The Town of Hillside, Code, Section 211-5, et.seq., provides that it is unlawful for any person over the age of 18 to assist, aid, abet, allow, permit or encourage an ineligible student to register or enroll in the Hillside School District, or to knowingly permit or use his or her address or residence in the registration or enrollment of an ineligible student. Anyone who violates the ordinance is subject to a fine of $1000.00 and to the payment of restitution which could include tuition costs, investigation expenses and attorney fees.

HILLSIDE PUBLIC SCHOOLS
STUDENT REGISTRATION: TO BE COMPLETED FOR ALL STUDENTS

PLEASE PRINT

STUDENT

Student's Name______________________________________ Date__________________
last first middle

Grade entering, Fall 2016________________

Student's Address____

Student's Home Phone__________________________ Check one: male_____ female______

Date of Birth ________________ Birthplace: City_______________ State_______ Country___________

Name of school attended in 2015-16 school year ____

PARENT(S)/GUARDIAN

Parent Military Affiliation: (Check one) _____ 1. Not Military Connected
_____ 2. Active Duty
_____ 3. National Guard or Reserve

Please provide the following information about the student's mother/guardian:

Name______________________ Address____

Home phone________________ Cell phone________________ Email___________________________

Employer's Name, Address, Phone Number ____

____

Please provide the following information about the student's father/guardian:

Name______________________ Address____

Home phone________________ Cell phone________________ Email___________________________

Employer's Name, Address, Phone Number ____

____

(please complete reverse side) **(rev. 2016)**

LANGUAGE/ETHNICITY

Language spoken at home____________________ Student's primary language ______________________

Student's ethnicity: ____African American ____Native American/Alaskan ____Asian
____Hispanic ____ Caucasian(non-Hispanic) ____Pacific Islander/Hawaiian

STUDENT'S BROTHERS AND SISTERS

Names of other children in the family	Birthdate	Grade entering Fall, 2016	School enrolled Fall, 2016
1.			
2.			
3.			

SPECIAL SERVICES (For placement purposes only. This information will be kept confidential.)

Has your child been educationally classified? _____Yes _____No

Has your child been referred to (please check all that apply): _____Child Study Team _____Speech services

_____ESL _____Remedial math or reading services

EMERGENCY CONTACTS: PLEASE LIST TWO

In case an emergency arises and school personnel are unable to reach you, they are to contact the persons below. Please designate persons who can pick up your child from school in case we are unable to reach you.

1. Emergency Contact Name_____________________________ Relationship to student_______________

   Emergency Contact Address____

   Home phone_____________________________ Work phone___________________________________

2. Emergency Contact Name_____________________________ Relationship to student_______________

   Emergency Contact Address____

   Home phone_____________________________ Work phone___________________________________

ATTESTED

I attest that the information provided on this registration form is true and complete. I understand that any individual who procures a public education for any student not lawfully domiciled in Hillside will be subject to liability under state law. Upon disenrolling the student(s), the district reserves the right to recover back tuition payments from the individual involved and to pursue all other relief available by law.

____ ____________________
Signature of Parent or Guardian Date

▪▪

FOR OFFICE USE ONLY
BIRTH CERTIFICATE AND HEALTH RECORDS

Note to school official: birth certificate and health records to be attached for first time enrollees. If presented, check here and copy. __________birth certificate __________health/immunization record

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HILLSIDE PUBLIC SCHOOLS
RESIDENCY AND GUARDIANSHIP VERIFICATION

PLEASE PRINT

STUDENT

Student's Name______________________________________ Date________________
last first middle

Student's Address____

Student's Home Phone________________________ Grade entering, Fall, 2016___________

TO BE COMPLETED BY SCHOOL PERSONNEL ONLY

RESIDENCY

Proof of legal residence in Hillside presented by parent or guardian at registration
School personnel shall place a check next to proofs presented and attach copies. Three proofs are required.

Category 1 _____ Current Tax Bill _____ Current Mortgage _____ Current Lease

Category 2 _____ Current utility bill for your residence (gas, electric, phone, etc)

Category 3 _____ Driver's License _____Financial account statement

_____Current pay stub w/address _____ State Agency document

GUARDIANSHIP

If a student does not live with a parent, documentation of guardianship is required in the form of a court order or a state agency placement document.

Proof of Guardianship presented: _____ court order
_____ state agency placement document

Registration will be complete for a student whose parent or guardian provides the above proofs, subject to verification. The Board retains the right to investigate the residency of any student at any time.

RESIDENCY/GUARDIANSHIP INVESTIGATION

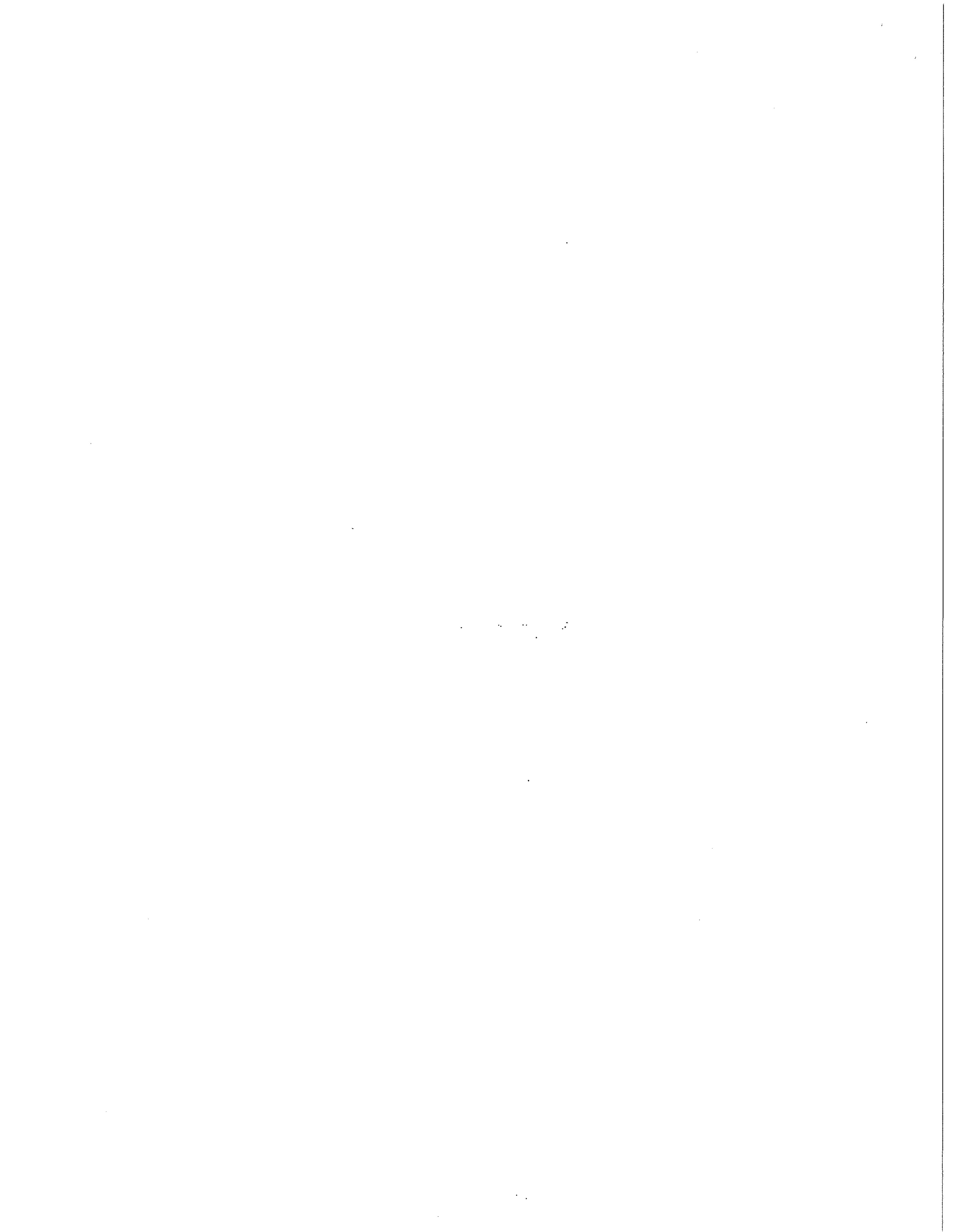
Purpose: _____ Verification of residency _____ Verification of guardianship (if both, place check by both)

Date(s) of Investigation ____

Findings of Residency Investigator ____

____

Signature of Residency Investigator ______________________________ Date ______________



STUDENT INVENTORY

Please complete all parts of the form. Do not leave any blanks.

STUDENT'S NAME____

ADDRESS____

PHONE #____

BIRTH DATE____

DATE ENTERED COUNTRY (If not born here)_______________________________________

STUDENT'S COUNTRY OF BIRTH____

MOTHER'S NAME____

MOTHER'S COUNTRY OF BIRTH____

FATHER'S NAME____

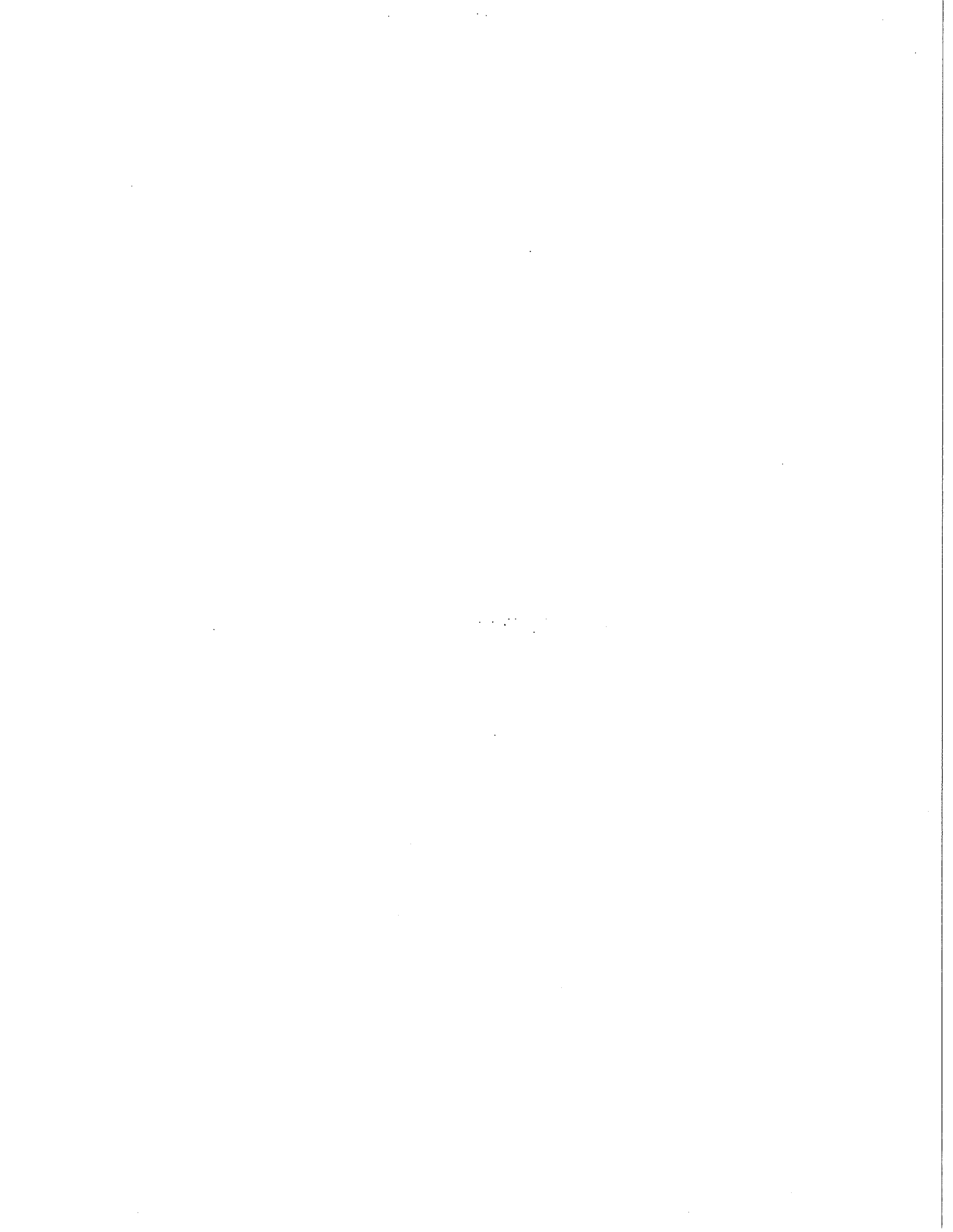
FATHER'S COUNTRY OF BIRTH____

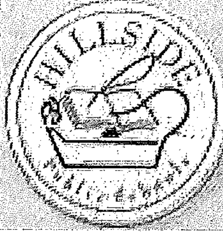
WHAT LANGUAGES ARE SPOKEN AT HOME?____

WHAT GRADE WILL THE CHILD ENTER IN SEPTEMBER?_________________________________

Was the child enrolled in a Bilingual or ESL program?____________ If yes, which program and where?____

*****Please return to M. Barrerios, R. Cohen, V. Dohm, T. Ermi or C. Sabates





Hillside Public Schools

195 Virginia Street
Hillside, NJ 07205
(908) 352-7664

________I give my child permission to appear in any newspaper, television show (news or any type of educational program) or through the internet (blog, article, video) originating from the Hillside School District. The appearance could include a name, photo, video, and/or resemblance. I also grant permission for the Hillside Public Schools to publish educational content created by my child (blogs, pictures, videos, etc.). It is understood that the Hillside Public Schools are not responsible for inappropriate content posted by my child or another person on any social media site that may be used in school (i.e. YouTube, Blogs, Flickr, Edmodo, etc.). I have also read and agree to the terms of Hillside Public School's Authorized Use Policy.

________ I do <u>not</u> give permission for my child to appear in any newspaper, television show, or through internet material originating from the Hillside Public Schools.

Student Name: ____
(Please Print)

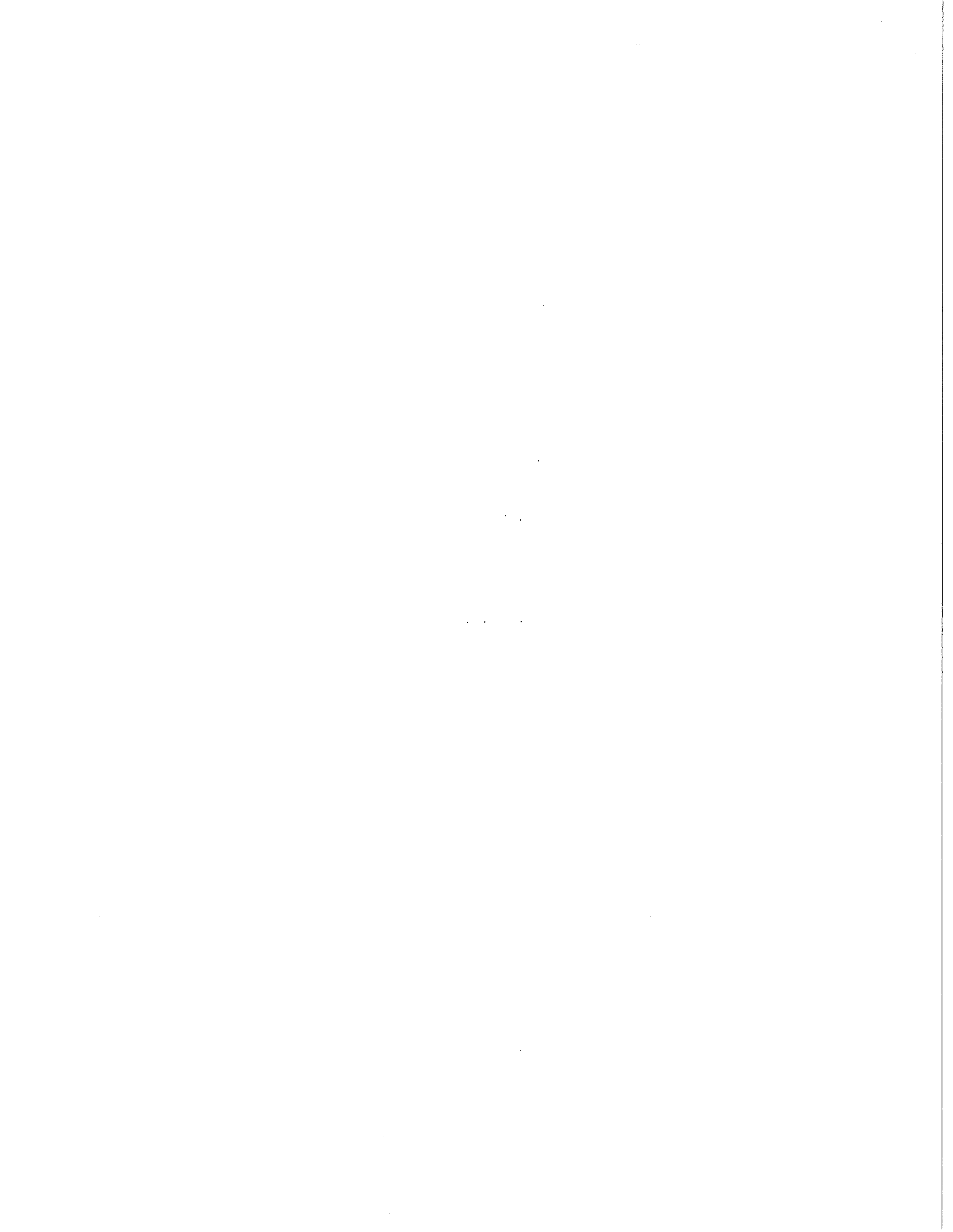
Student Signature: ____

Teacher/Homeroom: ____

Parent or Guardian Name:_____________________________________
(Please Print)

Parent or Guardian Signature: _________________________________

Date: ________________________



ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keepa copy of this form in the chart.)

Date of Exam ______________________

Name ______________________ Date of birth ______________

Sex _______ Age _________ Grade ___________ School ________________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________ Signature of parent/guardian ______________ Date ________

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HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________

Sex ______ Age ______ Grade ______ School ____________ Sport(s) ____________

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) ______________ Date of exam ______________

Address ______________ Phone ______________

Signature of physician, APN, PA ______________

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9-2681/0410

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

  Reason ______________________________

Recommendations ______________________________

EMERGENCY INFORMATION

Allergies ______________________________

Other information ______________________________

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ______________________________
(Date)

Approved ______ Not Approved ______

Signature: ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ______________________________ Date __________

Address ______________________________ Phone __________

Signature of physician, APN, PA ______________________________

Completed Cardiac Assessment Professional Development Module

Date __________ Signature ______________________________

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