LEONIA PUBLIC SCHOOLS

570 Grand Avenue, Leonia, NJ 07605

Joanne T. Megargee, Superintendent
Phone: 201-302-5200
Fax: 201-947-4782

January 2018

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 8, 2018. **All registration packets must be completed and returned to the Board of Education at 570 Grand Ave. by February 1, 2018 before 3:30 pm.**

Admission will be determined by a **lottery process** to be **held** on **Thursday, February 8, 2018 at 3pm in the Anna C. Scott gymnasium.**

To be eligible for the Pre-K program your child's fourth birthday **must** be 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 to have your child officially eligible for the lottery, you must have successfully produced proof of residency along with your child's birth certificate and completed immunization forms.

Tuition for the 2018-2019 school year is $7300 ($730 per month) payable by the **first of each month** (October through May) with **two months** of tuition **payable** by **June1st.** Checks should be mailed directly to the Leonia Board of Education, 570 Grand Ave. Leonia, NJ 07605 – Attn: Business Office.

Should you have any questions regarding Pre-K registration, please do not hesitate to call the Board Office at 201-302-5200 Ext. 1203. We look forward to meeting with you.

Joanne T. Megargee
Superintendent of Schools

LEONIA PUBLIC SCHOOLS

JOANNE T. MEGARGEE, Superintendent

570 GRAND AVENUE
LEONIA, N.J. 07605
E-Mail: Megargee@leoniaschools.org
Phone: (201) 201-302-5200 ext. 1201
Fax: (201) 947-4782

January 2017

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, 2018 before 3:30 pm to be eligible for the lottery process. The lottery selection will take place on February 8, 2018 in the Anna C. Scott gymnasium at 3pm.**

Please be reminded, in order to have your child 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

570 GRAND AVENUE
LEONIA, NJ 07605
(201) 302-5200
Fax (201) 947-4782

Name of Guardian____

Address: ____

Home Telephone # : ____________________________________

Business Telephone # : __________________________________

Cell Phone #: ______________________________________

- A **lease**, effective during the current school year, showing residence within the Borough of Leonia;

  OR
- A **recorded deed** showing ownership of residence within the Borough of Leonia.

  AND
- A **current utility bill**

  AND
- **Student Birth Certificate or Passport**

  AND
- **Transfer Card and Documentation** from prior schools **including Immunization records.**

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- If you do not have a lease or deed **in your name**, **OR** you **do not have** an updated lease, you must provide a **current signed Landlord Affidavit form or Resident Affidavit/Lessee form (available on our website or in the Board of Education Office.)**

- A **current signed affidavit form** stating that the student(s) listed above reside(s) with you and is/are financially dependent upon you even though you are not his/her/their parent or legal guardian. **[Documentation of financial dependency must be attached]**

I, __________________________, affirm that I am the natural parent/legal guardian of the student(s) listed above. I further state that this form and the attached documentation constitute true and accurate proof that the student(s) listed above reside with me within the Borough of Leonia. If any student listed above stops living with me, or if I move my residence out the Borough of Leonia, I will notify the Leonia Board of Education in writing within thirty (30) days.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to penalties as per N.J.A.C.6A:22-4.2.

Signed: ________________________

Dated: ________________________

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,Country of Birth: ___________________________________

****

If student was born outside the US, please provide the following information:

*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

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.
   Haemophlis 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. Dental Examination Report

Thank you,

Maria Barcelo-Martinez, Ed.D.
Principal

Linda Bernard, RN, MS
School Nurse

Pre-K

Date ______________

Anna C. Scott School
Highland Street, Leonia, NJ
201-302-5200
Fax: 201-592-1765
e-mail: bernard@leoniaschools.org

Child's Name ________________________________ ☐ Boy ☐ Girl Birthdate ______________

Parent/Guardian Name ____________________________ Phone number ________________________

Address ____

Physical Examination Report

Age ________ Ht. _______ Wt. _________ BP _____________

Eyes ________ Vision R 20/_____ L 20/_____ Ears _______ Hearing R _____ L ______

Respiratory ___________________________ Allergies _________________________

Cardiovascular _________________________ Seizure Disorder ____________________

Abdomen _____________________________ Genitalia _________________________

Musculoskeletal ________________________ Scoliosis __________________________

Neurological ___________________________ Skin _____________________________

Laboratory: Urinalysis: _____ HGB: _______ Cholesterol: _________ Lead: _________

Recommendations

1. Any defect of vision, hearing or speech? .... yes__________ no ________
2. Any conditions limiting classroom activity?......................... yes __________ no ________
   physical education?......................... yes __________ no ________
3. Any condition which may result in a classroom emergency?.......yes __________ no ________

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

____

Comments:

Immunizations: Insert month/day/year

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

Mantoux Test (TB) Date given _______ Result _______ X-ray date & result ____________

_________ ____________________ ____________________ ____________________

Exam Date | Physician/NP Signature | Physician/NP Name (print) | Phone/Address

Pre-K
Anna C. School

Nurse's Office
201-302-5200 ext. 2207
Fax: 201-592-1765
e-mail: bernard@leoniaschools.org

Medical History Questionnaire --- To be completed by Parent /Guardian

Student Name ______________________________ Date of Birth _________ Grade _________

The child named above:

1. Has been medically advised not to participate in physical education? 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____

7. Has food allergies, asthma, reaction to insect bites/stings? Yes ____ No _____
   If yes, describe ____

8. Has experienced special health problems or difficulties? Yes ____ No _____
   If yes, please explain ____

9. Wears glasses? Yes ____ No _____

10. Has any hearing loss? Yes ____ No _____
    If yes, describe ____

11. Has any condition which may create a classroom emergency, such as seizure disorder, diabetes, fainting spells? Yes ____ No ____
    If yes, please explain ____

12. Is your child toilet trained? Yes ____ No _____

____

Parent/Guardian Signature Print Name Date

Pre-k

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 _________________________________

____