Student Enrollment
Application Forms and Documents

Cape May City Elementary School
Cape May City School District
921 Lafayette Street
Cape May, NJ 08204

Enrollment Application Procedures and Instructions

Read these procedures and instructions carefully before filling out the forms.

1. Please make sure to complete the forms thoroughly. If you have any questions, please call the main office at 609-884-8485 and we will be happy to help.
2. The Board of Education reserves the right to request additional information and/or documentation in connection with the application of any student to verify that he or she is, in fact, eligible to attend school free of charge at Cape May City Elementary. The Board of Education also reserves the right to review any student's eligibility to attend Cape May City Elementary School at any time.
3. Students enrolling in the ***Preschool*** program must be at least three (3) years of age, on or before October 1st of the school year. Students enrolling in ***Kindergarten*** must be at least five (5) years of age, on or before October 1st of the school year.
4. Students transferring into Cape May City Elementary must have the Records Request form completed by a parent/guardian so the school district can obtain student's records from the previous school. Initial placement shall be made on the basis of a child's records from his or her previous school. However, such placement may be adjusted at the discretion of the administration depending upon the child's assessment, his or her progress and other such factors. Parents/Guardians will be informed in more detail of this policy pursuant to law.
5. **Important**: Your signature on the attached forms indicates that all information supplied is the truth to the best of your knowledge.

6. In order to complete your child's registration, submit a copy of the following documents:
    a. Child's original birth certificate
    b. Child's complete and updated immunization records (vaccines).
       Preschool Enrollment Requirement *– All children enrolled in Preschool must have a flu shot before December 31st of the school year.*
    c. Medical Examination/Physical conducted by a physician. There is a physical form enclosed.
    d. Proof of residency within the City of Cape May. Submit a copy of the Lease/Rental Agreement or Mortgage Statement/Tax Documentation.
        i. If you are residing with a relative, a notarized letter from the relative is required along with the proof of residency.
        ii. **Coast Guard Personnel** - the Housing Office will provide you with a form for this purpose.

CAPE MAY CITY SCHOOL DISTRICT
CAPE MAY CITY ELEMENTARY SCHOOL

Date: _____

Student's Legal Name:

Last Name	First Name	Middle Name

Gender: _____(M) _____(F) Date of Birth: ____ / ____ / ____ Current Grade: _____

Child's place of birth (country, state, city): _____

Child resides with: (circle one) Both Parents, Mother Only, Father Only, Guardian

Child's Address:

_____

_____

Phone Number: _____ Email: _____

Are you or your spouse an active member of the NJ Coast Guard? ____ (Y) ____ (N)

Parent/Guardian Information:

Father's Name: _____ Mother's Name: _____
Place of Birth: _____ Place of Birth: _____
Occupation: _____ Occupation: _____
Phone: _____ Phone: _____
Guardian's Name (if applicable): _____
Relationship to Child: _____

Child's Needs:

1. Has your child received special education services? i.e. Resource Room, Speech & Language Therapy ____ Yes ____ No
2. Does your child require special help? i.e. Remedial Reading and/or Supplemental Math, other remediations ____ Yes ____ No
3. Does your child show developmental lags in the areas of socialization, attention, following directions, self-help skills, language skills, etc. ____ Yes ____ No
4. Does your child require medical attention? ____ Yes ____ No

If you selected yes to any of the questions above, please explain:

_____
_____

CAPE MAY CITY SCHOOL DISTRICT
CAPE MAY CITY ELEMENTARY SCHOOL

AFFIDAVIT BY PARENT(S) OR COURT APPOINTED GUARDIAN

Child's Name: _____

Parent(s)/Guardian(s) Name: _____

1. Select the statement that is true.

_____ I/We are the parent(s) of the child listed above.
_____ I/We are the guardian(s) of the child listed above and will provide the guardianship paperwork upon registration.
_____ I/We are ***not*** the parent(s) or legal guardian(s) of the child listed above however the child lives in my home and I/we are seeking enrollment. (Complete Form #2 & #3)

2. Please list all of the children living in your home.

Name	DOB	Gender	Grade

3. Length of time at present address: _____

4. Read the following statement and then print and sign at the bottom, confirming that you have read and understand.

I/We fully understand and agree that the information in this application and any submitted documentation is true. I/We also understand that any false statements, information, or answers in this affidavit and any submitted documentation, may subject us to criminal prosecution for the crime of false swearing in violation of NJSA 2c:28-2. The punishment for this crime is a fine of up to $7,500 and/or imprisonment for up to 1 and a half years. I/We may also be personally liable to the Cape May City Board of Education for tuition.

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

CAPE MAY CITY SCHOOL DISTRICT
CAPE MAY CITY ELEMENTARY SCHOOL

RACIAL/ETHNIC IDENTIFICATION FORM

Child's Name: _____

The district is required by state and federal law to report the racial/ethnic make-up of students attending our school. This is not done by individual student; it is done by reporting numbers in each representative group. At this time the district must report only one racial/ethnic category per child. There is an option to select two or more races. However, only one will be used when reporting.

Please select one of the following required racial/ethnic designation for your child. This designation will be used for state and federal reports.

- ☐ White (not Hispanic)
- ☐ African American (not Hispanic)
- ☐ Hispanic
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Two or More Races (not Hispanic)

  List: _____

Parent Signature: _____ Date: _____

CAPE MAY CITY SCHOOL DISTRICT
CAPE MAY CITY ELEMENTARY SCHOOL

PARENT/GUARDIAN LANGUAGE QUESTIONNAIRE

Child's Name: _____ Age: _____ Grade: _____

Parent(s)/Guardian(s) Name: _____

Address: _____
_____

1. Do you speak any language other than English?	_____ Yes _____ No
If yes, please tell us what language(s) you speak. _____	
2. Do you speak any language other than English to your child?	_____ Yes _____ No
If yes, please tell us what languages you speak to your child. _____	
3. What was the first language your child learned? _____	

4. If you speak a language other than English, please answer the following:

When your child speaks to you or others at home, they usually speak…
_____ English only
_____ English and the other language
_____ The other language only

CAPE MAY CITY
ELEMENTARY SCHOOL

Zachary Palombo
Chief School Administrator
Michelle Cannaday
Confidential Secretary

Alexis Cartagena
Supervisor of Student Services
LeeAnne Tarr
Supervisor of Early Childhood

RECORDS REQUEST

Date: _____

Dear Principal,

My child, _____ a former student of _____
Child's Name Name of Former School

located _____
Address of Former School

has been registered at Cape May City Elementary School.

Please send all of the following records you may have for my child to Mr. Zachary Palombo, Chief School Administrator at the address below.

- Scholastic
- Health
- Medical Records
- Discipline
- All Child Study Team/Special Education Records
- Other: _____

Thank you for your prompt attention to this request.

Sincerely,

_____
Parent/Guardian Signature

CAPE MAY CITY SCHOOL DISTRICT
CAPE MAY CITY ELEMENTARY SCHOOL

HEALTH RECORD

Child's Name:	Gender:	DOB:
Address:		Phone:
Father's Name:	Mother's Name:	
Family Physician:	Phone:	

Child lives with (circle one): Both Parents Mother only Father Only Legal Guardian Other

Family Health History

Family	Birth Year	State of Health	Relative Has Had	No	Yes	Relative
Father			Significant Allergy			
Mother			Rheumatic Fever			
Brother			Heart Disease			
			Diabetes			
			Tuberculosis			
Sister			Convulsive disorder			
			Mental Illness			
			Cancer			

Child Birth History

Was mother ill during pregnancy? ___Yes ___ No Child's birth weight: ____ lbs. ____oz.
Complications during delivery? ___ Yes ___ No Difficulty after birth: ___Yes ___ No
Convulsions: ___ Yes ___ No Jaundice: ___ Yes ___ No Scars/Deformities: ___Yes ___ No
If response was yes to any of the above, please explain: _____
_____

Does your child have, or has your child ever had:

	No	Yes	Date		No	Yes	Date
Measles				Rubella			
Mumps				Chickenpox			
Rheumatic Fever				Asthma or wheezing			
Pneumonia or Bronchitis				Frequent sore throats			
Frequent ear infections				Trouble with speech			

	No	Yes		No	Yes
Food Allergies			Eczema or hives		
Tendency to bleed easily			Convulsions or other seizures		
Unusual nervousness, nail biting, or thumb sucking			Difficulty with toilet training or bed wetting		
Breath holding or temper tantrums			Nightmares or trouble sleeping		
Frequent vomiting or diarrhea			Urinary difficulties		
Dental problems			Poor appetite		
Hay Fever, sinus infections			Allergy to medicines		
Headaches			Nervous habits		
Fainting			Wears glasses		
Wears hearing aids			Other allergies: _____		
Bee Sting Allergy					

Medications taken by child: _____

Medical History

	No	Yes
Does your child have any hearing difficulty? If so, explain: _____		
Has your child's hearing ever been tested? If so, where: _____, when: _____ results: _____		
Has your child ever had a vision test? If so, where: _____, when: _____ results: _____		
Has your child had any serious accidents or illnesses? If so, explain: _____		
Has your child ever been hospitalized or had surgery? If so, explain: _____		
Does your child have any current physical problems? If so, explain: _____ _____		
Has your child's physician made any other medical treatment recommendations? If so, explain: _____ _____		
Has your child had any unusual reactions to medical treatment of any kind? If so, explain: _____ _____		

CAPE MAY CITY
ELEMENTARY SCHOOL

Zachary H. Palombo
Chief School Administrator
Michelle Cannaday
Confidential School Secretary

Alexis Cartagena
Supervisor of Student Services
Lee Anne Tarr
Supervisor of Early Childhood Education

Dear Parents and Guardians,

According to N.J.A.C. 6A:16-2.2, for entry into the school district, students must have a medical examination conducted within the last 365 days at the medical home (family physician or advanced practice nurse) with a full report sent to the school on the attached form. The report must be completed and submitted to the school **within 30 days** of registering your child for enrollment to the district. This statute applies only to students who are **new** to the district.

Please be advised that NJ State regulations require us to exclude children from school for noncompliance with this requirement. If your child is already enrolled and has previously attended school in this district, a yearly physical is highly recommended. If your child has had a physical within the last 365 days, please forward a copy to the School Nurse.

Also, please update your child's health information by the first day of school and regularly throughout the school year, especially in light of any changes.

Thank you,
Tiffany Bohn RN, BSN, CSN-School Nurse
Cape May City Elementary

CAPE MAY CITY
ELEMENTARY SCHOOL

Zachary H. Palombo
Chief School Administrator
Michelle Cannaday
Confidential School Secretary

Alexis Cartagena
Supervisor of Student Services
Lee Anne Tarr
Supervisor of Early Childhood Education

Dear Parents and Guardians,

Please notify the school staff immediately upon registration if your child has allergies requiring the use of epinephrine auto injection, asthma, or requires daily medication. An "Authorization for Administration of Medicine in Schools" form must be completed by the child's physician and signed by a parent or guardian. This form is required on the first day of school per New Jersey law in the event any medication has to be administered by the school nurse. Medications in any form cannot be administered without this completed form.

If your child has asthma, please have your physician complete an "Asthmas Treatment Plan" as well.

If your child has allergies that may require the use of an epinephrine auto injection, please have your physician complete the "Anaphylaxis Emergency Action Plan" form as well.

Please have these forms completed and returned on or before your child's first day of school.

Thank you,
Tiffany Bohn RN, BSN, CSN-School Nurse
Cape May City Elementary

Cape May City Elementary School District
Emergency Information and Authorization
School Year: **2023-2024**

Please complete all information on BOTH sides of the paper

Child's Last Name _____ **First** _____ **Middle** _____

Address _____ **Date of Birth:** _____

Home Phone: (____) _____ **Grade:** _____

To Parent/Guardian: To serve you child in case of injury or sudden illness, it is necessary that you give the following information for emergency calls.

Mother/Guardian: _____ Cell Phone _____
Name

Work address/Phone number _____

Father/Guardian: _____ Cell Phone _____
Name

Work address/Phone number _____

List 2 nearby friends or relatives who will assume temporary care of your child if you cannot be reached:

Name: _____ Name: _____

Address _____ Address _____

Phone: Home _____ Cell _____ Phone: Home _____ Cell _____

Relationship: _____ Relationship: _____

Please list other children attending this school (First and Last Name / Grade)

_____ _____

_____ _____

Continued on back of page.

Cape May City Elementary School District
Emergency Information and Authorization
School Year: **2023-2024**

Does 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. If you would like the school nurse to contact NJ FamilyCare on your behalf with your contact information you may sign below to release your name and address to NJFC*.

*Signature _____ Printed name: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b)

List any medical/surgical care your child has received during the past year: _____

Dental exam _____ (Date) Eye exam _____ (Date) Glasses Y / N

Allergies _____ (Type/Medication) Allergic reaction _____

Recent Immunizations _____ (Date/type) Restrictions _____

Doctor _____ Phone _____

Dentist _____ Phone _____

- I, the undersigned, do hereby authorize officials of Cape May City School District 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 form, 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 afore said child.
- I will not hold the school district financially responsible for the emergency care and/or transportation for said child

_____

Signature of Parents(s)/ Guardian(s) Date

Please complete all information on BOTH sides of the paper

Continued on back of page.

Cape May City School District
921 Lafayette Street
Cape May, New Jersey 08204

Report of Physical Examination

Name: _____ DOB: _____

Date of Examination: _____

Significant Medical History: _____

CURRENT STATUS:

Weight: _____ Height: _____

Pulse: _____ Blood Pressure: _____ Respirations: _____

Are these within normal limits for this patient? ___yes ___no

Allergies: _____

Current Medications: _____

GENERAL APPEARANCE:

Skin: _____ Ears (otoscopic): _____ Eyes: _____

Nose: _____ Throat: _____ Teeth/Mouth: _____

Neck: _____ Lymph Nodes: _____ Thyroid: _____

Hernia: _____ Abdomen: _____ Heart: _____

Lungs: _____ Orthopedic (Structural, Posture, Feet): _____

Extremities: _____ Menstruation: _____

Are there any modifications needed for full participation in the school program? ___No ___Yes

Physician's Comments: _____

_____

Examining Physician's Signature: _____

Examining Physician's Phone Number: _____

Visual Acuity: Tracking: _____ Muscle Balance: _____ Color: _____

Glasses ___yes ___no without glasses with glasses

Right	Left

Right	Left

Audiologic Screening: _____pass _____fail

Cape May City Elementary School
921 Lafayette Street
Cape May, NJ 08204
(609) 884-8485 Fax (609) 884-7037

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

_____ has been diagnosed with the following:
Student's Name

_____
Diagnosis/Condition

This diagnosis necessitates that this child receives the following medication during school hours.

Medication: _____

Dosage/Time: _____

Side Effects/Special Instructions: _____

_____

_____ _____
Physician's Signature **Date**

PARENTAL PERMISSION FOR ADMINISTRATION OF MEDICATION AND MEDICAL PRIVACY STATEMENT

1. The School Nurse has my permission to administer medication to my child, _____

   _____, as prescribed by the above physician's orders.

2. *Medical Privacy Statement: To insure the appropriate care of my child, I read and agree that pertinent health information regarding my child may be provided to the school nurse. I further agree that the school nurse may consult with my child's physician regarding the above medical condition.*

_____ _____ _____
Parent Signature **Phone** **Date**