



LEONIA PUBLIC SCHOOLS

570 Grand Avenue, Leonia, NJ 07605

Dr. Edward Bertolini, Superintendent
Phone: 201-302-5200 ext. 1200
Fax: 201-947-4782

January 2019

Dear Parent/Guardian(s):

It is Pre-K registration time. Pre-K 4 enrollment is **limited** for this full school day **tuition** program. Applications may be picked up at the Leonia Board of Education 570 Grand Ave. and the Anna C. Scott School **starting** January 7, 2019. **All registration packets must be completed and returned to the Board of Education at 570 Grand Ave. by February 1, 2019 before 3:30 pm.**

Admission will be determined by an **expanded lottery process** to be held on **Thursday, February 7, 2019 at 3pm in the Anna C. Scott gymnasium.**

To be eligible for the Pre-K program your child's fourth birthday **must** be on or by **October 1st**.

The following documents are required to complete the registration process:

- proof of residency (current lease or deed and current utility bill)
- your child's birth certificate
- application forms
- completed immunization forms

Please be reminded, in order for your child to be officially eligible for the expanded lottery, you must have successfully produced proof of residency along with your child's birth certificate and completed immunization forms.

Tuition for the 2019-2020 school year is \$7500 (\$750 per month). Please see attached letter for payment information.

Should you have any questions regarding Pre-K registration, please do not hesitate to call the Board Office at 201-302-5228. We look forward to meeting with you.

Dr. Edward Bertolini
Superintendent of Schools



LEONIA PUBLIC SCHOOLS

570 Grand Avenue
Leonia NJ 07605

Dr. Edward Bertollini, Ed. D.
Superintendent of Schools

Phone: (201) 302-5200 x 1200
Fax: (201) 947-4782
Email: Bertollini@leoniaschools.org

January 1, 2019

Re: Automatic Debit Service (ACH Debits) for monthly tuition payments

Dear Parent,

The tuition for the Pre K-4 Program for the 2019-2020 school year is \$7,500.00. The Leonia School District now requires an automatic debit service for your monthly tuition payments. By signing up for this service, you will authorize the Board of Education to debit your checking account on **the first of each month**, in the amount of **\$750.00**. This service will be available, for no additional charges, from **October 1, 2019** and will continue through **May 1, 2020**.

After signing your Tuition Agreement, which will be mailed to you, it must be returned to the Board Office by June 1, 2019, with a deposit of \$750.00, paid by check or money order. A second deposit of \$750.00 is due in the Board Office by August 1, 2019.

In order to set-up the automatic debit service, we will need your bank information. Please fill out all of the required information on the attached form. In the first space, where it says "COMPANY", please fill in **Leonia Board of Education** as the company. Then sign and return it to the Board Office, to Amy Kopp's attention, **with a voided check attached**.

Should you have any questions, or require any additional information, please feel free to contact Amy Kopp at 201-302-5200 x 1206, or by e-mail at Kopp@leoniaschools.org.

Sincerely,

Edward Bertollini
Superintendent of Schools

Authorization for Direct Payment via ACH (ACH Debit)

CONSUMER AUTHORIZATION FOR DIRECT PAYMENT VIA ACH (ACH DEBITS)

Direct Payment via ACH is the transfer of funds from a consumer account for the purpose of making payment.

I (we) authorize _____ ("COMPANY") to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits¹) as follows:

Checking Account / Savings Account (select one) at the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

Depository Name _____

Routing Number _____ Account Number _____

Amount of debit(s) or method of determining amount of debit(s) [or specify range of acceptable dollar amounts authorized]:

Date(s) and/or frequency of debit(s): _____

I (we) understand that this authorization will remain in full force and effect until I (we) notify COMPANY [insert manner of revocation, i.e. in writing, by phone, location, address, etc.] that I (we) wish to revoke this authorization. I (we) understand that COMPANY requires at least [X days/weeks] prior notice in order to cancel this authorization.²

Name(s) _____
(Please Print)

Date _____ Signature(s) _____

¹ The NACHA Operating Rules do not require the consumer's express authorization to initiate Reversing Entries to correct erroneous transactions. However, Originators should consider obtaining express authorization of debits or credits to correct errors.

² Written debit authorization must provide that the Receiver may revoke the authorization only by notifying the Originator in the time and manner stated in the authorization. The reference to notification should be filled with a statement of the time and manner that notification must be given in order to provide company a reasonable opportunity to act on it (e.g., "In writing by mail to 100 Main Street, Anytown, NY that is received at least three (3) days prior to the proposed effective date of the termination of authorization").



LEONIA PUBLIC SCHOOLS

Dr. Edward Bertolini, Superintendent

570 GRAND AVENUE

LEONIA, N.J. 07605

E-Mail: Bertolini@leoniaschools.org

Phone: (201) 201-302-5200 ext. 1200

Fax: (201) 947-4782

January 2019

Dear Parent/Guardian (s):

Attached you will find the Registration packet for the Pre-K 4 program. Enrollment is **limited** for this full school day **tuition** program. **All registration paperwork must be completed and returned to the Leonia Board of Education at 570 Grand Ave. by February 1, 2019 before 3:30 pm to be eligible for the expanded lottery process.** The lottery selection will take place on February 7, 2019 in the Anna C. Scott gymnasium at 3pm.

Please be reminded, in order for your child to be **officially** eligible for the lottery, you must have successfully produced proof of residency along with a copy of your child's birth certificate and completed immunization forms.

.....
Child's Name: _____

Parent Name: _____

Date Received: _____



LEONIA PUBLIC SCHOOLS

Leonia, New Jersey

SCHOOL REGISTRATION

School _____ Grade _____ Entry Date _____ Student ID# _____

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Nickname: _____ Student Email (Grade 6-12): _____ Gender: M _____ F _____

Home Address: _____

If Renting, Date Lease Expires: _____ Home Telephone: (____) _____

***Ethnicity** (must check one): Hispanic _____ Non-Hispanic _____

***Race** (must check at least one, or all that apply): White _____ Black/African American _____

Asian _____ Native American/Pacific Islander _____ American Indian/Alaskan Native _____

Date of Birth: _____ City, State and Country of Birth: _____

*US Entry Date: _____ *US School Entry Date: _____

1st Language Spoken: _____ Primary Language Spoken at Home: _____

Proficient in English: Yes _____ No _____ All Languages Spoken: _____

Names, Dates and Grades of Previous Schools of Attendance

School & Address	Grades Attended	First Date of Enrollment	Last Date of Enrollment	Public or Private

FAMILY INFORMATION FOR THE HOME WHERE THE CHILD LIVES

Guardian # 1 – Home Where the Child Lives

Relationship to Student: Mother ___ Father ___ Guardian* ___ Affidavit ___ Other _____

Last Name: _____ First Name: _____

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Email Address: _____

Cell Phone: () _____ Business Phone:() _____ Occupation: _____

Employer Name/Address: _____

Guardian # 2- Home where the Child Lives

Relationship to Student: Mother ___ Father ___ Guardian* ___ Affidavit ___ Other _____

Last Name: _____ First Name: _____

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Email Address: _____

Cell Phone: () _____ Business Phone: () _____ Occupation: _____

Employer Name/Address: _____

Guardian # 3 – Non Custodian Parent **No Contact Allowed** ___ **Receives Extra Mailing** ___

Relationship to Student: Mother ___ Father ___ Guardian* ___ Affidavit ___ Other _____

Last Name: _____ First Name: _____

Home Address (Street) _____ (City, State, Zip) _____

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Email Address _____

Home Phone: () _____ Cell Phone() _____ Business Phone:() _____

Employer/Address: _____ Occupation: _____

*If checked, guardianship papers must be produced for examination

4 – Student Resides at More than One Address: _____ Receives Extra Mailing: _____

Relationship to Student: Mother ___ Father ___ Guardian* ___ Affidavit ___ Other _____

Last Name: _____ First Name _____

Home Address (Street) _____ (City, State, Zip) _____

***If checked, guardianship papers must be produced for examination**

Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Email Address: _____

Home Phone () _____ Cell Phone: () _____ Business Phone: () _____

Employer/Address: _____ Occupation: _____

SIBLING INFORMATION						
Name	Birthdate	Grade	Gender	Relationship	School	Resides w/Student

My child has Health Insurance: Yes ___ No ___
If yes, please provide name of Insurance Company: _____

I acknowledge that the above information is accurate and all provided documentation is valid and current.

Please sign and date:

Guardian Signature: _____ Date: _____

Should it be determined that my child(ren)'s primary domicile is not in Leonia or Edgewater, I agree to pay tuition for the time my child(ren) has (have) been educated in the Leonia Public Schools.

Guardian Signature: _____ Date: _____

Pre-K 2019-2020

Anna C. Scott School
Highland Street, Leonia, NJ 07605
201-302-5200
Fax: 201-592-1765

Dear Parent/Guardian,

Welcome to the Leonia Public School System. Registering your child for the Pre-School at Anna C. Scott School requires that the following information be included and submitted to the Leonia Board of Education prior to school entry.

1. Physical examination done within one year of date of entry to school. The form must be completed by a physician or nurse practitioner licensed in the United States.
2. Immunization record consisting of primary series and booster doses as required by New Jersey law as follows:
 - DTP or DTaP Vaccine - 4 doses of vaccine.
 - Polio Vaccine - 3 doses of vaccine.
 - MMR - 1 dose given on or after the 1st birthday.
 - Haemophilis B (Hib) – 1 dose of vaccine on or after the 1st birthday
 - Varicella Vaccine (chicken pox) – 1 dose on or after the 1st birthday.
 - Influenza Vaccine - 1 dose (annually) between September 1st and December 31st
3. Mantoux Tuberculin Test - required for students entering from out of country. The Mantoux test is valid only if administered within 6 months of entry to school.
4. Medical History Questionnaire
5. Dental Examination Report

Thank you,

Maria Barcelo-Martinez, Ed.D.
Principal

Linda Bernard, RN, MS
School Nurse

Anna C. Scott School
201-302-5200 ext: 2207
Fax: 201-592-1765

e-mail: bernard@leoniaschools.org

Medical History Questionnaire ---To be completed by parent or guardian

Student Name _____ Date of Birth _____ Grade _____

The child named above:

1. Has been medically advised not to participate in any sport or activity? Yes ____ No ____
If yes, why? _____
2. Has recently been or is currently under a physician's care? Yes ____ No ____
If yes, why? _____
3. Has experienced loss of consciousness after an injury? Yes ____ No ____
If yes, describe injury. _____
4. Has experienced a fracture or dislocation? Yes ____ No ____
If yes, describe _____
5. Has undergone any recent surgery? Yes ____ No ____
If yes, describe _____
6. Takes any medication on a regular basis? Yes ____ No ____
If yes, name of medication _____
Reason for medication _____
7. Has a ***food allergy***, reaction to bee stings, pollen allergy? Yes ____ No ____
If yes, describe _____
8. Has asthma or history of asthma Yes ____ No ____
If yes, describe treatment _____
9. Has experienced frequent chest pain or palpitations? Yes ____ No ____
10. Has a recent history of fatigue or excessive tiredness? Yes ____ No ____
If yes, please describe _____
11. Has a history of a family member having a sudden death? Yes ____ No ____
12. Does your child wear glasses or contact lenses? Yes ____ No ____
If yes, in what situations? _____
13. Does your child have any hearing loss? Yes ____ No ____
14. Are there any medical conditions of which the school should be aware Yes ____ No ____
If yes, please explain _____

Parent/Guardian Signature

Print Name

Date

Anna C. Scott School
Highland Street
Leonia, NJ 07605
Physical Examination Form

Child's Name; _____ Gender: M F Birthdate: _____

Parent/Guardian Name: _____ Phone number: _____

Address: _____

Physical Report

Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R _____ L _____ Wears glasses Hearing: R _____ L _____

Respiratory: _____ Cardiovascular: _____

Musculoskeletal: _____ Scoliosis: _____

Neurological: _____ Skin: _____

Health History

Allergies:

Type: Food Insect Latex Medication Seasonal/Pollen Other

Difficulty with: Vision Hearing Speech

Existing conditions limiting classroom activity: _____

Physical education restrictions: _____

Asthma: medication _____

Seizure Disorder: Type _____ Last occurrence _____

Diabetes

Significant Medical/Surgical information: _____

Medication (s) currently prescribed (dose & frequency): _____

Immunizations: Insert day/month/year

Vaccine	1 st Dose	2 nd Dose	3 rd Dose	4 th Dose	5 th Dose
DPT - DTaP					
OPV - IPV					
MMR					
Hepatitis B					
Varicella					
HIB					
Influenza					
Hepatitis A					

Mantoux Test (TB) Date given _____ **Result** _____ **X-ray date & result** _____

Date of Examination: _____

Physician/NP Signature

Physician/NP Name (stampprint)

Phone #

Pre-k 2019-2020

ANNA C. SCOTT SCHOOL
Nurse's Office
Highland Street, Leonia, NJ 07605
(201) 302-5200 ext. 2207
fax: 201-592-1765
e-mail: bernard@leoniaschools.org

Dental Examination Report (to be filled in by family Dentist)

Name of Child _____ Age _____ Sex _____

Birth Date _____ Grade _____ Phone _____

Parent's Name _____

Date of Examination _____

Number of Carious Teeth _____

Number of Filled Teeth _____

Number of Missing Teeth _____

Condition of Gum _____

Signature of Dentist

Please Print:

Dentist Name _____

Address _____
