REGISTRATION REQUIREMENTS

Please complete the attached forms and return them to the appropriate school at the time of registration:

☐ PROOF OF AGE:

Original birth certificate or passport.

☐ MEDICAL:

Copy of immunization records. Please note that your child will not be able to attend school unless the Physical Examination/Immunization Form is completed and signed by your child’s physician. The physical exam must be no more than one year old as of the first day of attendance. If your child’s last physical exam does not meet these guidelines, please bring in proof of his/her immunization records and submit the updated physical before the first day of school. Also note that there are additional immunization requirements if you are registering a student in the 6th grade or higher.

☐ PROOF OF RESIDENCE:

Homeowners – Deed or Property Tax Statement
Renters – Current, signed lease with full names of all persons living at the address.
Non-Leaseholders – (You rent but do not have a lease or you reside with a family member.) Please complete the attached Affidavit of Owner/Landlord. If you are renting from the owner please attach a copy of the owner’s deed or property tax statement. If you are renting from a renter please attach a copy of the renter’s current signed lease.

☐ Unofficial copy of transcript and / or report card from previous school.
THE SOMERSET HILLS SCHOOL DISTRICT
Entrance Registration

Part 1: Student Information:

Student’s Legal Name ____________________________ Date of Birth: ____________________________
(last, first, middle) Gender: M F
Residence Street, City, Zip ____________________________
Mailing address (if different) ____________________________ (street, city, state, zip)
Siblings in District (name & grade) ____________________________

Ethnic Background (Required – Please check all that apply. See end of form for explanation.)

___ American Indian/Alaskan Native ___ Native Hawaiian/Pacific Islander ___ Asian

___ Black or African American ___ White or Caucasian ___ Hispanic or Latino

Country of Birth ____________________________ State of Birth ____________________________ City of Birth ____________________________

What was the first language your child learned to speak? ____________________________

Please indicate the primary language spoken at home, regardless of the language spoken by the student:

English ___ Spanish ___ Other ____________________________ (please specify)

What is the language most often spoken by the student? ____________________________

Part 2: Parent Information:

Parent(s)/Guardian(s) with whom student resides:

Name ____________________________ Relationship ____________________________ Cell Phone ____________________________

Name ____________________________ Relationship ____________________________ Cell Phone ____________________________

Home Telephone ____________________________ Other Telephone ____________________________ (specify)

Mother email address ____________________________ Father email address ____________________________

**If student does not reside with parent(s), proof of legal custody or guardianship papers must be attached**

Information about non-resident parent (if applicable):

Name ____________________________ Relationship ____________________________

Mailing address ____________________________ City, State, Zip ____________________________

Home Phone ____________________________ Cell or Business Phone ____________________________ Addl mailing required Y N

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.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: ____________________________ Printed Name: ____________________________ Date ____________________________

Written consent required pursuant to 20 U.S.C. § 1232g (b) (l) and 34 C.F.R. 99.30 (b).
Part 3: School information

Grade registrant is entering: ____________________ Last grade completed: ____________________

School name and address transferring from: _____________________________________________

________________________ (city, state)

What date did your child first enter a U.S. School (mm/dd/yyyy)? ________________________

Is your child currently receiving, or has your child ever received special education services through the school?  Y  N

Does your child currently have an IEP (Individual Educational Program)?  Y  N

Has your child ever been excluded from school as a result of a weapons charge?  Y  N

Has the registrant ever attended school in the Somerset Hills School District?  Y  N If Yes, Grades attended__________

I certify that the information provided herein is true and accurate:

Signature of parent or legal guardian _____________________________________________ Date ___________________

Explanation of ethnicity questions:

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race.

American Indian or Alaska Native – A person having origins in any of the original people of North and South America (including Central America) and who maintains a tribal affiliation or community attachment.

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White or Caucasian – A person having origins in the original peoples of Europe, the Middle East, or North Africa.

For Office Use Only

Type of Proof of Residency Submitted: ____________________________ Type of DOB proof: ____________________________

Starting date: ________________ Student #: ____________________ Counselor: ________________ Homeroom: ________________

Copies made of original documents to be placed in file: ___________________________ Date: ___________________________
THE SOMERSET HILLS SCHOOL DISTRICT
Student Transportation Request Form
(for eligible students)*

Student: _______________________________ Grade: ______

Home Address: __________________________________________

Mailing Address: _________________________________________

Home Telephone: _________________________________________

Cell Phone: _____________________________________________

Nearest intersection to student’s residence: ______________________

Parent/Guardian Name: _____________________________________

Siblings in district (list names, grades) __________________________

Will you be using before or after care program: _____ Before _____ After _____

Will your child be going to a childcare provider: ________________

If yes, please provide child care provider name/address/telephone

Name: ____________________________________________________

Address: __________________________________________________

Telephone: _________________________________________________

Transportation requests for new students will take five (5) days for processing

*The Transportation Office will determine eligibility for state-mandated or subscription busing

********************************************
Office Use Only:

Bus Pass Issued ______ Bus Route #:______ Bus Stop #:______
Subscription _______ Payment received _______ Check #:_______
Walker _____________
Train Pass Issued (9-12 only) _______ Student ID#:_____________
## SOMERSET HILLS SCHOOL DISTRICT

### AFFIDAVIT OF OWNER/LANDLORD

<table>
<thead>
<tr>
<th>Landlord Information</th>
<th>Tenant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Landlord:</strong></td>
<td><strong>Name of the Family:</strong></td>
</tr>
<tr>
<td><strong>Street Address:</strong></td>
<td><strong>Street Address:</strong></td>
</tr>
<tr>
<td><strong>City:</strong></td>
<td><strong>City:</strong></td>
</tr>
<tr>
<td><strong>Phone Number(s):</strong></td>
<td><strong>Phone Number(s):</strong></td>
</tr>
</tbody>
</table>

### Lease Information

*Please specify the terms of the lease:*

Relation to Renter: ___ No Relation ___ Family Member(s)

When did the tenant(s) move in? __/__/___

How long is the agreement effective? Until: __/__/___

What kind of rental agreement? ____________________________

List the names of all persons living in the apartment/house:

_________________________  ____________________________

I attest that, to the best of my knowledge, the information is true and correct and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.

Sworn and subscribed before me this ____________ day of ________________

_________________________  ____________________________

Signature of Tenant  Date

_________________________  ____________________________

Signature of Landlord  Date

Notary Public of New Jersey
Somerset Hills School District
Please send records to appropriate school listed below

RELEASE OF RECORDS

I hereby give my permission for:

________________________________________
Name of school student is leaving

_____________________________________
Street Address

__________        ___________        ___________
Town            State           Zip Code

To send all records (HEALTH, STANDARDIZED TEST RESULTS, PAST & MOST
RECENT REPORT CARDS, ANY DISCIPLINARY AND/OR SPECIAL SERVICES
RECORDS) for the student(s) listed below who are in the process of registering.

1. ____________________________________ Grade__
2. ____________________________________ Grade__
3. ____________________________________ Grade__
4. ____________________________________ Grade__

Send complete records to the appropriate school listed below:

Bedwell Elementary K-4   Bernardsville Middle School 5-8   Bernards HS 9-12
141 Seney Drive          141 Seney Drive               25 Olcott Avenue
Bernardsville, NJ 07924  Bernardsville, NJ 07924     Bernardsville, NJ
Fax # 908-204-0481        Fax # 908-953-2874           Fax # 908-766-9223

________________________________________
Parent/Guardian Signature

_____________________________________
Date
Return this form **ONLY** if you **DO NOT** want your child to be photographed

The Somerset Hills School District  
25 Olcott Avenue  
Bernardsville, NJ 07924

Date: ______________

I **DO NOT** want The Somerset Hills School District, or anyone authorized by The Somerset Hills School District, to use and reproduce photographs/videos of my child participating in school events for use in the newspapers or Somerset Hills School District publications.

Student: ___________________________________ Grade: ______

Address: ______________________________________

City: __________________ State: __________________ Zip: ______

Signature of Parent or Guardian: ______________________________________

*(If this form is not returned, The Somerset Hills School District understands permission is granted for use of all photographs.)*
THE SOMERSET HILLS SCHOOL DISTRICT

HEALTH EXAMINATION RECORD

TO PARENTS: A health examination by your family physician is important to your child's welfare and to the school in adapting its program to individual needs. It is recommended that your child be examined before entering school and periodically thereafter according to the recommendations of your child's physician and the school district. Please fill out your portion of this form. Have your physician complete their part when your child is examined.

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>Last</th>
<th>First</th>
<th>Initial</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF PARENT: (or Guardian)</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Work)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IN EMERGENCY NOTIFY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; Relationship</td>
</tr>
</tbody>
</table>

| Physician | Address | Phone |

| Dentist | Address | Phone |

HEALTH HISTORY (Check)

<table>
<thead>
<tr>
<th>DISEASES:</th>
<th>ALLERGIES:</th>
<th>OPERATIONS OR SERIOUS INJURIES (Dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>Hay Fever</td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Strep Throat</td>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Insect Stings</td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td>Ivy, Oak, Etc.</td>
<td></td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

SUGGESTIONS FROM PARENTS:

OTHER DISEASES OR DETAILS OF ABOVE

ANY OTHER PERTINENT INFORMATION

SPECIFIC ACTIVITIES TO BE RESTRICTED:

SPECIAL MEDICAL OR DIETARY REGIMEN:

PARENT'S SIGNATURE ____________________________ Date ____________

(Over)
# TO BE COMPLETE BY PHYSICIAN

**Student Name:**

<table>
<thead>
<tr>
<th>IMMUNIZATIONS'</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Td</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Polio</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hib Specify Type</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>HBG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(Specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate (PCV 7)</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Pneumococcal</td>
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<td></td>
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</tr>
<tr>
<td>Influenza</td>
<td>1a</td>
<td>1b</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis B Serology Date:</td>
<td>Titer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella Serology Date:</td>
<td>Titer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles Serology Date:</td>
<td>Titer:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physical Examination**

<table>
<thead>
<tr>
<th>DATE OF EXAMINATION:</th>
<th>CODE: Satisfactory ✓</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not Satisfactory X</td>
</tr>
<tr>
<td></td>
<td>Not Examined O</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heights</th>
<th>Throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Teeth</td>
</tr>
<tr>
<td>B.P.</td>
<td>Heart</td>
</tr>
<tr>
<td>Appearance, Nutrition</td>
<td>Lungs</td>
</tr>
<tr>
<td></td>
<td>Abdomen</td>
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<tr>
<td>Eyes</td>
<td>Genitilia</td>
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<td></td>
<td>Hernia</td>
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<td></td>
<td>Skin</td>
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<td></td>
<td>Musculoskeletal</td>
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<td>Ears</td>
<td>Hearing R</td>
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<td></td>
<td>Scoliosis</td>
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<td></td>
<td>Urinalysis</td>
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<td>(Hr/Hct)</td>
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</table>

**PHYSICIAN’S COMMENTS AND RECOMMENDATIONS:**
Give Details of Management of Significant Illnesses

**Address:** (Stamp) 

---

**Tel. No.**

---

**Signature:** ____________________________ M.D.