head, Neck (masses, range of motion, pain on motion)			
Eyes (Conjunctiva, Jaundice)			
Ears (Infection, Perforation)			
Nose (Obstruction), Throat			
Mouth, Teeth			
Chest and Lungs			
Cardiac (murmurs, clicks, rhythm)			
Abdomen (liver, spleen, masses)			
Back (deformity, range of motion, scoliosis)			
Extremities (Joint mobility, instability, deformity, muscle weakness, atrophy, scars)			
Testes (presence, descent, masses)			
Genitalia—Hernia			
Neurological (Reflexes, balance, coordination)			
Level of Maturation (Tanner score 1-4)			

Based on this history and physical exam, the following abnormalities were found:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### RECOMMENDATIONS

Based on this history & physical, this student:

- May participate in competitive athletics
- Should have the following health problems evaluated and treated prior to participation in competitive athletics: \_\_\_\_\_
- Has health problems which prohibit participation in the following athletic activities: \_\_\_\_\_
- Should be limited in classroom and physical education activities as follows: \_\_\_\_\_

M.D./D.O.

Signature and Address Stamp

School Physician Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_  
 Signature \_\_\_\_\_

**RIDGEFIELD PARK PUBLIC SCHOOLS EMERGENCY INFORMATION FORM**

**Homeroom:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Year:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**PUPIL'S NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PARENTS' OR GUARDIANS' NAME:** \_\_\_\_\_

**FATHER'S BUSINESS PHONE:** \_\_\_\_\_

**FATHER'S CELL PHONE:** \_\_\_\_\_

**MOTHER'S BUSINESS PHONE:** \_\_\_\_\_

**MOTHER'S CELL PHONE:** \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_

**To be notified in emergency if parent cannot be contacted:**

**1) Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**2) Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Hospital Preference** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_