

Registrar: Kimberly Allen

856-786-9300 x1000

856-829-9638 *fax*

KAllen@palmyra.k12.nj.us

Delaware Ave School Office

856-786-9300

Helene Mantagas x4001

HMantagas@palmyra.k12.nj.us

Student Health Requirements

IMMUNIZATIONS REQUIRED BEFORE FIRST DAY OF CLASSES:

4 doses of DPT vaccine (1 dose to be administered **after** 4th birthday)

3 doses of oral Polio vaccine (1 dose **after** 4th birthday)

3 doses of Hepatitis B Vaccine

2 doses of MMR (administered **after** 1 year of age and **before entering preschool**)

1 dose of Varicella (Chicken Pox) Vaccine

At least 1 dose of HIB

At least 1 dose for pneumonia

Please see letter in this packet for influenza vaccines

PHYSICAL EXAMINATIONS ARE REQUIRED FOR EACH STUDENT BEFORE ENTERING SCHOOL

THE PHYSICAL EXAMINATION IS BEST PROVIDED BY YOUR FAMILY DOCTOR WHO IS FAMILIAR WITH YOUR CHILD. If you have any questions please call the School Nurse, Ms. Mary Del Rossi, at (856) 786-9300 ext. 2004.

ASTHMA AND ALLERGIES

If you student has asthma or any allergies that require them to have medication at school please contact the School Nurse, Ms. Mary Del Rossi, at (856)786-9300 ext. 2004 for the required forms.

**REGISTRATION APPOINTMENTS WILL TAKE PLACE AT THE
PALMYRA COMMUNITY CENTER,
THE REGISTRAR WILL REACH OUT TO SET UP AN APPOINTMENT ONCE AN
ONCOURSE REGISTRATION HAS BEEN SUBMITTED.**

REGISTRATION CHECKLIST | STUDENT NAME _____

Must provide **original documents** to be copied and filed

REGISTRATION STARTS ONLINE at www.palmyraschools.com

Menu > Registration > New Student OnCourse Online Registration Portal

REGISTRATION IS BY APPOINTMENT ONLY

Appointments can only be made **after** you have completed your online registration.

All Registrations are processed at the Board of Education offices located at:

30 West Broad Street Palmyra, NJ 08065

Parent Information

Valid Photo ID *choose one*

- ☐ Driver's License
- ☐ State ID
- ☐ Passport

First Proof of Residency *choose one*

MUST BE IN PARENT/GUARDIAN'S NAME

If not please see **Special Circumstances** below

- ☐ Mortgage Statement
- ☐ Title/Deed
- ☐ City Tax Bill
- ☐ Formal Lease
- ☐ Rental Agreement

Second Proof of Residency *choose one*

MUST BE IN PARENT/GUARDIAN'S NAME

If not please see **Special Circumstances** below

- ☐ Utility Bill (Electric, Water, Internet, etc.)
- ☐ Credit Card Statement
- ☐ Bank Statement
- ☐ Vehicle Registration

**Students coming from Beverly/Riverton do not need to provide Residency Proof (Valid Photo ID still required)*

Special Circumstances

If Proof of Residency is NOT in your name, the Palmyra Resident MUST provide ID, Proof of Residency, and sign a school provided affidavit

Student Information

Proof of Birth *choose one*

- ☐ Birth Certificate
- ☐ Passport

SPECIAL CIRCUMSTANCES PLEASE BRING

- ☐ Custody Papers
- ☐ Foster Papers

Previous School Records

- ☐ Most Recent Report Card
- ☐ *For 9-12 Grade only* Transcripts
- ☐ Transfer Card A41 *from previous school in NJ*

Medical Records *bring all*

- ☐ Last physical, less than 1 year old
- ☐ Immunization Record

OR

- ☐ A45 Card *from previous school in NJ*

**If this is the student's first time in the country they must have a TB test and provide results*

Registrar: Kimberly Allen

Phone 856-786-9300 x1000

Fax 856-829-9638

Email

kallen@palmyra.k12.nj.us

In accordance with New Jersey State law (N.J.S.A. 18A:38-1 and 18A:7B-12), it is necessary to determine the residence of students entering the school district by answering the following questions:

I currently live in a: (please check the appropriate answer)

____ a. House that I own (address) _____
PLEASE PROVIDE PROOF OF MORTGAGE/DEED

____ b. House or apartment that I rent (address) _____
PLEASE PROVIDE A COPY OF YOUR LEASE

____ c. Hotel/ motel/ apartment

____ d. Shelter

____ e. Transitional housing facility

____ f. Domestic violence shelter

____ g. Runaway youth shelter

____ h. Home for adolescent school-age mothers

____ i. Migrant family dwelling

____ j. Family or friend's home out of necessity

Please print name/relation of the person with whom you are staying: _____

____ k. Family or friend's home by choice

Please print name/relation of the person with whom you are staying: _____

____ l. Other (please identify) _____

This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment. Additionally, I will be responsible for paying the Palmyra School District annual cost per pupil.

The Palmyra Board of Education has policies and procedures related to "Proof of Domicile" for students who attend our schools. The District shall only provide a free education to those students who are domiciled within the District or who otherwise qualify for a free education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 *et seq.* And N.J.A.C. 6A:22-1.1 *et seq.* A student shall be domiciled in the District "when he or she is living with a parent or legal guardian whose permanent home is located within the District." N.J.A.C. 6A-22-3.1. The home is permanent if "the parent or guardian intends to return to it when absent and has no present intent of moving from it..."*Id.* If the District discovers that a student is attending school whose parents are not domiciled within the District and who is not otherwise eligible for a free education, the District may apply for the student's removal and seek tuition reimbursement for the period of ineligible attendance with the provisions of N.J.S.A. 18A:38-1(b)(2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense, N.J.S.A. 18A:38-1©. If the applicant is convicted of such an offense, the applicant may be fined up to \$1,000.00 and/or be imprisoned for up to 6 months.

Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C:43-3. If convicted for such a crime, the applicant may be punished by a fine of \$10,000.00 and/or be imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read & understood the contents of this notification

Print Name of Parent/Guardian

Signature of Parent/Guardian

Date

Acknowledgements

Checking this box indicates you acknowledge this information is available to view on our website: www.palmyraschools.com

<input type="checkbox"/> YES	Free & Reduced Lunch Form	PTA Information	Attendance Policy
	After School Program Application	PHSFEE Information	Dress Code Policy
	District Handbook	FERPA/8310 Statement	District Backpack
	School Calendar	Acceptable Use Policy	Social Media Pages

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services ([U.S. ED EL Toolkit](#), Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: _____ Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

2.) Was the first language used by the student a language other than English?

_____ No _____ Yes

3.) Does the student speak or understand a language other than English?

_____ No _____ Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

The person completing this page must sign & date this document below.

- This survey must remain in the student's permanent file.
- If any language other than English is mentioned on this survey, the student must be referred to a qualified ELL specialist for additional language assessment.

Print Name of Parent/Guardian

Signature of Parent/Guardian

Date



PALMYRA BOARD OF EDUCATION
PALMYRA, NEW JERSEY 08065

Mark Pease
Interim Superintendent

Administrative Office
301 Delaware Avenue • 856-786-9300

Jared M. Toscano
Business Administrator/Board Secretary

February 6, 2024

Dear Parent/Guardian:

The New Jersey Department of Health and Senior Services (DHSS) requires the influenza vaccine for children six months through 59 months of age attending any licensed child-care or preschool facility.

You must provide documentation of your child receiving at least one dose of vaccine between September 1st and December 31st of each year in order for your child to continue attending school. If you choose not to have your child vaccinated you must complete the attached Immunization Waiver which will exclude your child from school from January 2, 2025 through March 31, 2025, as advised by the Health Department.

If you have any questions regarding this information, please contact the Burlington County Health Department at 609-265-5548 or the school nurse at 856-786-9300 ext 2004.

Sincerely,

Mark Pease
Interim Superintendent

Dear Mr. Pease,

I am aware of the New Jersey Department of Health's requirement for the upcoming school year that my pre-school child have an influenza vaccination.

I have chosen not to have this vaccination for my child and I request that my child be excused from school from January 2nd through March 31st 2025 as advised by the health department.

Name of Child: _____

Birth Date: _____

School/Class: _____

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____

Telephone: _____

Date: _____

PRESCHOOL HISTORY FORM

THANK YOU FOR HELPING US BECOME BETTER ACQUAINTED WITH YOUR CHILD

We would appreciate your completing the following form as fully as possible. All information is confidential.

PLEASE PRINT

[illegible]

Do you need Before or After School Care for your child? Yes _____ No _____

Child's Name	Nickname
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Mother's Name _____ Father's Name _____

Who does the child live with? _____

Birth date _____ Adults living at home _____

Siblings:

Brothers

Age

Sisters

Age

Who is authorized to pick child up from school?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Pets (types and names) _____

Was child adopted? _____ If so, at what age? _____

What was he/she told about the adoption? _____

PHYSICAL FACTORS

Is child in good general health? _____ Subject to colds? _____

Does he / she have a physical handicap? _____

Allergies? (List allergens)_____

Is your child potty trained? Yes? _____ No? _____

SPEECH

Does your child speak understandably? _____ Is there any speech defect or difficulty with letter pronunciation? _____ Does he / she use sentences? _____

At what age did your child begin using words? _____

Does your child have knowledge of upper and lower case letters, letter sounds and number recognition?

GROUP EXPERIENCES

Has your child ever attended nursery school? _____

If so, which one? _____

How long did your child attend? _____ How often (example: 3 times per week)? _____

May we have your permission to contact the school for any records of your child? _____

Has he / she had any other group experiences? _____

Please describe your child's reactions _____

PLAY AND SOCIAL EXPERIENCES

Does your child play alone? How often? _____

List a few activities that your child enjoys: _____

Describe your child's style of play (for example, is he / she assertive, demanding, active, passive, shy, etc.?)

Does he / she have many ideas of his / her own? Does he / she accept other children's ideas?)

Please describe fully:

SEPARATION

How does your child react when parents leave him / her? _____

With whom does the child most often stay? _____

Has child ever been separated from mother and/or father for any length of time? _____

Under what circumstances and what was the reaction? _____

SPECIAL OCCURANCES

Has he / she had any serious accidents? _____ If so, please describe: _____

Has your child ever been hospitalized? _____ If so, under what circumstances: _____

Has any family member been hospitalized during child's lifetime? _____

Has there been a death in the family during child's lifetime? _____

If so, how did he / she react? _____

GENERAL

Does your child have any dramatic fears that you feel the staff should be aware of?

Is there anything else that you feel would be important for your child's teacher to know?

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) (First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number () -	Work Telephone/Cell Phone Number () -	
Parent/Guardian Name	Home Telephone Number () -	Work Telephone/Cell Phone Number () -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)
	Height (must be taken within 30 days for WIC)
	Head Circumference (if <2 Years)
	Blood Pressure (if ≥3 Years)

IMMUNIZATIONS

- ☐ Immunization Record Attached
☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	