KINGWOOD TOWNSHIP SCHOOL
REGISTRATION FORM

Please print.

Student Name:_____ Age:_____ Birth date:_____ Place of Birth:_____

Grade:_____ Gender:_____ Ethnicity of Child (for state reports):_____

Home Address:_____

Mailing Address (if different):_____ Home Phone:_____

Person Enrolling Student:_____ Relationship (if other than parent):_____

	Parent/Guardian 1	Parent/Guardian 2
Name		
Home Address		
Home Phone		
E-mail Address		
Place of Work/Address		
Work Phone		
Cell Phone		

Marital Status of Parents: Married_____ Divorced_____ Remarried_____ Single_____

Student Lives With: Both Parents_____ Father_____ Mother_____ Other_____

If Other, Please Explain:_____

Court Designated Custodial Person(s) (Please attach paperwork)_____

Student Military Connection (circle) 1= Not Military connected 2= Active Duty dependent 3= National Guard or Reserve dependent

Native Language of Parent/Guardian/Person Enrolling Student:_____
(If English is not the native language, please check here ____ if English is spoken and understood by the parent/guardian/person enrolling student.

PLEASE TURN OVER – FORM IS TWO SIDED

SIBLING INFORMATION: Please list other children in the family.

	NAME	GENDER	DATE OF BIRTH
1.			
2.			
4.			

EMERGENCY INFORMATION

The following information is required in case your child becomes ill or injured at school or in the event of an emergency and you cannot be reached. Please list three adults who can act in your absence to assume responsibility for your child.

	NAME	Address	Home Phone	Cell Phone
1.				
2.				
3.				

In case of accident or serious illness, 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 this physician, the school may make whatever arrangement that they deem necessary.

Family Physician:_____ Physician Phone:_____

I give permission for the school nurse to administer: **Tylenol** Yes___ No___ **Ibuprofen** Yes___ No___ **Benadryl** Yes___ No____

Please list any medical conditions (allergies, etc.)_____

DOES YOUR CHILD HAVE HEALTH INSURANCE?

YES_____ If yes, name of insurance 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.
You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature:_____ Printed Name:_____ Date:_____
Written consent required pursuant to 20 U.S.C. 1232g(b)(1) and 34 C.F.R. 99.30(b)

Date of Entrance:_____ School Last Attended: (Name and town):_____

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