PALISADES PARK SCHOOL DISTRICT
PALISADES PARK, NEW JERSEY
Dr. Joseph Cirillo
Superintendent of Schools
Phone: 201-947-3550
Fax: 973-388-2975

Eligibility to attend Palisades Park Public Schools is determined by the Superintendent using the entirety of evidence presented and gathered. The following documents will help to prove your child's eligibility. Official notarization is recommended.

1. PROOF OF AGE:
   A. BIRTH CERTIFICATE – IF CHILD WAS BORN IN UNITED STATES
   B. PASSPORT/VISA, ALIEN CARD OF FAMILY REGISTER
   C. PARENT PHOTO IDENTIFICATION
   D. DIVORCE/CUSTODY PAPERS, IF APPLICABLE

2. PRIMARY PROOF OF RESIDENCE:
   LEASE, DEED, MORTGAGE or STOCK CERTIFICATE
   TELEPHONE NUMBER OF LANDLORD OR MANAGEMENT OFFICE

3. THREE (3) ADDITIONAL PROOFS OF RESIDENCY. EXAMPLES ARE:
   A. HOME PHONE BILL **WITH A NUMBER AND ADDRESS OF SERVICE** (page one of bill)
   B. DRIVER'S LICENSE
   C. CURRENT BILLS (PSE&G, WATER, OR CABLE)
   D. CURRENT MAJOR CREDIT CARD BILL
   E. POST OFFICE CHANGE OF ADDRESS
   F. WORK ORDERS OR INVOICES

4. TRANSFER CARD AND REPORT CARD FROM PREVIOUS SCHOOL

5. **A COMPLETED PHYSICAL EXAMINATION FORM FOR REGISTRATION. THIS MUST BE SIGNED AND DATED BY THE DOCTOR WITHIN TWELVE (12) MONTHS PRIOR TO ENTERING.**

6. **IF CHILD IS ENTERING FROM OUT OF STATE OR COUNTRY, DOCUMENTATION OF THE MANTOUX TUBERCULIN SKIN TEST GIVEN NO MORE THAN SIX (6) MONTHS, AND GIVEN IN THE UNITED STATES, PRIOR TO ENTERING. IF THE MANTOUX TUBERCULIN SKIN TEST IS POSITIVE, YOU MUST SUBMIT A SEPARATE REPORT FROM THE RADIOLOGIST OF THE CHEST X-RAY RESULTS.**

SID NUMBERS

(Student Identification Numbers)

PLEASE NOTE:

All students transferring into the Palisades Park School District from another NJ Public School District, grades Kindergarten thru 12th, must have his/her SID number.

The SID number must be provided by the exiting school to complete the registration and enrollment in Palisades Park Schools. **(It is the parent/guardian's responsibility to obtain this number if the exiting NJ school does not list it on the transfer documents.)**

Student Identification numbers are being assigned by the NJ State Dept. of Education and it is a mandate for all NJ public school students to have an SID number.

Thank you for your cooperation.

PALISADES PARK SCHOOL DISTRICT CALENDAR

SCHOOL YEAR 2023-2024

September (17 days)

M	T	W	T	F
				1
~~4~~	5	6	***7***	***8***
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

October (21 days)

M	T	W	T	F
2	3	4	5	***6***
~~9~~	10	11	12	13
16	17	***18***	19	20
23	24	25	26	27
30	31			

November(17 Days)

M	T	W	T	F
		1	2	3
6	~~7~~	8	~~9~~	~~10~~
13	14	15	16	17
20	21	***22***	~~23~~	~~24~~
27	28	29	30	

December(16 Days)

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	***22***
~~25~~	~~26~~	~~27~~	~~28~~	~~29~~

January (20 days)

M	T	W	T	F
~~1~~	~~2~~	3	4	5
8	9	10	11	12
~~15~~	16	17	18	19
22	23	***24***	25	26
29	30	31		

Sept. 4	Labor Day Observ.
Sept. 5/6	Faculty Report
Sept. 7/8	Students Report/ Early Dismissal (Staff Development)
Oct. 9	Columbus Day
Oct. 18	Early Dismissal (Staff Development)
Nov. 7	Election Day (Staff Development)
Nov. 9, 10	NJEA Convention
Nov. 23,24	Thanksgiving
Dec. 25-31	Holiday Recess
Jan. 1-2	New Year's Observ.
Jan. 15	M. L. King, Jr. B'day
Jan. 24	Early Dismissal (Staff Development)
Feb. 16-20	Winter Recess
Mar. 20	Early Dismissal (Staff Development)
Mar. 29	Good Friday
Apr. 1-5	Spring Recess
May 27	Memorial Day
June 18	Tentative Last Day of School (180th Day)

*Last 5 days of school are Half-Day Sessions

PLEASE NOTE: In case of Emergency, Spring Recess has been designated as "Make-up" days. Please DO NOT make any permanent plans or reservations for those days.

February (18 days)

M	T	W	T	F
			1	2
5	6	7	8	9
12	13	14	15	~~16~~
~~19~~	~~20~~	21	22	23
26	27	28	29	

March (20 days)

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	***20***	21	22
25	26	27	***28***	~~29~~

April (17 days)

M	T	W	T	F
~~1~~	~~2~~	~~3~~	~~4~~	~~5~~
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

May (22 days)

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	***24***
~~27~~	28	29	30	31

June

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

Graduation date will be tentatively scheduled at the March Board Meeting.

Early Dismissal on October 6, November 22, December 22, March 28, and May 24.

Adopted: 4/26/2023

Palisades Park School District
REGISTRATION

Early Childhood Center _____ Lindbergh Elementary _____ Palisades Park Jr./Sr. HS _____

Date Registered: _____ Start Date: _____ Student ID # _____

Name of Student _____ Gender _____M _____F

DOB _____ Birth Document _____ Grade Level _____

Birth City _____Birth State _____Birth Country _____Date Entered US _____

Primary Language: _____ Language Spoken at Home _____

Ethnicity (circle) White Black Hispanic Am. Indian Asian Hawaiian Nat. Pac. Islander

School Previously Attended_____ Address_____
(Transfer Students Only)
Phone # _____ _____

Name of Parent/Guardian _____ Phone_____

Address_____

Name of Parent/Guardian_____ Phone_____

Address_____

Siblings _____ _____ _____
(Name, DOB) (Name, DOB) (Name, DOB)

Medical Information:
Physician's Name_____ Office #_____

Dentist's Name_____ Office #_____

Hospital Preference_____

Child's Insurance Carrier_____ Child Has No Insurance _____

May we release the above insurance information to the State for NJ Family Care? Yes _____ No _____

Please list any known allergies, medical conditions or medications taken on a daily basis:

_____

In a medical emergency, I hereby authorize the school district to seek emergency medical assistance for my child when I cannot be reached:

PARENT/GUARDIAN SIGNATURE_____ Date_____

Palisades Park School District
REGISTRATION

CONTACT INFORMATION

STUDENT NAME: _____ **GRADE:** _____

Contact Type	Name	Relationship to Student	Home Phone	Mobile Phone	Email Address
Mother					
Father					
Guardian					
Emergency Contact					
Emergency Contact					
Emergency Contact					

Palisades Park School District

Home Language Survey
(Encuesta sobre el lenguaje del hogar)

Child's name: _____ Date of birth: _____
(El nombre del niño/학생 이름) (Fecha de nacimiento/생년월일)

Date of school entrance: _____ (Fecha de ingreso a la escuela /학교 등록 한 날짜)

1. What was the first language used by the student? _____
   (¿Qué idioma uso el niño cuando empezó a hablar? /자녀가 태어난 후 처음 사용한 언어가 무엇입니까?)

2. At home, what language does the student hear or use a language other than English more than half of the time?
   (¿Qué idioma habla la familia en casa la mayor parte del tiempo? /집에서 자주듣고 쓰는 언어가 무엇입니까?)

   _____

3. Does the student understand a language other than English? What language (s) does the primary caregiver (s) speak to the child most of the time?
   (¿Qué idioma (s) habla el (los) cuidador (es) principal (es) al niño (a) la mayor parte del tiempo?

   /자녀와 대화시 어떤 언어를 사용 하십니까?) _____

4. What language (s) does the child speak to his/her brothers and sisters most of the time?
   (¿Qué idiomas habla el niño a sus cuidadores primarios la mayor parte del tiempo?)

   (자녀가 형제와 대화시 어떤 언어를 주로 사용합니까?) _____

5. Has the student recently moved from another school district where he/she identified as an English Language Learner? What is the name of the school and where is it? (El estudiante recientemente se mudo de una escuela donde fue identificado como un estudiante de Ingles como Segunda Idioma? Como se llama la escuela y en que pueblo esta ubicado?) (자녀가 다른 학교에서 영어를 배워야 하는 학생으로 영어를 배운적이 있습니까?)

   _____

Name: _____ Relationship with student: _____ Date : _____
(Nombre/이름) (Relacion con el estudiante/학생과의 관계) (Fecha/날짜)

REQUEST FOR SPECIAL SERVICES INFORMATION

Date: _____

Students Name: _____ D.O.B. _____

My child has an Individualized Educational Plan (IEP) from his/her previous school.

_____ Yes

_____ No

My child has a 504 Plan from his/her previous school.

_____ Yes

_____ No

Parent's Signature: _____

PALISADES PARK SCHOOL DISTRICT
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STUDENT PHOTO RELEASE PERMISSION SLIP

As a parent or guardian of this student, I hereby consent to the use of photographs/videotape taken during the course of the school year for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

_____ Yes, I give consent for the Palisades Park School District to photograph my child for school purposes and/or at school events.

_____ No, I do not authorize the Palisades Park School District to photograph my child for any event.

Student's Name: _____ DOB: _____

_____	_____	_____
(parent/guardian name - print)	(parent/guardian - signature)	(date)

INTERNET SAFETY POLICY AGREEMENT

As a student and parent/guardian of the Palisades Park Public Schools, I have read and I comprehend the Internet Safety and Technology Policy set forth and I agree to abide by its tenets. I understand and I represent the Palisades Park School District by my words and by my deeds as I use the school district's technology and the resources of the Palisades Park School District Computer Network. I further understand that my signature below authorizes my use of the Palisades Park School District Computer Network and all computer and network technology in the district. I agree to follow the rules of this policy and I understand the consequences for any infraction.

_____	_____	_____
(student name - print)	(student - signature)	(date)

_____	_____	_____
(parent/guardian name - print)	(parent/guardian – signature)	(date)

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

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 Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐ M ☐ F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZATION REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING *(Not Required)*	
						TEST DATE	RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (if Td or DT[1] Indicate in corner box)							
POLIO-INACTIVATED POLIO VACCINE (IPV) (if oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)					[5] Document below single antigen vaccine receipt, serology titers, or Varicella disease history		
HAEMOPHILUS B (HIB) [2]							
HEPATITIS B [3]					Hepatitis B	DATE:	TITER:
VARICELLA [4]					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE [2]					Measles	DATE:	TITER:
INFLUENZA [6]					Mumps	DATE:	TITER:
OTHER, SPECIFY:					Rubella	DATE:	TITER:

☐ Provisional Admission Attached - Date Granted:_____ ☐ Medical Exemption Attached ☐ Religious Exemption Attached

IMM-8
OCT 08

(1) REQUIRES MEDICAL EXEMPTION
(2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
(3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04
(4) REQUIRED FOR DAY/CHILD CARE ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04
(5) MMR single antigen receipt requries MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)

VISION EXAMINATION FORM

The Board of Education recommends that all school children have a complete eye examination before entering school in the fall. Good vision is essential to success in school. It is our hope that pre-school eye examinations will help many children to receive the proper vision correction through early detection and/or treatment.

Upon completion of the eye examination, have the examiner indicate his/her findings and recommendations on the form below. This form should be returned to the school nurse.

Student's Name_____ **Date**_____

I have given a complete eye exam with the following diagnosis and recommendations:

		Distance	Near		Distance	Near
Vision Without Correction	O.D.			O.S.		
Vision With Correction						

Muscle Balance _____ Color Test _____

Stereopsis Eye _____

Eye Defects _____

Recommendations/Conclusions

1. Normal Eye Examination Yes ☐ No ☐
2. Corrective lens prescribed Yes ☐ No ☐
3. Re-examine on _____ (Date of Return Visit)
4. Other (Preferential seating, low vision, aides, etc.) _____

_____ _____

Physician's Signature Date

Please Print:

Name of Physician _____

Address _____

Phone Number _____

Dr. Charles R. Smith, Jr., Early Childhood Center
270 First Street
Palisades Park, New Jersey 07650

Diane Nickoloff, B.S.N., R.N., C.S.N.
School Nurse

201-947-2761
201-947-0873 (Fax)

Date

To be filled out by the **family dentist** and **returned to the school nurse.** Thank you

Name of Child_____ Grade_____

Date of Birth_____ Telephone number_____

Date of Last Dental Exam_____

Number of Carious Teeth_____

Number of Filled Teeth_____

Number of Missing Teeth_____

Condition of Gums_____

Next Dental Check-up_____

Comments from the Dentist_____

_____

_____
Dentist's Signature

Please Print or Stamp:

Dentist's Name_____
Address:_____