OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, N.J. 07863
908-453-4101
www.oxfordcentral.org

Kindergarten Registration at Oxford Central School
2020-2021 School Year

Oxford Central School will hold kindergarten registration for the 2020-2021 school year on Thursday, March 26th at the school. To register, your child must be 5 years old on or before October 1st, 2020. The following must be brought to registration:

- Updated official immunization record from the doctor. This must show evidence of immunizations for diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hepatitis B and varicella.
- Original Birth Certificate
- Proof of residency (2 documents)
- Recent picture of your child

Please call Barbara Svercauski (OCS School Nurse) at the following number to schedule your appointment—(908) 453-4101 Ext. 2106. Also, please call this number should you have any questions.

Registration packets will be available for pick up at the school beginning the week of February 3rd. These should be brought to your scheduled registration appointment.

Your child does not need to be present during registration. If your child is already enrolled in prekindergarten at OCS, you do not have to attend this registration.

Thank you,
Barbara Svercauski
OCS School Nurse
OXFORD CENTRAL SCHOOL  
17 Kent Street, Oxford, N.J. 07863

EMERGENCY CONTACT

1. **Student Information**
   Name ________________________________________________
   Address ____________________________________________
   Home Telephone # ______________________ Date of Birth ______________
   Grade ____________________ Teacher ______________________

2. **Parent/Guardian Information**
   Guardian #1 name ___________________________ Home # ______________
   Work tel. # (w. ext) ________________________ Cell # ______________
   E-mail ______________________________________
   Guardian #2 name ___________________________ Home # ______________
   Work tel. # (w. ext.) ________________________ Cell # ______________
   E-mail ______________________________________

Are either parent/guardian members of a branch of the Military? _____ yes/no
Active Duty / Retired _______ Branch of Military _______ Rank _______

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated. Notify the school immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the school with a copy of the order.

3. **Child Care Provider Information**
   Those designated below are authorized to pick up my child from school in an emergency:
   Child care provider’s name ____________________________
   Tel. # ___________________________ Cell tel. # ______________
   Child care provider’s name ____________________________
   Tel. # ___________________________ Cell tel. # ______________

4. **Local Contact Information (Designate 1 parent in our school)**
   1. Local contact’s name __________________________ Relationship to child ________
      Home tel. # ___________________________ Work tel. # (w. ext.) ______________
      Cell tel. # ___________________________
   2. Local contact’s name __________________________ Relationship to child ________
      Home tel. # ___________________________ Work tel. # (w. ext.) ______________
      Cell tel. # ___________________________

5. **Out of Town Contact Information**
   Name __________________________________ Relationship to child ________
   Home tel. # ___________________________ Work tel. # (w. ext.) ______________
   Cell tel. # ___________________________

6. **Medical/Physician Information**
   List student’s known allergies or medical conditions ____________________________
   Doctor’s name ___________________________________ Tel. # ______________
   Hospital preference ______________________________
   Insurance company ______________________________
   Dentist’s name ________________________________

PLEASE COMPLETE REVERSE SIDE
7. 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 Family Care 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).

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this form and do 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 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 ___________________________

Please keep a copy of this form for your records. Important: Please update your school immediately if any information changes.
Oxford Central School
17 Kent Street
Oxford, NJ 07863

Student History

Child's Name ________________________________

1. Has there been any family incidents (i.e., death, separation, family financial concerns, etc.) recently that may have upset the child? Yes ______ No ______

If checked yes, please describe below

____________________________________________________________________________________________________________________________________________________

2. Family:

How many children are in your family? ______

Any foster children? ______ Adopted? ______

Any others living at home other than parents? __________________________________________________________

Relationship? ________________________________________________________________

Who has legal custody of the child? _________________________________________________

Do both parents work? __________________________________________________________

Who cares for the child? __________________________________________________________

Foreign language spoken at home? _______________________________________________

How does the child react to situations when one or both parents leave home? ______ Cries ______ Accepts it well ______ Temper Tantrum ______ Adjusts quickly to situation

Has the child traveled much? ______ Where? __________________________________________

3. Development:

Did you have any difficulties ______ Before ______ During ______ After the birth of your child?

Please explain _________________________________________________________________

_____________________________________________________________________________

4. At what age (approximately) did the child learn to:

Crawl ________ Walk ________ Toilet Trained ________

Can dress him/herself? ________ Tie shoe laces ________

Button ________ Zip ________
Student History

Has the child had formal pre-school experience? __________
Where? ___________________________________________ How long? _________________________
How clear and well-formed was the child's speech and how is it now? ____________________________________________________________________________

Does the child have children his/her age to play with in his/her neighborhood? ___________________________________________________________________

Did the child have difficulty learning to ride a bicycle ____, skip rope ____, learn to throw or catch? _______
Handedness __________________________ (left, right, or both)
What the child's favorite activities? _______________________________________________________________________

Does the child know his full name? ______ Address? ______ Telephone number? ______________
Does the child know nursery rhymes? ______ Songs? ______ Stories? ______ ABC's ______
Does your child listen to instructions when he is called, directed, etc.? _______________________________________________________________________

Does your child have any fears? __________________________ Please explain: __________________________________________________________________

____________________________________________________________________________________

Does your child take a nap? __________________________________________________________________________

Is there any other condition or experiences you would wish to mention that could affect the learning situation of your child? ____________________________________________________________________________

____________________________________________________________________________________

Signature of Parent/Guardian ___________________________ Date ________________
OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, N.J. 07863
908-453-4101
www.oxfordcentral.org

Mr. Robert Magnuson
Chief School Administrator

Ms. Nancy DeRiso
Business Administrator

Oxford Central School Students are C.O.R.R.E.C.T.

Proof of Residency Certification

Registration Date: ____________________________

I/We ____________________________, parent/guardian of ____________________________
(Print Parent/Guardian's Name) (Print Student's Name)

Affirm that I/We reside in the town of Oxford at the property located at:


I certify that the address provided is my home that "is permanent when the parent or guardian intends to return to it when absent and has no present intent of moving from it, notwithstanding the existence of houses or residences elsewhere" and is where we return to each night. If the board of education finds this to be untrue, I understand that I will be liable for back tuition to be paid to the district.

Two of the following documents have been provided and copies attached as proof of residency: (Note: If unable to provide documentation at time of registration, proof of residency information must be provided with thirty (30) days of the date of registration.)

______ Current driver’s license

______ Current property deed, lease agreement or property tax bill

______ Current utility bill

______ Other – Please describe (other acceptable items may include pay stub from current employer showing property address, post office mailbox number showing property address, automobile registration, or voter registration card).

Office Use Only:

I __________________________ have reviewed the material(s) presented on ______________ and ______________ and

(Administrator's Signature) (Date)

Approve/ deny (circle one) the above named student's admittance to the Oxford Central School. Original certification and copies of documentation are to be kept in students file.

Courage 🦅 Optimism 🦅 Respect 🦅 Responsibility 🦅 Empathy 🦅 Citizenship 🦅 Trustworthiness
SECTION A: Pupil Background Section

Circle grade for which enrolling: PS PK K 1 2 3 4 5 6 7 8

Pupil:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
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Address:

<table>
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<tr>
<th>Street and Number</th>
<th>Apt. #</th>
<th>Home Phone</th>
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Birth Date: __________ Birth Place __________

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<th>mo/day/year</th>
<th>City</th>
<th>State</th>
<th>Country</th>
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Transfer Card Received: ___ YES ___ NO Verified: B.C. ___ Passport ___

Last school attended

<table>
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<tr>
<th>Name of school/Address</th>
<th>Phone Number</th>
<th>Grade</th>
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Pupil is in a:

1. special education program ___ YES ___ NO
2. basic skills program ___ YES ___ NO
3. ELS, bi-lingual education program ___ YES ___ NO
4. speech/language program ___ YES ___ NO
5. gifted and talented program ___ YES ___ NO

Ethnicity Codes: W/White
B/Black/African American
H/Hispanic/Latino
A/Asian
I/American Indian/Alaska Native
P/Native Hawaiian/Pacific Islander

___________ Ethnicity

Check one: First language spoken at home is _______ English

*(Indicate country/dialect) _______________________

Other*

SECTION B: Parent/Guardian and Family Data Information

Parent/Guardian #1 ______________________________

Day time phone __________________
Cell Phone __________________

Employer __________________________ Address __________________

Work Phone __________________________

Parent/Guardian #2 ______________________________

Day time phone __________________
Cell Phone __________________

Employer __________________________ Address __________________
Marital Status:  □ married  □ alternative □ separated □ single □ divorced □ widow □ widower

Other children at home (list oldest first, youngest last)

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Name</th>
<th>DOB</th>
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SECTION C, Medical Section

The following items if not submitted at the time of registration, must be completed prior to the first day of attendance. If compliance is not forthcoming by that time, the pupil will not be accepted for admission and this application shall be void.

Physician's certificate has been provided (or letter) attesting that the pupil has had a physical examination within the last school year.

Medical records have been provided certifying immunization per state requirements on form provided by district OR

Modification or Exemption from requirements due to religious beliefs.

Dependency Verification (any one of the following)

- Birth certificate/passport bearing same surname of pupil as parent/guardian
- Copy of section of a court decree awarding custody of the pupil
- Letter from a department of state or federal government
- A properly executed affidavit of support

I/we fully understand that the Oxford Township School District retains the full right to verify any information contained in this application at any time during the period for which enrollment is pending or after enrollment has actually taken place. If at any time the pupil registered no longer qualifies as a Oxford Township pupil, I/we shall forthwith advise the office of the Chief School Administrator, Oxford Central School, 17 Kent Street, Oxford, NJ 07863. I/we fully understand that failure to do so shall hold me/us legally responsible for all tuition costs, legal costs, and any other expenses incurred by the Oxford Township School District during that period of time for which the pupil was not so qualified for enrollment. I/we understand that no documents or pupil records, awards, or diplomas shall be issued to the pupil or to his parent/guardian or be forwarded to any other school district or school until such costs have been settled with the Oxford Township School District.

Signature of parent/guardian  Date

Signature of school registrar  Date

Comments or notations by school district
Oxford Central School
Name/Photo/Video Release Form
2020 - 2021

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personal identifiable information to be published on the district and/or school's web site.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as a school do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, e-mail address, phone numbers and locations and times of class trips.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of the school and such rescission will take effect upon receipt by the school.

Check the following choices:

I GRANT permission for this student's photo/image and other personal identifiers listed above to be published on the school website, public Internet site, in local newspapers, social media sites maintained by OCS, and in the school yearbook.

Yes ____  No ____

Student Name (print): ___________________________ Grade: ____

Parent/Guardian Name (print): ___________________________

Parent/Guardian Signature: ___________________________

Relation to Student: ___________________________

Date: ___________________________
Required Health Information for Kindergarten Attendance

State of New Jersey Vaccine Requirements for Kindergarten Entry:

DTP/DTaP Series—4 to 5 doses needed depending upon age at school entry
Hepatitis B Series—3 doses
MMR Series—2 doses
Polio Series—3 to 4 doses needed depending upon age at school entry
Varicella—1 dose

Please provide the school with an official copy of your child’s immunization record. This copy is provided by your child’s physician.

The State of New Jersey also requires that your child have a physical performed and documented by your physician before entrance into school. This may have been completed up to one calendar year prior to your child’s entrance into kindergarten at Oxford Central School. The required form can be found in this packet.

PLEASE NOTE: All immunization and physical requirements must be completed and on file with the school nurse before the beginning of the 2020-2021 school year. If this is not done, your child will not be allowed to attend school on the first day.

It is also suggested that your child have a dental evaluation.

Please feel free to contact me with any questions you may have.

Thank you,
Barbara Svercauskii RN
School Nurse
### UNIVERSAL CHILD HEALTH RECORD

**SECTION I: TO BE COMPLETED BY PARENT(S)**

- **Child's Name (Last)**
- **First**
- **Gender**
- **Male**, **Female**
- **Date of Birth**

- **Does Child Have Health Insurance?**
  - **Yes**
  - **No**

- **If Yes, Name of Child's Health Insurance Carrier**

- **Parent/Guardian Name**
- **Home Telephone Number**
- **Work Telephone/Cell Phone Number**

- **Parent/Guardian Name**
- **Home Telephone Number**
- **Work Telephone/Cell Phone Number**

**I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.**

- **Signature/Date**
- **This form may be released to WIC.**
  - **Yes**
  - **No**

### SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

- **Date of Physical Examination:**
- **Results of physical examination normal?**
  - **Yes**
  - **No**

**Abnormalities Noted:**

- **Weight (must be taken within 30 days for WIC)**
- **Height (must be taken within 30 days for WIC)**
- **Head Circumference**
  - **(If < 2 Years)**
- **Blood Pressure**
  - **(If ≥ 3 Years)**

### IMMUNIZATIONS

- **Immunization Record Attached**
- **Date Next Immunization Due:**

### MEDICAL CONDITIONS

- **Chronic Medical Conditions/Related Surgeries**
  - **List medical conditions/ongoing surgical concerns:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Medications/Treatments**
  - **List medications/treatments:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Limitations to Physical Activity**
  - **List limitations/special considerations:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Special Equipment Needs**
  - **List items necessary for daily activities**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Allergies/Sensitivities**
  - **List allergies:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Special Diet/Vitamin & Mineral Supplements**
  - **List dietary specifications:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Behavioral Issues/Mental Health Diagnoses**
  - **List behavioral/mental health issues/concerns:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

- **Emergency Plans**
  - **List emergency plan that might be needed and the signs/symptoms to watch for:**
  - **None**
  - **Special Care Plan Attached**
  - **Comments**

### PREVENTIVE HEALTH SCREENINGS

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note If Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>High/Hypotension</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
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<tr>
<td>Lead: Capillary</td>
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<td>Vision</td>
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<tr>
<td>Venous</td>
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<td>Dental</td>
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<td>TB (mm of Induration)</td>
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<td></td>
<td>Developmental</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
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**I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.**

- **Name of Health Care Provider (Print):**
- **Health Care Provider Stamp:**

- **Signature/Date:**

---

**Distribution:**
- Original-Child Care Provider
- Copy-Parent/Guardian
- Copy-Health Care Provider
Oxford Central School Kindergarten and Preschool/PreK
Registration Health Inventory

PARENT TO COMPLETE

Please complete the following information and return to the school nurse at registration. Please use the back of the form if necessary.

STUDENT: ___________________________ DOB: ___________________________
Mother's name: ___________________________ Cell #: ___________________________
Father's name: ___________________________ Cell#: ___________________________
Home phone #: ___________________________
Child's Physician: ___________________________ Phone #: ___________________________
Specialist Name: ___________________________ Phone #: ___________________________
Please list names of child's siblings and birthdates of each:

________________________________________________________________________

________________________________________________________________________

1. Please indicate any problems that occurred with either pregnancy or birth of this child. (i.e. premature or full term, c-section, diabetes (mom), hypertension (mom), etc.)

________________________________________________________________________

________________________________________________________________________

2. DEVELOPMENTAL ISSUES:
Age at walking: ____________ Age began talking: ____________
Age at toilet training: ____________
Describe present eating and sleeping habits:

Any difficulty with: bed wetting __________________________;
bowel habits __________________________; speech __________________________;
other __________________________

3. HEALTH HISTORY: Has your child had any of the following? (Please circle any that apply) If yes, explain on other side.
Hospitalizations Constipation (frequent)
Operations Diarrhea (frequent)
Frequent colds Joint pain, swelling or limping
Frequent sore throats Frequent earaches
Hearing loss Tubes placed in ears
Vision problems Wears glasses
Dental problems Headaches
Urinary issues Bronchitis
Speech problems Coordination problems
Skin issues Pneumonia
Heart disease
Lyme disease

Asthma or Reactive airway disease diagnosed by doctor
Allergic reaction to foods, medications, other

Seizure disorder; if yes on meds
ADHD or other behavior issue
List any medication prescribed by doctor taken by child

Any comments:

List any recent significant injuries:

List any recent medical tests:

Date of last physical by doctor:

4. EMOTIONAL/BEHAVIOR HISTORY:
Describe relationship with parents:

Describe relationship with any siblings:

Does your child exhibit any of the following? (Please circle any that apply) If yes, explain on other side.
Excessive shyness Persistent crying
Temper tantrums Nail biting
Difficulty interacting with other children

5. OTHER
Please list any significant medical, social or behavioral history in child’s Immediate family:

Please provide any further information that you feel would help provide a more healthful environment for your child:

1/6/16