

FRANKLIN BOROUGH SCHOOL
 50 Washington Avenue, Franklin, NJ 07416
 973-827-9775 (phone) - 973-827-6522 (fax)
STUDENT PROFILE - REGISTRATION FORM

Start Date: _____

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH	TODAY'S DATE
STREET ADDRESS					HOME PHONE ()	CELL PHONE ()
MAIL SHOULD BE ADDRESSED TO THE PERSON(S) LISTED BELOW:					GENDER	
					BOY	GIRL
MAILING ADDRESS					RACE (Optional)	
					W	B
NAME (CIRCLE ONE) MOTHER, STEPMOTHER, GUARDIAN				OCCUP.		BUS. PHONE ()
				CELL # ()		
NAME (CIRCLE ONE) FATHER, STEPFATHER, GUARDIAN				OCCUP.		BUS. PHONE ()
				CELL # ()		
EMERGENCY CONTACT #1 (OTHER THAN PARENT) **				PHONE ()		RELATIONSHIP
				CELL # ()		
EMERGENCY CONTACT #2 (OTHER THAN PARENT) **				PHONE ()		RELATIONSHIP
				CELL # ()		
CHILD'S DOCTOR					DOCTOR'S PHONE #	
NAME AND PHONE # OF LAST SCHOOL ATTENDED					HEALTH CONCERNS	
OTHER CHILDREN IN FAMILY (LIST BELOW):						
NAME	AGE	GRADE	NAME	AGE	GRADE	Child resides with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian

**** SOMEONE AUTHORIZED TO TRANSPORT/CARE FOR YOUR CHILD - PLEASE NOTIFY SCHOOL OF ANY CHANGES.**

PLEASE CHECK ALL THAT APPLY:

___ I am the natural parent. ___ I have sole legal custody. ___ I have joint legal custody.

___ I am the adult the child is living with now. ___ I am a legal guardian. ___ I am a stepparent.

_____ **I give my permission to release my child's photo and/or name for school-related activities.**

_____ **I DO NOT give my permission to release my child's photo and/or name to the media for school-related activities.**

_____ **However, I do GIVE my permission to publish my child's picture in the school yearbook.**

_____ **Signature - Relationship to child** _____ **Date**

Please complete the reverse side.

CHILD'S NAME	DATE OF BIRTH
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HEALTH INSURANCE - Does the above-named 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)

MEDICAL HISTORY

1. Please explain any history of serious illness, hospitalizations, or surgery. _____

2. Does the child have any allergies? _____ Allergic to: _____

3. Is the child on any medication? _____ Current Medication _____

May we share this information with your child's teachers? Yes No

4. Is there a history of any of the following?

- Multiple ear infections yes no
- Hearing problems yes no
- Visual problems yes no
- Speech problems yes no
- High blood pressure yes no
- Heart murmur yes no
- Asthma yes no
- Diabetes yes no
- Pneumonia yes no
- Chronic or recurrent stomach complaints yes no
- Kidney or bladder infections yes no
- Febrile (high temperature) convulsions yes no
- Epilepsy yes no
- Meningitis/Encephalitis yes no
- Head trauma causing concussion or loss of consciousness yes no
- Eating problems yes no
- Sleeping problems yes no
- Behavioral problems yes no

PLEASE GIVE DETAILS ON ANY OF THE ABOVE YES ANSWERS: _____

Child's City of Birth: _____ State of Birth: _____ Country of Birth: _____

 Name of person completing this form (PLEASE PRINT)

 Signature of person completing this form

 Date

OFFICE USE: <input type="checkbox"/> Proof of Residency <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Immunizations
