Student: ______________________________ Grade: ________________

HAMMONTON SCHOOL DISTRICT

REGISTRATION GUIDELINES

MUST ALL BE ORIGINALS

BIRTH CERTIFICATE
_____ Saw Original
_____ Saw copy (must produce original within 30 days)

PROOF OF RESIDENCE (any combination of the following)
_____ Letter from Waterford
_____ Driver's License
_____ Property tax bill, deed, settlement sheet, mortgage documents
_____ Utility bill with name and address (electric or gas only)
_____ Notarized affidavit from landlord/family/friends where student and parent/guardian reside. Their names must be listed on letter and also required is proof of address and identification of person submitting letter.
_____ Current rent receipt and lease (must have landlords name, address & phone number on it)
_____ Certificate of Eligibility
_____ DYFS Letter

PROOF OF PARENT (one required)
_____ Driver's License
_____ Birth Certificate (Parent's)
_____ Baptismal Certificate (Parent's)
_____ Marriage Certificate
_____ Passport

CUSTODY PAPERS (if applicable)
_____ Not Applicable
_____ Saw Original of most recent judgment

IMMUNIZATION RECORD
_____Submitted as appropriate

PRIOR SCHOOL
_____Transfer Card (If New Jersey)
_____Grades
_____IEP (If Applicable)

BUS:
______Yes
______ No

HOMEROOM NO______ LOCKER INFO_______STUDENT ID_____

Hammonton School District
Student Information Permanent Record

Student: ______________________________ Homeroom: ____________

Address: ______________________________ Birthdate: ____________

______________________________ Age: ____________

Home Phone: (_____) ______________________________

Email Address: ______________________________

It may be necessary to contact you if your child is ill or if there is an emergency concerning your child.

Mother's Name: ______________________________

Mother's Address: ______________________________

Place of Employment: ______________________________

Address of Employer: ______________________________

Home Phone: ______________________________

Work Phone: ____________________ Cell Phone: ____________________

Father's Name: ______________________________

Father's Address: ______________________________

Place of Employment: ______________________________

Address of Employer: ______________________________

Home Phone: ______________________________

Work Phone: ____________________ Cell Phone: ____________________

Natural Parents are: Married_____ Separated_____ Divorced_____ Other_____

Who lives in the household with your child?

Person's Name:	Relationship to Child: (ex. father, step-father, sister, step-sister, etc.)
1. ____________________	____________________
2. ____________________	____________________
3. ____________________	____________________
4. ____________________	____________________
5. ____________________	____________________

WE MUST HAVE A COPY OF THE MOST RECENT CUSTODY AGREEMENT

Did child attend a Preschool Program? ______ If So, where________________________

Does student have any relatives in his/her grade level? ____________________________

Does student have any relatives that are staff members? ____________________________

____

Name of Previous school | City | State | Country

Was your child in any Special Programs?

Basic Skills Reading____ Language____ Math____ Child Study____ Speech____ Enrichment/Gifted & Talented____ Receiving Counseling____ Bilingual/ESL____ Any Outside Services____

HAMMONTON SCHOOL DISTRICT
FAMILY HEALTH HISTORY

NAME ______________________________ BIRTH DATE __________________ GRADE _____

ADDRESS ____ SEX _____

FATHER ____________________ MOTHER ____________________ TELEPHONE ___________

FAMILY PHYSICIAN ______________________________________ TELEPHONE ___________

IN EVENT OF EMERGENCY (NAME) ____

RELATIONSHIP ____ TELEPHONE ___________

PERSONAL HEALTH HISTORY

BIRTH WEIGHT _____LBS. _____OZ. WALKED ALONE WHEN _____ MONTHS OLD

HAS CHILD HAD ANY OF THE FOLLOWING :	YES	NO	DATE
MEASLES	____	____	______
MUMPS	____	____	______
RUBELLA	____	____	______
CHICKEN POX	____	____	______
RHEUMATIC FEVER	____	____	______
ASTHMA OR WHEEZING	____	____	______
PNEUMONIA OR BRONCHITIS	____	____	______
FREQUENT SORE THROATS	____	____	______
FREQUENT EAR INFECTIONS	____	____	______
TROUBLE WITH HEARING	____	____	______
TROUBLE WITH SPEECH	____	____	______
TROUBLE WITH VISION	____	____	______
FREQUENT VOMITING OR DIARRHEA	____	____	______
TENDENCY TO BLEED EASILY	____	____	______
ECZEMA OR HIVES	____	____	______
CONGENITAL DEFECTS	____	____	______
HEPATITIS	____	____	______
NEURO MUSCULAR DISEASES	____	____	______
DIABETES	____	____	______
R.H. FACTOR	____	____	______
BONE DEFECTS	____	____	______
CONVULSIONS OR OTHER SEIZURES	____	____	______
UNUSUAL NERVOUSNESS, NAIL BITING OR THUMB SUCKING	____	____	______
NIGHTMARES OR TROUBLE SLEEPING	____	____	______

	YES	NO	DATE
BREATH HOLDING OR TEMPER TANTRUMS	____	____	______
DIFFICULTY TOILET TRAINING OR BED WETTING	____	____	______
KIDNEY OR BLADDER PROBLEMS	____	____	______
ANY SEVERE INJURY	____	____	______
ANY SEVERE ILLNESSES	____	____	______
ANY OPERATIONS	____	____	______
ALLERGIES	____	____	______

FAMILY HEALTH HISTORY

HAVE ANY RELATIVES IN THE FAMILY HAD:

	YES	NO	RELATIVE
SIGNIFICANT ALLERGIES	____	____	__________
RHEUMATIC FEVER	____	____	__________
HEART DISEASE	____	____	__________
TUBERCULOSIS	____	____	__________
CONVULSIVE DISORDER	____	____	__________
MENTAL ILLNESS	____	____	__________
CANCER	____	____	__________
DIABETES	____	____	__________

ALL MEDICAL INFORMATION IS KEPT STRICTLY CONFIDENTIAL. IN ORDER TO KEEP YOUR CHILD WELL AND SAFE DURING THE SCHOOL DAY, BY SIGNING BELOW, YOU WILL ALLOW THE NURSE TO SHARE PERTINENT MEDICAL INFORMATION WITH APPROPRIATE SCHOOL PERSONNEL.

PARENT/GUARDIAN SIGNATURE:______________________________

NOTES FOR NURSE USE ONLY

IMMUNIZATIONS:

DPT	________	________	________	________
POLIO	________	________	________	________
MEASLES	________	________		
MUMPS	________	________		
TB	________	________		
HIB	________________			
HEP B	________________			

Sample Medicaid Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent .

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) ____Mailed to parent(s) ____Emailed to parent(s) ____IEP meeting ____ Hand Delivered

Hammonton Public Schools

566 Old Forks Road
PO Box 631
Hammonton, NJ 08037-0631
(609) 567-7000 • Fax (609) 561-3567
Website: www.hammontonps.org

C. Dan Blachford, Ed.D
Superintendent of Schools

John Lavell
Supervisor of Special Education

Special Education Medicaid Initiative (SEMI) Parental Consent form

____ School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district <u>does not</u> impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: ______________________________

Child's Date of Birth: ____/______/______

Parent/Guardian: ____

Date: ___/____/____

I give consent to bill for SEMI: Yes ☐
No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

HAMMONTON SCHOOL DISTRICT

HOME LANGUAGE SURVEY

The information on this survey is used to determine eligibility for bilingual/ESL services and the diversity of native languages we must report to the New Jersey Department of Education. We appreciate your cooperation in completing this form.

____

Today's date

Student's Full Name ____ **Grade** ____________

Address ____

Date of Birth ______________ **Age** _______ **Place of Birth** ______________________

Parent(s)/Guardian(s) Name(s) ____

Nationality (Optional) ____________________ **Phone Number** ______________________

First registration date as a new student in Hammonton ______________________________

Language Information

(*Please check appropriate line below.*)

What language did your child first speak? English _____ Spanish _____ Other ____________ (specify language)

What language do you, as **Parent/Guardian**, speak **most often** to your child at home? English _____ Spanish _____ Other ____________ (specify language)

What language does **your child speak most often** at home? English _____ Spanish _____ Other ____________ (specify language)

What language does **your child use most often when speaking to other family members** in your household? English _____ Spanish _____ Other ____________ (specify language)

What was the FIRST DATE (month/day/year) your child was registered into a United States school? ____________________

If your child has attended other schools in the U.S., how many years does this total? ________

Thank you for completing this survey.

DISTRICT USE ONLY (Please forward copy to secretary for BE & ESL Services at ECEC)

	Y	N			
			ISGE	☐ Y	☐ N
NLOTE	☐	☐	SY 20__-__	YR_____	
IPT	☐	☐	SY 20__-__	YR_____	
LEP	☐	☐	SY 20__-__	YR_____	

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