Dr. Edythe B. Austermuhl
Superintendent

Megan Stoddart
Business Administrator

Kristin Braidwood
Supervisor of Special Services

BERLIN TOWNSHIP SCHOOL DISTRICT
(856) 767-9480 Fax (856) 767-8235 225 Grove Avenue West Berlin, NJ 08091
www.btwpschools.org

Registration Information For Parents and Guardians

Thank you for your interest in our school district. The purpose of this cover letter is to give you the information you will need to register your child in our schools.

Our John F. Kennedy Elementary School is for grades Preschool through 3. Our Dwight D. Eisenhower Middle School is for grades 4 through 8. We have a before and after school program called CARE and information on this program is included in our registration packet.

All registrations are done by appointment only. To schedule an appointment, please call Loretta Marshall at 856-767-9480, ext. 1111. Parents, please complete the registration packet. You will need to provide transfer paperwork from your child's previous school. That paperwork consists of a transfer card, a copy of your child's health card from the school nurse and the most recent report card and/or progress report. In addition, we will require your child's birth certificate and a copy of their immunization records. A physical examination is required to be done for all students entering preschool or kindergarten for the first time.

Proof of residency is also required. Please refer to the registration packet for acceptable forms of proof of residence. If your child is classified by the Child Study Team, a copy of the most recent IEP is required at registration.

When the registration is complete, entry into our student information system, Honeywell Instant Alert and transportation software will be made. You will receive a phone call or postcard with bus stop information.

If you have any questions regarding any of the requirements for registration, please contact Loretta Marshall at 856-767-9480, ext. 1111.

Thank you!

BERLIN TOWNSHIP SCHOOL DISTRICT
225 GROVE AVENUE, WEST BERLIN, NJ 08091
Phone: (856) 767-9480 Fax: (856) 767-8235

Student Name: _____ Date: _____

In order that the requirements of various State and Federal laws are met, the following information is necessary for the registration of students in the Berlin Township School District:

1. RESIDENCY REQUIREMENT

If the student is the child of a parent or guardian, or an adult student, whose permanent home is in the Berlin Township School District *or* if the student is living with a parent or guardian temporarily residing within the Berlin Township School District, even if the parent has a domicile elsewhere — please provide, if possible, TWO or more of the following:

- Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency.
- Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location.
- Court orders, State agency agreements and other evidence of court or agency placements or directives.
- Receipts, bills, cancelled checks and other evidence of expenditures demonstrating personal attachment to a particular location, or, where applicable, to support of the student.
- Medical reports, counselor or social worker assessments, employment documents, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency.
- Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, guardian, person keeping an "affidavit student," adult student, person(s) with whom a family is living, or others as appropriate.
- Documents pertaining to military status and assignment.
- Any business record or document issued by a governmental entity.
- Any other form of documentation relevant to demonstrating entitlement to attend school.

Please Note: The forms of documentation may demonstrate your student's eligibility for enrollment in the district. The totality of information and documentation you offer will be considered in evaluating an application, and, unless expressly required by law, the student will not be denied enrollment based on your inability to provide certain form(s) of documentation where other acceptable evidence is presented. You will not be asked for any information or document protected from disclosure by law, or pertaining to criteria which are not legitimate bases for determining eligibility to attend school. You may voluntarily disclose any document or information you believe will help establish that the student meets the requirements of law for entitlement to attend school in the district, but we may not, directly or indirectly, require or request: income tax returns, documentation/information relating to citizenship or immigration/visa status or social security numbers.

If the student's parents are domiciled in different districts, regardless of which parent has custody, please provide a copy of a court order or written agreement between the parents of the student designating the district for school attendance.

If the student resides with a Berlin Township School District resident (other than a parent or guardian), please provide ALL of the following:

- Student Residency Form (included in this registration packet).
- A sworn statement from the student's parent or guardian, together with documentation to support its validity, that he or she is not capable of supporting or providing care for the student due to family or economic hardship and the student is not residing with the Berlin Township School District resident solely for the purpose of receiving a free public education.
- A sworn statement from the person keeping the student that he or she is domiciled within the school district, is supporting the child without remuneration and intends to do so for a time longer than the school term, and will assume

all personal obligations for the student pertaining to school requirements *and* a copy of his or her lease if a tenant, a sworn landlord's statement if residing as a tenant without written lease, or a mortgage or tax bill if an owner.

Please Note: A student will not be considered ineligible because required sworn statements(s) cannot be obtained, so long as evidence is presented that the underlying requirements of the law are being met. A student will not be considered ineligible when evidence is presented that the student has no home or possibility of school attendance other than with a non-parent district resident who is acting as the sole caretaker and supporter of the student. A student will not be considered ineligible solely because a parent or guardian provides gifts or limited contributions, financial or otherwise, toward the welfare of the student, provided that the resident keeping the student receives no payment or other remuneration from the parent or guardian for the student's actual housing and support. Receipt by the resident of social security or other similar benefits on behalf of the student do not render a student ineligible. It is not necessary that guardianship or custody be obtained before a student will be considered for enrollment on an "affidavit" basis.

2. DOCUMENTATION OF RELATIONSHIP TO STUDENT

- Parent – Provide a certified copy of the student's birth certificate (within thirty days of registration)
- Legal Guardian – Provide official records appointing the student's legal guardian
- Foster Parent – Provide official records from the agency appointing the student's foster parent
- Domicile Affidavit (signed by Berlin Township resident)
- Affidavit of Non-Support (signed by Parent – corresponds with above)

3. DOCUMENTATION OF GRADE PLACEMENT

Please provide one or more of the following items as documentation of grade placement:

- Transfer Card
- Current Report Card
- Official Transcript

Please Note: Absence of a student's prior educational record does not affect a student's eligibility to enroll in school, although the initial educational placement of the student may be subject to revision upon receipt of records or further assessment by the District.

4. DOCUMENTATION OF HEALTH

Please provide one of the following items as documentation of health:

- Immunization Record
- Religious Exemption Letter

Please Note: Absence of student medical information does not affect a student's eligibility to enroll in school, although actual attendance at school may be deferred as necessary in compliance with rules regarding immunization of students.

Any person who fraudulently allows a child of another person to use his residence and is not the primary financial supporter of that child AND any person who fraudulently claims to have given up custody of his child to a person in another district commits a disorderly person offense. It is illegal for any person to make a false statement on this form in an attempt to cause the Berlin Township School District to provide a free education to a person under false pretenses. It is illegal for any person to offer a written instrument that contains a false statement or false information to the Berlin Township School District in an attempt to secure a free education.

STUDENT REGISTRATION FORM

(For office use only)

LID Number: _____ SID Number: _____

School Start Date: _____

A. BASIC INFORMATION - PARENTS/GUARDIANS - PLEASE COMPLETE

1. STUDENT NAME (as it appears on birth certificate):

_____

Last First Middle Suffix

2. GENDER (circle one): MALE FEMALE

3. DATE OF BIRTH: _____

4. CITY OF BIRTH: _____

5. STATE OF BIRTH: _____

6. COUNTRY OF BIRTH: _____

7. PRIMARY LANGUAGE SPOKEN IN HOME: _____

8. HOME PHONE NUMBER: _____

9. CELL PHONE NUMBER: _____

10. HOME ADDRESS: _____

11. MAILING ADDRESS (if different from above): _____

12. STUDENT'S PREVIOUS MAILING ADDRESS: _____

13, FATHER'S FULL NAME: _____

14. MOTHER'S FULL NAME: _____

15. MOTHER'S MAIDEN NAME: _____

16, GUARDIAN'S FULL NAME (if applicable): _____

17. IF. GUARDIAN, WHAT IS YOUR RELATIONSHIP TO THE STUDENT?

_____

18. LEGAL PAPERWORK INVOLVED FOR STUDENT (circle below):

CUSTODY: YES NO Date Received: _____

DCP & P: YES NO Date Received: _____

OTHER: _____ Date Received: _____

19. NAME OF PREVIOUS SCHOOL ATTENDED:_____

20. ADDRESS OF PREVIOUS SCHOOL ATTENDED:

_____

_____

21. PHONE NUMBER OF PREVIOUS SCHOOL ATTENDED: _____

22. IS YOUR CHILD CLASSIFIED BY THE CHILD STUDY TEAM? (CIRCLE ONE) Y N

23. IF YOU ANSWERED YES TO THE ABOVE, THE MOST RECENT IEP MUST BE SUPPLIED AS SOON AS POSSIBLE TO DETERMINE STUDENT SERVICES

OTHER: (The information that is requested below is required by the New Jersey State Department of Education. The State Department of Education has begun an initiative to track background information and test scores for each child enrolled in public schools throughout the state. NJ Standards Measurement and Resources for Teaching (NJSMART) information will be collected by the state each year. It is pertinent that we have this information for the completion of our reports.)

A. CHILD'S ETHNICITY: HISPANIC OR LATINO – PLEASE CIRCLE ONE

YES NO

B. CHILD'S RACE: PLEASE CIRCLE ALL THAT APPLY

AMERICAN INDIAN BLACK OR AFRICAN AMERICAN

ASIAN CAUCASIAN

NATIVE AMERICAN OR OTHER PACIFIC ISLANDER

C. HEALTH INSURANCE

DOES YOUR CHILD HAVE ANY HEALTH INSURANCE INCLUDING NJ FAMILYCARE, MEDICAID OR OTHER PRIVATE INSURANCE?

YES NO

IF SO, PLEASE LIST YOUR INSURANCE PROVIDER'S NAME (ie AETNA, BCBS, HORIZON)

_____

IF NO INSURANCE, MAY A REPRESENTATIVE OF NJ FAMILYCARE CONTACT YOU? Y N

Written consent required pursuant to 20 U.S.C. 1232g(b)(1) and 34 C.F.R. 99.30(b). NJ FamilyCare provides free or low cost insurance for uninsured children and certain low income parents. For more information please call: 1-800-701-0710.

D. MILITARY CONNECTED STUDENT INDICATOR:

Please check the appropriate description below, please only check ONE description

_____ **Not Military Connected – Parent is not military connected**

_____ **Active Duty – Student is a dependent of a member of the U.S. Active Duty Forces**

_____ **National Guard or Reserve – Student is a dependent of a member of the National Guard or Reserve Forces**

PLEASE PRINT YOUR NAME HERE:_____

PLEASE SIGN YOUR NAME HERE:_____

DATE:_____

BERLIN TOWNSHIP BEFORE AND/OR AFTER SCHOOL CHILDCARE PROGRAM

C.A.R.E. (Children's Afterschool Recreation Education)

C.A.R.E. is a convenient and reasonably priced before/after school program for students in PK – 8th grades. This program is located in the John F. Kennedy School.

C.A.R.E. provides a healthy snack, homework time and help, age appropriate games, outdoor activities, crafts, trips and more.

If interested, please call (609) 929-4271

Berlin Township Schools

Yearly Medical Update

Child's Name:_____ Grade/Teacher:_____

Family Doctor:_____ Office #:_____

1. Does your child take medication on a regular basis? _____Yes _____No. If yes, please indicate the exact name and reason:_____.

2. Does your child wear glasses? _____Yes _____ No.

3. PLEASE LIST ANY MEDICAL PROBLEMS, INCLUDING ALLERGIES:_____
   _____
   _____
   _____

4. Does your child have specific food allergies? _____ Yes _____ No. If yes, please describe:_____

5. Does your child require an epi-pen for any allergies? _____ Yes _____ No. If yes, please explain:_____

6. Does your child have any physical limitations? _____ Yes _____ No. If yes, please explain:_____

Please list the telephone numbers in order of importance to call between 8:00am and 3:00pm in case your child is sick and needs to be picked up from school. These are the 1st numbers we will use in case of an emergency.

Name/Relationship	Phone Number
1._____	_____
2._____	_____
3._____	_____
4._____	_____

I GIVE PERMISSION FOR PERTINENT MEDICAL INFORMATION TO BE SHARED WITH APPROPRIATE STAFF IN ORDER TO ENHANCE YOUR CHILD'S EDUCATION AND SAFETY.

_____YES _____NO **Parent/Guardian Signature:**_____

Health Screening Permission Form

The State of NJ requires schools to perform yearly health screenings. The purpose of these screenings is for early detection of problems which may affect your child's health and/or learning. Listed below are the screening services that are provided at each grade level. Please inform the school nurse in writing if you do not wish for your child to participate in these services.

Height/weight/Blood Pressure – Grades K-8th

Vision Screening – Grades K, 2,4,6, & 8

Hearing Screening – Grades K,1,2,3,&7

Scoliosis Screening – Grades 5 & 7

Fluoride Rinse Program

Fluoride rinse is provided one time per week throughout the school year for grades 1 – 6 only.

_____ YES, my child may rinse one time per week.

_____ No, we do not wish to participate.

Please contact your school nurse if any of the above information has changed. We look forward to a happy and healthy year with your student.

Parent/Guardian Signature_____ Date_____

Please answer the following questions so we may better meet your child's individual needs.

Family Doctor Name: _____

Family Doctor Address: _____

Family Doctor Telephone: _____

Does your child take medication on a regular basis? Circle one Y N

If yes, please list the name of the medication and the dosage:

_____

Please check all areas that apply for each question:

Does your child wear any corrective devices?

Eyeglasses _____ Contact Lenses _____ Braces _____

Dental Retainers _____ Other _____

Does your child have any?

Hearing problems _____ Hearing Loss _____ Hearing Aid _____

Has your child had tubes inserted into the ears by a physician to alleviate fluid and ear infections? Circle one **Y** **N**

If yes, please list date and doctor's name that performed the procedure

Date _____ Doctor's Name _____

Is your child allergic to any of the following?

_____ Pollen _____ Reaction _____
(plant name)

_____ Insect Sting _____ Reaction _____
(insect name)

_____ Food Products _____ Reaction _____
(food name)

_____ Medication _____ Reaction _____
(medication name)

_____ Other _____ Reaction _____
(describe)

Does your child react severely to any of the above? Circle one **Y** **N**

If yes, please explain:_____

If an epi-pen may be needed, will you give permission for this to be delegated?

Circle one **Y** **N**

Does your child have:

Asthma _____ Diabetes _____ Seizures _____

Anxiety _____ Depression _____

If yes was checked to any of the above, please explain:

_____

Does your child have any medical condition(s) that would limit normal school activity, including physical education and play periods?

Circle one Y N

If yes to the above, please explain:

Has your child had any broken bones? Circle one Y N

If yes, please list what bone and year of break:

Please list any other medical conditions of which the nursing office should be aware:

STUDENT HEALTH HISTORY

STUDENT NAME: _____ **DATE OF BIRTH:** _____
FIRST LAST MONTH/DAY/YEAR

CHILD'S BIRTH WEIGHT: _____ POUNDS _____ OUNCES

PLEASE CHECK YES OR NO FOR EACH CATEGORY LISTED:

	NO	YES
ILLNESS OF MOTHER DURING PREGNANCY	_____	_____
COMPLICATIONS OF DELIVERY (EX. CESAREAN SECTION)	_____	_____
DIFFICULTY SOON AFTER BIRTH	_____	_____

WALKED ALONE WHEN _____ MONTHS OLD

SAID A FEW WORDS WHEN _____ MONTHS OLD

HAS CHILD HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO AND PROVIDE DATES:

	NO	YES	DATE
MEASLES	_____	_____	_____
MUMPS	_____	_____	_____
RUBELLA	_____	_____	_____
CHICKEN POX	_____	_____	_____
RHEUMATIC FEVER	_____	_____	_____
ASTHMA OR WHEEZING	_____	_____	_____
PNEUMONIA/BRONCHITIS	_____	_____	_____
FREQUENT SORE THROAT	_____	_____	_____
FREQUENT EAR INFECTIONS	_____	_____	_____
TROUBLE WITH HEARING	_____	_____	_____
TROUBLE WITH SPEECH	_____	_____	_____

	NO	YES
ALLERGIES	_____	_____
FREQUENT VOMITING/DIARRHEA	_____	_____
TENDENCY TO BLEED EASILY	_____	_____
ECZEMA OR HIVES	_____	_____
CONVULSIONS OR SEIZURES	_____	_____
UNUSUAL NERVOUSNESS	_____	_____
NAIL BITING	_____	_____
THUMB/FINGER SUCKING	_____	_____
NIGHTMARES/TROUBLE SLEEPING	_____	_____
BREATH HOLDING/TEMPER TANTRUMS	_____	_____
DIFFICULTY WITH TOILET TRAINING OR BED WETTING	_____	_____
HISTORY OF HEART MURMUR	_____	_____
ANY SEVERE INJURIES OR OPERATIONS	_____	_____
OTHER	_____	_____

PLEASE SPECIFY:

_____

Relation: Name	Year of Birth:	State of Health: Good/Fair/Poor
Father: _____	_____	_____
Mother: _____	_____	_____
Brother: _____	_____	_____
Brother: _____	_____	_____
Brother: _____	_____	_____
Sister: _____	_____	_____
Sister: _____	_____	_____
Sister: _____	_____	_____

Has any relation ever had any of the following? Please check Yes or No and list relationship to student

	NO	YES	RELATIONSHIP
SIGNIFICANT ALLERGY	_____	_____	_____
RHEUMATIC FEVER	_____	_____	_____
HEART DISEASE	_____	_____	_____

	NO	YES	RELATIONSHIP
DIABETES	_____	_____	_____
TUBERCULOSIS	_____	_____	_____
CONVULISVE DISORDER	_____	_____	_____
MENTAL ILLNESS	_____	_____	_____
CANCER	_____	_____	_____

THANK YOU FOR COMPLETING THE HEALTH OFFICE FORMS OF

THIS REGISTRATION PACKET

BERLIN TOWNSHIP SCHOOL DISTRICT

Student Residency Questionnaire

NOTE: PLEASE REMOVE ALL INFORMATION IN THIS BOX BEFORE USING THIS FORM; UPDATE THIS FORM TO REFLECT THE NEEDS AND SPECIFICS PERTAINING TO YOUR DISTRICT. This form is an example of what most districts in Texas have found useful to include in their student enrollment packets to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. This form is adapted from one developed by Cypress Fairbanks ISD.

Name of School _____

Name of Student: _____ Sex: ☐ Male ☐ Female
Last First Middle

Birth Date ____/____/____ Age: _____ _____
Month / Day / Year NJSMART Student Identification Number Supplied by School District

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?

_____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (*Check one box.*)

- ☐ In a motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accomodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) _____

Address _____ Zip _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian _____ Date _____

Please send a copy to _____ **at the Central Office.**
Fax: xxx-xxx-xxxx

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature

Medicaid Notification

Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).
The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.
In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?
- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.
What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) ___Mailed to parent(s) ___Emailed to parent(s) ___IEP meeting _x_ Hand Delivered

BERLIN TOWNSHIP SCHOOL DISTRICT
Huster Administrative Building
225 Grove Avenue
West Berlin, New Jersey 08091
(856) 767-9480

"Educating Today for Tomorrow's Success"

SUPERINTENDENT OF SCHOOLS
Dr. Edythe Austermuhl

BUSINESS ADMINISTRATOR
Megan Stoddart

SUPERVISOR OF SPECIAL SERVICES
Kristin Braidwood

Special Education Medicaid Initiative (SEMI) Parental Consent form

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, **nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.**

Child's Name: _____

Child's Date of Birth: _____/_____/_____

Parent/Guardian: _____

Date: ____/_____/_____

I give consent to bill for SEMI:

Yes ☐
No ☐

This consent can be revoked at any time by contacting the administrator at your child's school.

Dr. Edythe B. Austermuhl
Superintendent

Megan Stoddart
Business Administrator

Kristin Braidwood
Director of Special Services

BERLIN TOWNSHIP SCHOOL DISTRICT

(856) 767-9480 Fax (856) 767-8235 225 Grove Avenue West Berlin, NJ 08091
www.btwpschools.org

PERMISSION TO RELEASE ALL STUDENT RECORDS TO:

Berlin Township School District
Huster Administration Building
225 Grove Avenue
West Berlin, NJ 08091
ATTN: RECORDS

Last School Attended: _____

School's Mailing Address: _____

City, State, Zip _____

The following student has enrolled in Berlin Township School District on: _____

NAME: _____

GRADE _____

DATE OF BIRTH _____

I give permission for you to release the records for the student indicated above. (Note – permission is not required under NJAC)

I understand under the Federal No Child Left Behind requirements, I must now also authorize the release of my child's discipline records to be included with the release of my child's permanent records, and my signature below indicates my authorization and permission to release the records to the above-mentioned school as soon as possible.

_____ _____
Parent/Guardian Signature Date

** According to New Jersey Administrative Code 6:3-2.1 to 2.8, *"Mandated pupil records shall be forwarded to the receiving district…."*. **Cumulative Folder, Health Records, Grade-to-date, Child Study Team Records, Test Results and any other mandated records on the pupil listed above as soon as possible.**