

## Hainesport Township School District

Mr. Joseph R. Corn  
Superintendent  
[jcorn@hainesport.k12.nj.us](mailto:jcorn@hainesport.k12.nj.us)

Mrs. Meredith Gocke  
Confidential Secretary  
[gocke@hainesport.k12.nj.us](mailto:gocke@hainesport.k12.nj.us)

Form R-1

### Proof of Residency/Domicile

The Hainesport Board of Education has policies and procedures related to "Proof of Domicile" for students who attend Hainesport Township School. These policies and procedures are based upon New Jersey Statutes Annotated 28-2.5 and New Jersey Administrative Code 18A: 38-1. A procedure requiring proof of current domicile in Hainesport is mandatory for all new registrants at the time of registration.

*Domicile is defined as "an individual's true, fixed, and permanent place or home to which whenever absent he or she has the intention of returning." Whether a family is renting an apartment, purchasing a home, or moving in with another Hainesport resident, concrete proof of domicile as defined by N.J.S.A.18A:38-1 et seq. shall be provided before the pupil is enrolled into Hainesport Township School.*

Any false or fraudulent statements, answers, or declarations contained in Affidavits or in the application for admission may render the applicant personally liable to the Hainesport Board of Education for the payment of tuition for any period of unlawful attendance. Tuition rates are determined annually in June for the next school year.

Applicants who fraudulently allow a child to use their residence or who fraudulently claim to have given up custody may be charged with a Disorderly Persons Offense. If the applicant is convicted of such an offense, the applicant may be fined up to \$1,000.00 and/or imprisoned for up to six months. Any false statements, answers, or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A.2C:28-2. If convicted of such a crime, the applicant may be punished by a fine of \$7,500.00 and/or imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understand the contents of this notification.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

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Form R-2

## Kindergarten Registration Data Form for School Year 2024-2025

| Student Information:                              |       |                                                   | Registration Date:                                |
|---------------------------------------------------|-------|---------------------------------------------------|---------------------------------------------------|
| Last                                              | First | Middle                                            | Grade Level:                                      |
| Date of Birth:                                    |       | Gender:                                           | City of Birth:                                    |
| Home Phone:                                       |       | U.S. Citizen:                                     | Race/Ethnicity:                                   |
| Primary Language Spoken at Home:                  |       |                                                   | Mailing Address (if different from Home Address): |
| Street:                                           |       |                                                   |                                                   |
| City:                                             |       | Zip Code:                                         |                                                   |
| P.O. Box # if applicable:                         |       |                                                   |                                                   |
| Siblings                                          |       |                                                   |                                                   |
| Name:                                             |       | Name:                                             |                                                   |
| Date of Birth:                                    |       | Date of Birth:                                    |                                                   |
| Parent(s)/Guardian(s)                             |       |                                                   |                                                   |
| Parent/Guardian #1                                |       | Parent/Guardian #2                                |                                                   |
| Name:                                             |       | Name:                                             |                                                   |
| Relationship:                                     |       | Relationship:                                     |                                                   |
| Address (leave blank if same as student address): |       | Address (leave blank if same as student address): |                                                   |
| Street:                                           |       | Street:                                           |                                                   |
| City:                                             |       | City:                                             |                                                   |
| Zip Code:                                         |       | Zip Code:                                         |                                                   |
| Home Phone:                                       |       | Home Phone:                                       |                                                   |
| Cell Phone:                                       |       | Cell Phone:                                       |                                                   |
| Work Phone:                                       |       | Work Phone:                                       |                                                   |
| Email Address:                                    |       | Email Address:                                    |                                                   |
| Employer:                                         |       | Employer:                                         |                                                   |
| Student Health Insurance Provider:                |       |                                                   |                                                   |
| Emergency Contacts                                |       |                                                   |                                                   |
| Name:                                             |       | Name:                                             |                                                   |
| Relationship:                                     |       | Relationship:                                     |                                                   |
| Home Phone:                                       |       | Home Phone:                                       |                                                   |
| Cell Phone:                                       |       | Cell Phone:                                       |                                                   |

HOME OF THE HAWKS

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Form R-2 (pg. 2 of 2)

### Registration Data Form for School Year 2023-2024

#### Residence Information

\*Please note, your response to the question below will not affect enrollment.

Is your family living with a friend/relative due to loss of housing, economic hardship, or homelessness? Yes \_\_\_\_ No \_\_\_\_

#### Custody Information

Is there a joint custody agreement or parenting plan in effect? Yes \_\_\_\_ No \_\_\_\_ If yes, copies of custody agreements and/or court orders must be provided and kept on file with the school for enforcement.

#### Student Services

Has the student ever been retained? Yes \_\_\_\_ No \_\_\_\_ If yes, what grade(s)? \_\_\_\_\_

Has the student ever been homeschooled? Yes \_\_\_\_ No \_\_\_\_ If yes, what grade(s)? \_\_\_\_\_

Has the student ever received any of the following services? (Please check all that apply.)

- ☐ Special Education
- ☐ 504 Plan
- ☐ Gifted & Talented
- ☐ ELL/ESL services
- ☐ Remedial Reading
- ☐ Remedial Mathematics
- ☐ Other (Please explain): \_\_\_\_\_

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Form R-8

### New Jersey Home Language Survey

#### Purpose

The home language survey is used solely to offer appropriate educational services ([U.S. ED EL Toolkit](#), Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

#### Student Information

Student Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Current Address: \_\_\_\_\_

#### Survey Questions

1.) List all languages used in the student's home:

\_\_\_\_\_

2.) Was the first language used by the student a language other than English?

\_\_\_\_\_ No \_\_\_\_\_ Yes

3.) Does the student speak or understand a language other than English?

\_\_\_\_\_ No \_\_\_\_\_ Yes

4.) When interacting with others at home (for example: parents, guardians, siblings), does the student understand or use a language other than English ***most of the time***?

\_\_\_\_\_ No \_\_\_\_\_ Yes

5.) When interacting with others outside the home (for example: friends, and caregivers), does the student understand or use a language other than English ***most of the time***?

\_\_\_\_\_ No \_\_\_\_\_ Yes

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Form R-3

### NJ FamilyCare Act Form

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private, or other?

☐ NO. My child does not have health insurance.

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). NJ FamilyCare provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information visit <http://www.nifamilycare.org/default.aspx> to apply online or call 1-800-701-0710.*

☐ YES. My child has health insurance.

Doctor \_\_\_\_\_  
Name/Address

Phone \_\_\_\_\_

Dentist \_\_\_\_\_  
Name/Address

Phone \_\_\_\_\_

Hospital \_\_\_\_\_  
Name/Address

Phone \_\_\_\_\_

*I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and to 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 card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.*

\_\_\_\_\_  
Signature of Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

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Form R-4 (pg. 1 of 2)

### Student Health History Questionnaire (to be completed by Parent/Guardian)

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Last Eye Exam \_\_\_\_\_ Last Dental Exam \_\_\_\_\_

Child's Physician \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

**Please "x" if a close family member has had:**

Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Asthma \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Scoliosis \_\_\_\_\_ Allergy (list) \_\_\_\_\_

Other \_\_\_\_\_

**Please "x" if the child has had:**

|                                                       |                                 |                                 |
|-------------------------------------------------------|---------------------------------|---------------------------------|
| _____ Anemia                                          | _____ Frequent colds            | _____ Asthma                    |
| _____ Frequent earaches                               | _____ Pneumonia                 | _____ Frequent sore throats     |
| _____ Chickenpox                                      | _____ Frequent stomach aches    | _____ Strep Throat              |
| _____ Frequent vomiting                               | _____ Frequent diarrhea         | _____ Frequent constipation     |
| _____ Scarlet Fever                                   | _____ Meningitis                | _____ Rheumatic Fever           |
| _____ Lyme Disease                                    | _____ Heart Problems (murmur)   | _____ Past concussions (number) |
| _____ Head or Neck Injury                             | _____ Seizures/Seizure Disorder | _____ Headaches                 |
| _____ Trouble with vision                             | _____ Glasses worn              | _____ Trouble with hearing      |
| _____ Hearing Aid                                     | _____ Problems with speech      | _____ Operations                |
| _____ Orthopedic problems                             | _____ Chronic Illness           | _____ Tendency to bleed easily  |
| _____ Use of adaptive aids (braces, wheelchair, etc.) |                                 |                                 |
| _____ Tuberculosis/positive Mantoux test              |                                 |                                 |
| _____ Problems with toileting/bedwetting              |                                 |                                 |

Allergies your child has, Type of allergy (environmental, food, insect bite/sting, medication):

\_\_\_\_\_  
\_\_\_\_\_

Type of allergic reaction:

\_\_\_\_\_  
\_\_\_\_\_

Medication(s) used to treat reaction:

\_\_\_\_\_  
\_\_\_\_\_

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Form R-4 (pg. 2 of 2)

### **Medications:**

Please list any medications (prescription or over-the-counter) your child is taking regularly and reason for taking.

### **Birth and Early Development:**

Birth Weight: \_\_\_\_\_ Was the baby full term? Yes \_\_\_\_\_ No \_\_\_\_\_

Cesarean delivery: Yes \_\_\_\_\_ No \_\_\_\_\_ Cesarean delivery: Scheduled \_\_\_\_\_ Emergency \_\_\_\_\_

Explain any problems during pregnancy, birth, or neonatal period:

### **At what age did your child:**

Crawl \_\_\_\_\_ Stand unassisted \_\_\_\_\_ Walk \_\_\_\_\_  
Speak \_\_\_\_\_ Speak in sentences \_\_\_\_\_ Feed Self \_\_\_\_\_  
Become toilet trained \_\_\_\_\_

### **About Your Child:**

Please "x" if your child:

Bites Nails \_\_\_\_\_ Sucks fingers/thumb \_\_\_\_\_ Has trouble sleeping \_\_\_\_\_

Describe any fears your child has (e.g., the dark, loud noises, etc.)

What is your child's usual bedtime? \_\_\_\_\_

### **Would you consider your child:**

Usually quiet and reserved \_\_\_\_\_ Almost always active \_\_\_\_\_ Sometimes quiet and sometimes active \_\_\_\_\_  
Your child is: Right-handed \_\_\_\_\_ Left-handed \_\_\_\_\_

Is there any additional information that you think would assist us in planning an educational program for your child?

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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Form R-5

### Acknowledgment of Required Documentation for Immunizations & Physical Examination

#### New Jersey State Law requires the following immunizations:

- o Measles immunization (2 doses after 1 year of age)
- o Mumps immunization (1 dose after 1 year of age)
- o Rubella immunization (1 dose after 1 year of age)
- o Polio (3 doses with one of these doses given on or after the 4th birthday or any 4 doses)
- o DTap (4 doses with one of these doses given on or after the 4th birthday or any 5 doses)
- o Hepatitis B (3 doses)
- o Varicella (1 dose on or after 1 year of age or proof of disease by a physician)

***I, the undersigned, hereby acknowledge that I have read and understand that if I do not provide an up-to-date and doctor-certified immunization record for my child by August 31, 2024, my child will be excluded from school until such time that I provide this documentation.***

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

#### A physical exam is required within 365 days of entrance to school and must be presented by August 31, 2022.

***I, the undersigned, hereby acknowledge that I have read and understand that if I do not provide proof from a doctor that my child has had a physical examination within the previous 365 days, by August 31, 2024, my child will be excluded from school until such time that I provide this documentation.***

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

***I, the undersigned, hereby acknowledge that I have read and understand that the District also requires that all incoming Kindergarten students have the Hainesport Township School District Physical Examination form completed by a doctor and submitted to the Health Office by August 31, 2024; and also acknowledge that failure to do this will result in my child being excluded from school until such time that I provide this documentation.***

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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Form R-6

### Physical Examination Form

NAME OF CHILD: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ BP: \_\_\_\_\_

SKIN: \_\_\_\_\_ EYES: \_\_\_\_\_

EARS: \_\_\_\_\_ NOSE: \_\_\_\_\_

MOUTH: \_\_\_\_\_ THROAT: \_\_\_\_\_

SPEECH: \_\_\_\_\_ HEART: \_\_\_\_\_

LUNGS: \_\_\_\_\_ ABDOMEN: \_\_\_\_\_

GENITALIA: \_\_\_\_\_ SCOLIOSIS: \_\_\_\_\_

JOINTS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

ASTHMA: \_\_\_\_\_

SIGNIFICANT ILLNESSES/INJURIES: \_\_\_\_\_

SURGICAL HISTORY: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

RECENT IMMUNIZATIONS AND DATES: \_\_\_\_\_

The student may participate fully in all school activities: \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list restrictions and reasons: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Stamp:

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Form R-9

### Registration Checklist & Submission Form

**The following forms must be completed and submitted at the time of registration:**  
*(All forms are mandatory unless otherwise stated)*

- ☐ Form R-1, Proof of Residency/Domicile
- ☐ Form R-2, Registration Data Form for School Year 2024-2025
- ☐ Form R-3, NJ FamilyCare Act Form
- ☐ Form R-4, Student Health History Questionnaire
- ☐ Form R-5, Acknowledgement of Required Documentation for Immunizations & Physical Examination
- ☐ Form R-8, New Jersey Home Language Survey
- ☐ Form R-9, Registration Checklist & Submission Form

**The following documents must be presented at the time of registration:**

- ☐ Original Birth Certificate or Letter from DCP&P
- ☐ **One (1) proof of residency (written lease agreement or ownership-related document)**
- ☐ Three (3) additional proof of residency/domicile from the following:
  - ☐ Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords, and other evidence of property ownership, tenancy, or residency
  - ☐ Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location
  - ☐ Court orders, State agency agreements, and other evidence of court or agency placements or directives
  - ☐ Receipts, bills, canceled checks, and other evidence of expenditures demonstrating personal attachment to a particular location, or where applicable, to support of the student
  - ☐ Medical reports, counselor or social worker assessments, employment documents, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency
  - ☐ Affidavits, certifications, and sworn attestations pertaining to statutory criteria for school attendance, from the parent, guardian, person keeping an "affidavit student," adult student, person(s) with whom a family is living, or others as appropriate
  - ☐ Documents of military status and assignment
  - ☐ Any business record or document issued by a governmental entity
  - ☐ Any other form of documentation relevant to demonstrating entitlement to attend school
  - ☐ IEP/Evaluation Reports (if applicable)

**The following documents must be submitted on or before August 31, 2024:**

- ☐ Up-to-date, doctor certified immunization record
- ☐ Form R-6, Hainesport Township School District Physical Examination Form

I, the undersigned, hereby acknowledge that I am lawfully permitted to register the above child at the Hainesport Township School District.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Date

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### Special Education Medicaid Initiative (SEMI) Parental Consent Form

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. This information may be disclosed only to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

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

Please complete the section below.

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I have received the Notification Regarding Parental Consent Form and confirm that I am able to provide informed consent.

Parent/Guardian Signature: \_\_\_\_\_

As parent/guardian of the child named above, 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).

I understand that billing for these services by the district does not 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.

I give consent to bill for SEMI:      ☐ YES      ☐ NO      Date: \_\_\_\_\_

This consent can be revoked at any time by contacting an administrator at your child's school.

Revised January 2022 SEMI Parental Consent

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### Medicaid 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 the 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, Psychological, Counseling, Speech Therapy, Audiology, Occupational Therapy, 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.

#### **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.

Spring/Annual Review Period 2022

Method of Delivery (specify): Registration Packet

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