

BETHLEHEM TOWNSHIP SCHOOL DISTRICT
ETHEL HOPPOCK MIDDLE SCHOOL
908-479-6336 option 5 (main office)

New Student Registration Packet Instructions

The following information will be required at the time of registration:

1. Transfer Card from previous school
2. Official Birth Certificate (original with raised seal, we will make a copy)
3. Proof of Residency (copy of a tax bill, utility bill, etc. that indicates family's address)
4. Complete and Return the Attached Forms:
 - a. Family Record Form
 - b. Emergency Information Form
 - c. Chickenpox Form
 - d. Permission to Request Records Form
 - e. Health Information Forms

If all of the above requirements are not available at the time of registration, your child's registration will not be considered complete.

Please visit the nurse's web page for more important information and forms.

Please sign-in to the Genesis Parent Portal in order to complete important technology forms for your student once they are registered.

If you have any questions or concerns, please call the phone number listed above.

BETHLEHEM TOWNSHIP SCHOOL DISTRICT
ETHEL HOPPOCK MIDDLE SCHOOL

280 Asbury/West Portal Road
Asbury, New Jersey 08802

Gregory C. Farley, Ed.D
Principal

(908) 479-6336
fax (908) 479-1021

_____ has entered our _____ grade as of _____

In order to better serve the needs of the pupil, we need the following information:

1. Official Administrative Record (identifying data, grade level completed, grades, attendance records).
2. Health Records
3. Standardized Achievement and Aptitude Test Scores
4. Diagnostic Evaluations (may include psychological, social history, etc.)
5. Other (specify)



Gregory C. Farley, Ed.D
Principal

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The above school records for _____ may be released to the Ethel Hoppock
Middle School:

School: _____

Address: _____

Phone Number: _____

Parent/Guardian Signature: _____

Date: _____

BETHLEHEM TOWNSHIP SCHOOL DISTRICT FAMILY RECORD FORM

(PLEASE PRINT)

NAME OF STUDENT: _____ SEX: M F _____ NICKNAME (IF ANY) _____
LAST FIRST

DATE OF BIRTH: _____ BIRTHPLACE: _____ TELEPHONE #: _____
MONTH / DAY / YEAR (INDICATE IF UNLISTED)

MAILING ADDRESS: _____

PARENT CHILD IS LIVING WITH	LAST NAME (IF DIFFERENT)	LIVING	CITIZEN	OCCUPATION	BUSINESS ADDRESS	BUSINESS TELEPHONE #
FATHER						
MOTHER						
GUARDIAN (ONLY IF APPLICABLE)						

OTHER CHILDREN IN FAMILY: # OF BOYS OLDER? _____ YOUNGER _____
 # OF GIRLS OLDER? _____ YOUNGER _____

MARITAL STATUS OF PARENTS (PLEASE CHECK ONE): MARRIED _____ SEPARATED _____ DIVORCED _____ REMARRIED _____

ETHNICITY (PLEASE CHOOSE ONE; THIS INFORMATION IS USED FOR STATE REPORTING PURPOSES ONLY):
 _____ AMERICAN INDIAN / ALASKAN NATIVE _____ ASIAN / PACIFIC ISLANDER _____ BLACK - NOT HISPANIC ORIGIN _____ HISPANIC _____ WHITE - NOT HISPANIC ORIGIN

IS ENGLISH THE PRIMARY LANGUAGE SPOKEN IN THE HOME? YES _____ NO _____
 (IF NO, INDICATE PRIMARY LANGUAGE): _____

**BETHLEHEM TOWNSHIP SCHOOL DISTRICT
 ETHEL HOPPOCK MIDDLE SCHOOL
EMERGENCY INFORMATION FORM**

STUDENT'S NAME: _____ BIRTHDATE: _____ TODAY'S DATE: _____
Last First

GRADE _____
 ADDRESS _____ SOC. SEC. # _____
 _____ ** PHONE # _____

(Ethnic background for State funding use only - optional) - _____

WHERE PARENTS CAN BE REACHED IN AN EMERGENCY (PLACE OF BUSINESS)

MOTHER: _____ BUSINESS ADDRESS _____ PHONE # _____
Name
 Email address: _____

FATHER: _____ BUSINESS ADDRESS _____ PHONE # _____
Name
 Email address: _____

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO ARE AT HOME DURING THE DAY WHO WILL ASSUME THE TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED IN CASE OF EMERGENCY.

1. NAME _____	2. NAME _____
ADDRESS _____	ADDRESS _____
RELATIONSHIP _____	RELATIONSHIP _____
PHONE # _____	PHONE # _____

* In case of accident or serious injury, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact the physician, the school may make whatever arrangements are necessary for the health and safety of my child.

(SIGNATURE OF PARENT/GUARDIAN) _____

RECENT ILLNESSES/INJURIES: _____

ALLERGIES/BEE STINGS: _____

MEDICATIONS: _____

LATEST TETANUS IMMUNIZATION: _____

LOCAL PHYSICIAN'S NAME: _____ PHONE # _____
 ADDRESS: _____

LOCAL DENTIST'S NAME: _____ PHONE # _____

HOSPITAL OF CHOICE: HUNTERDON MEDICAL CENTER _____ WARREN HOSPITAL _____

SIBLINGS:	NAME	AGE	SCHOOL CURRENTLY ATTENDING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE INDICATE BY CHECKING THE BOX BELOW IF YOU DO NOT WANT YOUR ADDRESS/PHONE NUMBER RELEASED FOR PUBLICATION IN THE CLASS ROSTER. ** **

BETHLEHEM TOWNSHIP SCHOOL DISTRICT

DATE _____

PAST HEALTH RECORD: TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name (as it appears on birth certificate) _____
LAST FIRST

Date of Birth _____ Sex: _____ Phone #: _____

1. Diseases (Give approximate year)

Asthma _____
Bronchitis _____
Chicken Pox _____
Eczema _____
Measles _____
as documented by MD

Mumps _____
Pneumonia _____
Rheumatic Fever _____
Scarlet Fever _____
Frequent Strep infections _____
Seizure disorder _____
Other _____

Diabetes _____

2. Frequent:

Sore Throat _____ Earache _____
Headache _____ Colds _____
Earache _____

3. Pain: Joints _____ Other _____
Muscular _____

4. High Fever: Age _____ Degree: _____

5. List any operations and age: _____

6. Serious accidents or injuries and ages: _____

7. Is your child on any medication on a regular basis? _____

8. List any known allergies that need special consideration: _____

9. Any indication of visual difficulty? _____

10. Any indication of hearing difficulty? _____

11 Does your child have :
any additional comments: _____

Please return to the school health office

School Nurse

BETHELHEM TOWNSHIP SCHOOLS

Ethel Hoppock Middle Middle School
280 Asbury West Portal Rd.
Asbury, New Jersey 08802
908 479-6336 (Phone) 908 479-1021 (Fax)

Dear Parents/Guardians:

This is to inform you that the New Jersey Department of Health and Senior Services (DHSS) has recently revised the administrative rules with substantive changes to include the requirement of new vaccines for students attending sixth grade in September of 2008. The amended regulations state the following:

Every child born on or after January 1, 1997 and entering grade six on or after September 1, 2008 shall have received one (1) dose of Tdap (Tetanus, diphtheria, acellular pertussis) given no earlier than the 10th birthday.

Children entering or attending grade six on or after September 1, 2008 who received a Td booster dose less than five (5) years prior to entry or attendance shall not be required to receive a Tdap dose until five (5) years have elapsed from the last DTP/Dtap or Td dose.

Every child born on or after January 1, 2007 and entering or attending grade six on or after September 1, 2008 shall have received one (1) dose of a meningococcal-containing vaccine, such as the medically-preferred meningococcal conjugate vaccine.

Students must provide documentation of these immunizations from their Primary Care Provider by the beginning of school in September of 2008. Therefore, we are requesting that your Primary Care Provider complete the form below and return to the Ethel Hoppock Middle School at your earliest convenience.

If you have any questions regarding these new requirements, please feel free to contact me at 908 479-6336 ext. 2225. Thank you for your cooperation in this matter.

Sincerely,

School Nurse

Student Name: _____

Date: _____

Teacher: _____

Age: _____

The above-named student has received:

1. The Tdap booster on _____
Month/Day/Year

2. The Meningococcal vaccine on _____
Month/Day/Year

Signature of Primary Care Provider

Print or Stamp of Primary Care Provider

Please return to the school nurse

Bethlehem Township Board of Education
Ethel Hoppock Middle School
Health Office

If your child has had the chickenpox, please fill out the following information:

This is to verify _____ has had the Varicella
(Name of Student)

Virus (Chickenpox) on or about _____ and does not need the
(Month/Day/Year)

vaccine.

Parent signature

Date

Please return this form to the Health Office.

BETHLEHEM TOWNSHIP SCHOOL DISTRICT
Ethel Hoppock Middle School
Asbury, NJ 08802

HEALTH ALERT LIST

Privacy practice prohibits generating a list for all staff regarding your students' health issues but it is important that you complete the form below and list any health issues as follow:

- A. Major health issues: (those which are life threatening)
such as food allergies & bee sting allergies with a systemic reaction, seizure disorders, Diabetes, Asthma, etc.
- B. Minor Health issues: (those not life threatening) such as hearing/vision deficits that require preferential seating arrangements, orthopedic problems, bladder disorders, allergies, etc.
- C. Medication (those that are administered daily and/as needed).
Forms for medications that require administration during school hours are available from the health office. All medications administered in school require written parental permission and a physician order.

It is important that we have up to date health information on your child. It is advised that when your student has a physical exam with their physician that a copy be added to their health record.

Please do not hesitate to notify the health office whenever there is a change in your child's health status.

Name _____ Grade _____ Date _____

PLEASE LIST:

- A. Major health issues:
- B. Minor health issues:
- C. Medication:

Please contact the nurse to discuss information you wish to be shared with additional staff.

Parent /Guardian

Signature _____

Ethel Hoppock School

Health Office

280 Asbury/West Portal Rd.

Asbury, NJ 08802

(908)479-6336 Fax (908)479-1021

Over-the-Counter Medication Administration Parent Permission

Student's Name _____ Grade _____

I give the School Nurse permission to administer the following medications to my child when needed. Please write YES or NO in each space. If your child is allergic to either medication, please write this in as well.

_____ Acetaminophen (generic Tylenol) dose by weight.
_____ Ibuprofen (generic Motrin/Advil) dose by weight.

***If medication is used in excess, a request will be sent home to have the student visit their family physician.

If your child requires additional over-the-counter medication while in school, please list below.

State law requires a physician's order and the parent permission form be completed. This must include reason for medication; dosage; frequency; & side effects.

The parent/ guardian must provide medication in the original container.

_____ Other _____
List medication here

_____ Physician's Note Attached

I will advise the school nurse if, for any reason, my child should not be taking any of these medications in the future.

Parent/Guardian Signature: _____ Date: _____

Bethlehem Township



PTA

Fostering cooperation and communication between the school, home, and community in order to best meet the needs of the students of Bethlehem Township

Dear Families,

The Bethlehem Township PTA would like to welcome you to the Bethlehem Township School District. Our goal as a PTA is to work with the school community to enhance the educational experiences of our children by providing cultural and social events throughout the year.

In order for us to send you information about the BTPTA, we will need you to fill out the following information and return it through either backpack mail (send it to school with your student and it will get to the PTA mailbox) or USPS.

Backpack mail: PTA Conley Mailbox

USPS address: BTPTA, 940 Iron Bridge Road, Asbury, NJ 08802

Thank you for taking the time to provide us with this information.

Sincerely,
The BTPTA

Family Name: _____

Mailing Address: _____

Home Phone #: _____ Cell Phone # _____

I do not wish to be published in the Bethlehem Township School Directory.

Your information will not be shared with anyone outside the Bethlehem Township School District.

Child(ren) Information:

Name	Birthdate	Grade	Teacher

Parent/Guardian Information

	Parent/Guardian	Parent/Guardian
Name:		
Cell #:		
Email:		