REGISTRATION CHECKLIST

You will need to bring the following documents to register your child for school:

1. Original Birth Certificate with raised seal (we will make a copy for you, if necessary)
2. Proof of residency
   - Tax Bill
   - Closing Papers on a new home
   - Lease agreement if renting
   - If you are residing with a relative, you will need to complete a 'Parent Affidavit' and the relative you are residing with will need to complete an 'Application by a Resident' (this application needs to be notarized). Please inquire in the office if you need these documents.
3. Copy of Immunization records
4. Completed health survey
5. A physical exam is not necessary for registration but your child will need one before entering school in September

BYRAM TOWNSHIP SCHOOLS

STUDENT REGISTRATION

Student Information

(Note: It is important for parents/guardians to inform the office, in writing, of any changes in address, phone numbers guardianship, emergency contacts, etc.)

First Name:		Middle Name:
Last Name:	**Suffix Name:**	Nick Name:

Birth Date (mm/dd/yyyy):	**Gender**	Male	Female

Ethnicity	American Indian/Alaskan	Asian	African-American
	Hawaiian/Pacific Islander	Hispanic	White

Birth City:	**Birth State (US only):**	**Birth Country:**
Citizenship:	**Primary Language:**	**Home Language:**

Legal Residence Information		
Street Address:		
City:	**State:**	**Zip Code:**
Mailing Address (if different):		
City:	**State:**	**Zip Code:**
Home Phone Number (xxx-xxx-xxxx):		
Parent/Legal Guardian	**Name(s):** **Signature:**	
Custody Ruling (circle): Yes No	If Yes, show Legal Custody status (circle): Joint Father Mother Guardian	

Emergency Contacts	**List at least 2 contacts that will assume temporary custody of your child if you cannot be reached. Please ask prior permission from the contacts listed.**
Name & Relationship	**Phone Number (xxx-xxx-xxxx)**
1.	
2.	
3.	

----------Office use only----------

Original Birth Certificate		Immunizations		Proof of Residency	
Registered – Grade Level		Homeroom		Year of Graduation/Class of	

Parent Information

(Note: It is important for parents/guardians to inform the office, in writing, of any changes in address, phone numbers guardianship, emergency contacts, etc.)

Marital Status (choose one)	Married	Divorced	Separated	Single

Father's Information	Father resides with student (circle one) Yes No		
	If not, parent is to receive copies of (choose)	Attendance Letters	Schedules
		Report Card	Discipline Letters
Father's Name:			
Mailing/Street Address:			
City:	**State:**	**Zip Code:**	
Phone Number Information (including area code xxx-xxx-xxxx)			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Employer:			
Email Address:			

Mother's Information	Mother resides with student (circle one) Yes No		
	If not, parent is to receive copies of (choose)	Attendance Letters	Schedules
		Report Card	Discipline Letters
Mother's Name:			
Mailing/Street Address:			
City:	**State:**	**Zip Code:**	
Phone Number Information (including area code xxx-xxx-xxxx)			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Employer:			
Email Address:			

All Children in Family: Birth date

Name	Month	Day	Year	In school (Y/N)	Grade
1.					
2.					
3.					
4.					
5.					
6.					

Additional Information concerning the Student (For example: Step-parent, Restraining Orders, etc.):

Student Medical Information

Student Name:					
Disease History	**Other info**	**Year**	**Disease History**	**Other Info.**	**Year**
Allergies			Asthma		
Lyme Disease			Chicken Pox		
Hepatitis			Convulsive Dis.		
Neuromusc. Dis.			Diabetes		
Otitis media			Rheumatic Fever		
Strep Infections			Mononucleosis		
Drug Sensitivities			Heart Disease		
Congenital Defects					
Other					

Operations or Injuries	**Year**

Attention: If the student listed above has any Special Health Concerns, please indicate the concern and the procedure to follow and *CONTACT YOUR SCHOOL NURSE:*	
Name	Telephone
Physician	
Dentist	
Orthodontist	

In Case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, the school may make whatever arrangements seem necessary.

Please **CROSS OUT** the following services that you **DO NOT** want done for your child:

1. Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
2. Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.

Signature of legal Parent/Guardian:	
Date:	Print name:

BYRAM TOWNSHIP SCHOOLS
GRADE LEVEL PHYSICAL EXAMINATION

Name_____Exam Date_____Age_____Date of Birth_____

Address_____City/State/Zip_____Home Phone_____

School_____Sport_____Grade_____Age_____

Physician_____Phone_____Fax_____

Address:_____City/State/Zip_____

PHYSICIAN OR PROVIDER INFORMATION

Height_____Weight_____Blood Pressure_____/ _____Pulse_____bpm.
Vision R 20/_____L 20/_____ Corrected: Y/N Glasses: Y/N

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes /Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment(inc.liver,spleen)			
Tanner Stage: Testes/Onset of Menses:			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of Motion:			
Scoliosis:			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination: Romberg:			
Heel Walk:			
Tandem Walk:			
Nose Touch:			
Toe Walk:			
Most recent Immunizations/Dates:			
Medications currently in use:			
Additional Observations:			

Print Name of Physician_____Physician's/Provider's Signature_____
_____

QUESTIONNAIRE REGARDING INCOMING KINDERGARTENERS

1. Child's full name _____

2. Child's name as you would like him/her called/have items labeled in class (i.e. Billy instead of William):

   _____

3. The date on which your child turns 5 years old: _____

4. Will this child be your oldest child attending Byram Schools next year? _____yes _____no

5. In which town do you live? If Byram, please list the neighborhood in which you live. (Forest Lakes, East Brookwood, Cranberry Lake, etc.) _____

6. Does/did your child attend pre-school? If so, please list school and teacher's name.

   _____

7. To the best of your knowledge, does your child regularly interact with any other children who will be in Byram's Kindergarten next year? If so, please list the names of those children and how often they are together/in what capacity they are together. (Babysitting arrangement, neighbor, playdates, cousins, pre-school, etc.)

   _____

8. Are there any incoming Kindergarten children that your child should be separated from? Please list the child(ren) and explain _____

9. Does your child have food allergies or food restrictions? _____

10. Does your child have any difficulties with speech? _____

11. Was your child's first language English? _____yes _____no.
    Is there a language, other than English, spoken in your home? _____yes _____no
    Please explain (frequency, who speaks it, does your child understand/speak it, how often is it spoken, etc)

    _____

12. Any other information of which we should be aware (use back if needed):

    _____

    _____

    _____

_____ _____ _____

Name of person completing form Signature Date

Honeywell Instant Alert® for Schools Revised 09/2009

Byram Schools-Parent/Guardian Account Setup & User Interface

Access the Instant Alert Account Setup & User Login at the following website:
Website URL: https://instantalert.honeywell.com Note – use of https:// for secure website access

Each student family has been setup on the Instant Alert system with an account record. For families with returning students, your prior account, username, password, alert settings, etc., remain in effect. Follow the instructions under Family Account Holders to update your settings as needed. For new student families, this account record includes the parent/guardian name(s), home phone number and associated student(s) information. Follow the instructions for Initial Account Setup.

Initial Account Setup - Minimum Requirements

1. Go to the Honeywell Instant Alert for Schools website, listed above.
2. Select 'Parent' in the New User box.
3. Complete the requested entries on the student information form to verify your account. Click 'Submit'.
4. Complete the registration screens to create a username & password. Click "Proceed" at the confirmation screen to complete your Personal Profile and Setup; verify the Home Phone number being used for alerts. *Note:* Remember your Login Name and Password so you may use it to update your profile.
5. **You are done** – The Alert system will continue to use the home phone number on record for any alerts. Follow the directions below to change or add any account information.

Family Account Holders

Log in to your account

1. Go to the Honeywell Instant Alert for Schools website, listed above.
2. Log in using the Login Name and Password you have created.

View and check details about yourself and your family members

1. Upon successful login, click on 'My Family.'
2. Click on a parent name to view and edit parent details.
3. Click on a student name to view details about your children enrolled in our schools.

Configure alert settings for yourself

1. Click on 'Alert Setup.'
2. Click on the check boxes to select which alert type you would like to have sent to which device. Click on 'Save' when complete.
3. If you would like to add another contact device, select the device type and enter the device details. Select the person to whom the device belongs and click on 'Add.'
4. *Note:* Be sure to select which alert types you would like to have sent for any device added.
5. For e-mail, text messaging and pagers you may send yourself a test message. Click on 'Send Test Message' to send yourself a message.

Identify key contacts for your children

1. Click on 'Other Contacts.'
2. Click on 'Add New Contact' and complete the form.
3. Click on 'Save' when complete.
4. If you would like this person to receive Alerts from the school, return to the 'Alert Setup' page to configure this person's alert settings.

For Assistance: https://instantalert.honeywell.com

Click on the **Help Request** link in the lower right hand side of the page

Be sure to set your e-mail spam filter to receive e-mail from Honeywell.com.

Honeywell Instant Alert ® for Schools will not sell, rent, loan, trade, or lease any personal information of our members, the children for whom they have responsibility, or others listed as contacts in the system. We will use the utmost care in protecting the privacy and security of your information.

BYRAM SCHOOL DISTRICT
ELEMENTARY STUDENT HEALTH SURVEY

Name: _____Birthdate: _____
Primary Language spoken at home _____Other Languages _____
Grade: _____Sex: _____ Name of Local Doctor: _____

Has your child ever had or has now? (Please check at right of each item)

	Yes	No	Year		Yes	No	Year
High blood pressure				Excessive worry or anxiety			
Heart condition				Depression			
Asthma				Ulcer			
Sever Allergies				Severe or chronic abdominal pain			
Contact with tuberculosis				Excessive colds			
Positive tuberculin test				Speech Problem			
Tumor, growth or cancer				Eye trouble			
Diabetes or sugar in urine				Wears glasses			
Serious skin disease				Frequent ear infections			
Concussion				Hearing loss			
Frequent or severe headache				Frequent or painful urination			
Dizziness or fainting spells				Intestinal trouble			
Severe head injury				Wets or soils pants			
Epilepsy (convulsions)				Scoliosis in family			

Has your child had any orthopedic (bone or joint) problems? What? When? Explain:
_____

Has your child had any operations? What? When? Explain: _____

Has your child ever had serious illnesses or injuries other than those already noted? What? When? Explain: _____

_____

Has your child been diagnosed with Attention Deficit Disorder? Explain: _____

_____

List any medications your child is allergic to: _____

_____

Does your child have severe bee sting sensitivity? Local_____ or General_____Explain:_____

_____

Does your child have other health or behavior problems (learning, hyperactivity tantrums, coordination)?_____

_____

Is your child under regular medical supervision for any of the above conditions? If yes, give name of physician: _____

Do you have any special question or concerns about your child's health?_____

_____

If so, please contact the school nurse for a confidential conference.

BYRAM TOWNSHIP SCHOOLS

STUDENT EMERGENCY INFORMATION

School Year 20___

Name & Number to call first _____

Grade _____ Teacher _____

Student Name: _____ Sex (circle): Male Female
(Last) (First) (MI)

Home Address: _____ Birth date ☐☐/☐☐/☐☐☐☐
(MM) (DD) (YEAR)

Mailing address: _____ City: _____ State: _____ Zip: _____

Parent Information

Father/Guardian		Mother/Guardian	
Name:		Name:	
Address:		Address:	
Employer:		Employer:	
City, State:		City, State:	
Home Phone	Work #	Home Phone	Work #
Cell #		Cell #	

(Note: it is important for parents/guardians to inform the office, in writing of any changes in address or phone numbers.)

Child resides with: _____ Any Custody issues : _____

Emergency contacts: (List neighbors or nearby relatives who will assume temporary custody of your child if you cannot be reached. PLEASE ask permission to use these names.)

Name	Relationship	Phone
1.		
2.		
3.		
4.		

Note: It is important for parents/guardians to inform the Health Office, in writing of their child's health needs and/or changes during the school year.

My child receives regular care for the following medical conditions:

☐ No medical condition

☐ Yes, **please check below:**

Allergy to (list): ☐ Food_____ ☐ Bee Sting _____

☐ Medications_____ ☐ Other _____

☐ Asthma ☐ Rheumatic Heart ☐ Heart Disease ☐ Sickle Cell Anemia ☐ Chronic Cough/Wheezing

☐ Diabetes ☐ Cancer/Leukemia ☐ Hearing Problems ☐ Vision Problem ☐ Hemophilia Seizures

Other:_____

Other health information:

☐ Operations or injuries (include date):_____

☐ Mediations (list): _____

☐ Other health issues or concerns: _____

Brothers/Sisters Names Date of birth

_____

_____

_____

_____

Physician (and number): _____

Dentist (and number): _____

Orthodontist (and number): _____

I, the undersigned, do hereby authorize officials of Byram Township Schools to contact directly the persons named on this card 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 t financially responsible for the emergency care and/or transportation for said child.

Does your child have Health Insurance?

Yes _____ Name of 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.

Please CROSS OUT the following services that you DO NOT want done for your child:

1. Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
2. Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.
3. Permission to release my name and address to the NJ FamilyCare Program to contact me about health insurance. (Written consent required pursuant to 20 USC § 1232g (b)(1) and 34 CFR 99.30 (b).)

Signature of legal Parent/Guardian: _____

Date: _____ Print name: _____