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
940 IRON BRIDGE ROAD
ASBURY NJ 08802

Telephone (908) 479-6336 **Fax – (908) 479-1021**

_________________________________ has/have entered our _____________ grade(s)

as of _____________________________. In order to better serve the needs of the pupil, we need the following records:

1. Official Administrative Record (identifying data, grade, level completed, grades, attendance records).
2. Health Records
3. Teacher Observations and Ratings
4. Standardized Achievement and Aptitude Test Scores
5. Diagnostic Evaluations (may include psychological evaluations, psychiatric Evaluations, learning evaluations, social history, etc.)
6. Other: (Specify) ____
____

Sincerely,

Edward Keegan, Ed.D.

Interim Chief School Administrator

PERMISSION TO RELEASE INFORMATION

The above school records for ______________________________may be released to the Ethel Hoppock Middle School from:

School: ____

Address: ____

____

Date: ____

____
Signature of Parent/Guardian

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): ______________________________

Revised 1/17/06

Bethlehem Township School District

Home Language Survey*
Parent/Guardian Language Questionnaire

Name:_______________________________________ Age: _____
[first] [middle] [last]

Date of School Entrance_____________________

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent
[ ] Guardian [ ] Other ____________________

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English______ Other [specify]______________________________

2. What language does the family speak at home most of the time?

   English______ Other [specify]______________________________

3. What language does the parent [guardian] speak to the child most of the time?

   English______ Other [specify]______________________________

4. What language does the child speak to his/her parent [guardian] most of the time?

   English______ Other [specify]______________________________

5. What language does the child speak to her/her brothers and sisters most of the time?

   English______ Other [specify]______________________________

6. What language does the child speak to his/her friends most of the time?

   English______ Other [specify]______________________________

7. In which language do you wish to receive school communication?

   English______ Other [specify]______________________________

Signature:_________________________________ Date:______________
[person completing the survey]

*Adapted from the sample survey in A Manual for Community Representatives of the Title VI Steering Committee, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

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	________	Mumps	________
Bronchitis	________	Pneumonia	________
Chicken Pox	________	Rheumatic Fever	________
Eczema	________	Scarlet Fever	________
Measles	________ as documented by MD	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 ᵢ
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 <u>has had the chickenpox</u>, 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.

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

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

________ 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:		