
Welcome to
Kindergarten

FRANKLIN TOWNSHIP SCHOOL DISTRICT

Lindsay Gooditis, Principal

Home of the Lions

226 Quakertown Road, Quakertown, NJ 08868
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www.ftschool.org · #PawPride

January 14, 2020

Dear Parent/Guardian:
Preschool children who will be five on or before October 1st, are invited to the annual kindergarten registration of the Franklin Township School scheduled for March 30 and March 31. To enable us to formulate the best possible educational plan for your child, registration will take approximately 20-30 minutes. During this time, screening will occur by the following staff: kindergarten, physical education, speech language therapist and the school nurse. At the completion of each screening, assessments will be reviewed with you.

School policy is to have your family physician complete the physical examination. If your child's physical has been done within the last year (365 days), please submit this documentation. If the physical examination has not occurred within the last year (365 days), kindly have the enclosed physical form completed by your family doctor. We strongly recommend that your child have a dental examination prior to entering school, if he/she has not had one in the last six months.

Immunizations:
The Franklin Township Board of Education is required to follow the New Jersey Department of Health and Senior Services (DHSS) vaccine mandates. Please provide the day of the appointment, a hard copy of the most recent immunizations, or your signed Religious Exemption letter. If you have any questions, please call the school nurse at 908-735-7929 x214.

Please call the school office at 908-735-7929 x200 to schedule an appointment. Please bring the following records with you on the date of your appointment:

1. The child's birth certificate. (Original)
2. Physical form filled out by your doctor and immunization record
3. School Enrollment Form
4. Progress report from preschool
5. Proof of Residency
6. Home Language Survey

Since this is a very special day for your pre-kindergarten child and he/she needs your undivided attention, we request that no other children be brought with you on this day.

Sincerely,

Lindsay Gooditis

Lindsay Gooditis
Principal

Franklin Township School
Quakertown, New Jersey 08868

ENTRANCE REGISTRATION FORM Date_____

1. Pupil's full name_____
   Last ***First*** ***Middle***
2. Sex_____ Ethnicity/Race _____Birth Date_____
   (Not Optional)
3. Place of Birth_____
   City ***State*** ***Country***
4. Name of Parent or Guardian_____
5. Marital Status of Parents: (circle one) Married Divorced Separated
6. Custody Disposition_____(copy of order needed if entered).
7. Address of Parent or Guardian_____
   Street *City* *Zip*

7A. Will your family be residents of Franklin Township as of the first day of your child(ren)'s enrollment?
(Circle one) Yes No If No, explain_____

_____

7B. New Construction (Circle one) Yes No Resale (Circle one) Yes No

8. Home Telephone_____
9. Email Address_____
10. Are both parents living at home? (Circle one) Yes No Absent: father mother
11. Name of Father_____Occupation_____
    Place of Employment_____Telephone_____
    Name of Mother_____Occupation_____
    Place of Employment_____Telephone_____
12. Mailing address if different from item 7_____

_____

13. Other children in the family:

BOYS	GIRLS
Number older_____	Number older_____
Number younger_____	Number younger_____

14. Language first used by student_____
15. Primary language spoken in the home_____

16. School last attended_____

17. Address of school_____Telephone_____

18. Dates of Attendance_____Name of Teacher in last year_____

19. Date of withdrawal from previous school_____

20. Grade on last day attended_____

21. Was this student receiving services under speech therapy, resource room, a program for exceptional children or special education? (Circle one)Yes No
If yes, please describe program_____

_____

22. Please describe any condition(s) that would prevent your child from participating in a full school program in Franklin Township_____

_____

_____ _____

Signature of Parent or Guardian *Date*

Franklin Township School Emergency Care Form

PLEASE COMPLETE ALL INFORMATION BELOW:

Student's Name_____Home Phone _____

Address_____ Please check if this ☐ is a new address

(Please notify the school if the above address changes during the school year)

Grade _____ **Teacher's Name** _____ **Date of Birth** _____

Please list telephone numbers at which parents can be reached.

1. _____ **2.** _____

Cell Phone Numbers:

Mom's Cell _____ **Dad's Cell** _____

Mom's Work _____ **Dad's Work** _____

EMAIL ADDRESS_____

Please list name and telephone number of two people whom we may contact in case your child becomes ill and we can't contact you.

1. _____Phone_____

2. _____Phone_____

List of any known allergies:_____

Please list any current health problems:_____

Is medication required: Yes_____ No_____

Does your 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 please 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)(1) and 34 C.F.R. 99_30 (b).

Please indicate in the space below if there has been a divorce or separation since the previous school year. If there has been a divorce or separation and the non-custodial parent cannot sign the child out of school, legal documentation must be provided.

***PLEASE BRING CUSTODY PAPERS TO BE KEPT ON RECORD (CONFIDENTIAL)**

No Change in Marital Status _____ Divorce _____ Separation _____

Non-Custodial Parent May _____ May Not _____ sign child out of school.

In case of an accident or serious illness, I request the school to contact me. It will be the parent/guardian responsibility to come to the school for the child. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary for the welfare of my child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

FAMILY DOCTOR _____Phone_____

I have carefully read and understand the attachment explaining the school's EARLY ALERT PROGRAM. By affixing my signature below & by providing the appropriate information, I agree to be bound by the terms of the EMERGENCY CARE AND EARLY ALERT procedures.

_____ _____

Date Parent's Signature

(over)

AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES

Our School Medical Inspector, Ronald M. Frank, MD has authorized the administration of the following medications by the School Nurse in the School Health Office. However, parental/guardian permission is required before a student can receive any of the listed medications. If you would like your child to be able to receive any of the listed medications in school if needed, please complete the following and return it to the Health Office. Students will receive only ONE DOSE during the school day.

The following section is to be completed by the PARENT/GUARDIAN:

_____ _____

Student's Name Date

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.: 6A: 16-2 3. I understand the ultimate responsibility for administration of the medication is mine and I am fully aware that the duties of the School Nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

I authorize the administration of (check all that apply):

☐ Acetaminophen dosed according to weight and product label.

☐ Ibuprofen dosed according to weight and product label.

☐ TUMS® dosed according to product label.

Signature (parent/guardian):_____

Printed Name:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

RECOMMENDATIONS ARE EFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY.

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

_____.

*Restrictions:(please describe)_____

_____

_____

*Must have physicians orders.

Dental Exam:_____ _____

Date Braces

Eye Exam:_____ _____

Date Glasses/Contacts

Home Language Survey*
Parent/Guardian Language Questionnaire

PLEASE PRINT

Name:_____ Age: _____
[First] [Middle] [Last]

Date of School Entrance_____

Child's Native Language_____

Country of Origin_____ Date of Arrival in US_____

Siblings at Home:

_____English_____Other Language_____
_____English_____Other Language_____
_____English_____Other Language_____
_____English_____Other Language_____
_____English_____Other Language_____
_____English_____Other Language_____

Other Adult Members of the Family:

_____English_____Other Language_____

_____English_____Other Language_____

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English_____ Other [specify]_____

2. What language does the family speak at home most of the time?

   English_____ Other [specify]_____

3. What language does the mother [guardian] speak to the child most of the time?

   English_____ Other [specify]_____

4. What language does the father [guardian] speak to the child most of the time?

   English_____ Other [specify]_____

5. What language does the child speak to his/her mother most of the time?

   English_____ Other [specify]_____

6. What language does the child speak to his/her father most of the time?

   English_____ Other [specify]_____

7. What language does the child speak to his/her friends most of the time?

   English_____ Other [specify]_____

8. Please list any previous schooling:

   A. Name of School[s]_____

   Location [City/Country]_____

   Grades Completed_____

   Dates of Attendance_____

   Language[s] of Instruction_____

   B. Name of School[s]_____

   Location [City/Country]_____

   Grades Completed_____

   Dates of Attendance_____

   Language[s] of Instruction_____

9. Please list any previous ESL/Bilingual program attended, if any:

   Place: _____ Dates attended: _____

10. In which language do you wish to receive school communication?

    English_____ Other [specify]_____

Signature: _____ Date: _____
[Person completing the survey]

FRANKLIN TOWNSHIP
HUNTERDON COUNTY
NEW JERSEY

PROOF OF RESIDENCEY

☐ COPY OF LEASE ATTACHED

☐ COPY OF DEED ATTACHED

Birth Certificate

☐ Original Birth Certificate (to be copied)

Custody Papers, If Applicable

☐ Custody Papers Enclosed

Franklin Township School

HEALTH EXAMINATION RECORD

NAME_____ DATE_____

BIRTHDATE _____Parent/Guardian Signature_____

To be completed by physician:

A. **HISTORY**

1. List any allergies:_____
2. Are there any significant health problems of which the school health personnel should be aware?_____
3. Is child taking any daily medication? If yes, please list:_____
4. Is there any past history of serious illness, injury or operation?_____
5. Is there any family history of significant heritable disease?_____

B. **PHYSICAL EXAMINATION**

Height _____ Weight _____ B.P._____

Visual Acuity: Od_____ Os_____ **corrected**_____yes_____no

Hearing_____

Check the following if normal. If abnormal, indicate and explain in detail to the side.

_____Head
_____Eyes
_____Ears
_____Nose
_____Mouth
_____Dentition
_____Throat
_____Thyroid
_____Lungs
_____Heart
_____Abdomen
_____Genitalia
_____Extremities
_____Neurologic
_____Back
_____Scoliosis
_____Skin
_____Nodes

C. **TB TESTING**

Test date_____Date Read_____ Result_____INH Therapy _____Prescribed _____
Not Prescribed_____

D. **IMMUNIZATIONS** (Please insert month, day and year). Please refer to Parent/Student Handbook for NJ mandated immunizations.

D.P.T.	1._____	2._____	3._____	4._____	5._____	6._____
I.P.V.	1._____	2._____	3._____	4._____		
MMR	1._____	2._____				
HIB	1._____	2._____	3._____	4._____		
Varivax	1._____	2._____				
Hep B	1._____	2._____	3._____			
Meningococcal (age11)	1._____					

E. LEAD TEST

Test date _____Result_____

Physician's address and phone number:

Physician's Signature_____

Physician's Name - PLEASE PRINT