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 (at least two from the following categories)

_____ Letter from Waterford
_____ Driver's License
_____ Current property tax bill, deed, settlement sheet or mortgage documents
_____ Current utility bill with name and address and service location (gas or electric only)
_____ Current lease and rent receipt (must have landlord's name, address and phone number)
Lease must list all occupants.
_____ Certificate of Eligibility
_____ DCPP/DYFS letter

PROOF OF PARENT (one required)

_____ Driver's License
_____ Birth Certificate (Parent's)
_____ Marriage Certificate
_____ Baptismal Certificate (Parent's)
_____ Passport

CUSTODY PAPERS (if applicable)

_____ Not Applicable
_____ Saw original of most recent judgment

IMMUNIZATION RECORD

_____ Submitted as appropriate

PRIOR SCHOOL
_____ Transfer Card
_____ Grades
_____ IEP (if applicable)

BUS:
_____ YES
_____ NO

HOMEROOM #__________ 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_____

Is the student's parent or guardian on Active Duty, in the National Guard or in the Reserve components of the United States Military Services? Yes or No

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 BOARD OF EDUCATION

Student Residency Questionnaire

Name of Student: ____

Date of Birth: ____________________ Grade: ______ Sex: O Male O Female

Name of Parent/Legal Guardian: ____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435.
The answers to this residency information help to determine the services the student may be eligible to receive.

Is your current address a temporary living arrangement? O No O Yes

If you answered NO to the above question, please sign below. If you answered YES please continue.

Is this temporary living arrangement due to the loss of housing or economic hardship? O No O Yes

If you answered NO to the above question, please sign below. If you answered YES please continue.

Presenting a false record or falsifying records is an offense under Section 37.10, PENAL code & enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

______________________________ ____________________
Parent/Guardian Signature Date

Temporary Residence: ______________________________ O Family O Friend O Other ________

______________________________ O < 6 months O 6-12 months O 12 months

Previous Permanent Residence: ____

Resided at this address *longer* than 1 year O YES, Previous school/district attended: ____________________

Resided at this address *less than* 1 year O No, Previous school/district attended: ____________________

AND address of residence at that time: ____

I, the parent/guardian understand that the district of origin will make the decision for placement based on the best interests of the child after consulting with me. If I disagree with that decision, I know that I may appeal to the County of Superintendent of Schools.

Placement Request: O Return to previous school O Attend Hammonton Public Schools O Other

District Responsible for Tuition: ______________________ Liaison Contacted: ______________

District agrees with placement: O YES O NO ______________________________

Parent/Guardian agrees with placement: O YES O NO

I acknowledge I am currently in a homeless situation and residing at the temporary address I have provided above.

______________________ /__________ ______________________ /__________
Parent/Guardian Signature Date Homeless Liaison Signature Date

---

Office Use Only

______ Email Notification
(Principal / Counselor / Guidance Secretaries / Transp. Homeless Liaison/ Technology / Free & Reduced Lunch)

______ Realtime *Federal Tab*
______ Email to Dist. of Origin
______ Registrar School Code

______ Notification to Business Office
McKinney-Vento Form _____Signed ____Faxed

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 ________

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)

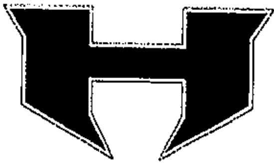
What was the FIRST DATE (month/day/year) your child was registered into a United States school? ____________

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		Y	N
			ISGE	☐	☐
NLOTE	☐	☐	SY 20_ _ - _ _	YR______	
IPT	☐	☐	SY 20_ _ - _ _	YR______	
LEP	☐	☐	SY 20_ _ - _ _	YR______	



Hammonton Public Schools

566 OLD FORKS ROAD
HAMMONTON, NJ 08037
Phone: 609-567-7000
Website: www.hammontonschools.org

Supervisor of Special Services
Sharon DeNafo, Ed.S. NCSP (ext. 343)

Medicaid (SEMI) 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.

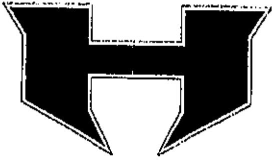
What type of services does the School-Based Program cover?

Evaluations	Psychological Counseling
Speech Therapy	Audiology
Occupational Therapy	Nursing
Physical Therapy	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.



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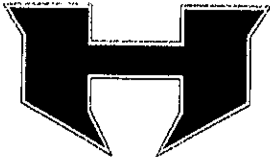
Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

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



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Special Education Medicaid Initiative (SEMI) Parental Consent Form

The Hammonton 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 the 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.

PLEASE COMPLETE THE FOLLOWING:

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 insurance to pay for special education or related services under Part 300 (services under the IDEA).

Please Print:

Child's Name:________________________________

Child's Date of Birth: _____/________/_________

Please Print:
Parent/Guardian's Name: ______________________________________

Please Provide Signature
Parent/Guardian:____ Date:____/_____/_____

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

This consent can be revoked at any time by contacting Sharon DeNafo at (609)567-7000 ext 343.