St. Mark Christian Academy
80 David Street, South River, NJ 08882 - (732)743-9670
Info@stmarkacademy.com - www.stmarkacademy.com

REGISTRATION CHECKLIST

WELCOME TO ST. MARK CHRISTIAN ACADEMY!

IN ORDER TO BE SURE YOUR CHILD HAS BEEN REGISTERED PROPERLY, THE FOLLOWING FORMS AND DOCUMENTATION MUST BE COMPLETED AND RETURNED BEFORE 8/1/2022:

1. REGISTRATION FORM _____
2. B6T TRANSPORTATION FORM _____
3. TEXTBOOK FORM _____
4. NURSING SERVICES FORM _____
5. EMERGENCY CONTACT FORM _____
6. PERMISSION TO ADMINISTER MEDICATION _____
7. TUITION PAYMENT AGREEMENT _____
8. BEFORE/AFTERCARE AGREEMENT, IF APPLICABLE _____
9. IMMUNIZATION HISTORY _____
10. BIRTH CERTIFICATE _____
11. PHYSICAL EXAM _____
12. REGISTRATION FEE OF $400 _____
13. 1ST MONTH TUITION DUE BY JULY 1 _____
14. ORDER UNIFORMS _____
15. GYM UNIFORM _____
16. SPIRIT WEAR _____
17. HAVE YOU SIGNED UP TO VOLUNTEER? _____

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REGISTRATION FORM

Pre-K thru Grade 8 – Please fill out COMPLETELY

_____New Family _____Sibling Application _____Single Child

If your child is entering Pre-K, please complete pg. 2, as well.

1. Child's Name: _____
Sex: M F Age: _____ DOB: _____Birthplace: _____
Enrolling Grade:_____
2. Child's Name: _____
Sex: M F Age: _____ DOB: _____Birthplace: _____
Enrolling Grade:_____
3. Child's Name: _____
Sex: M F Age: _____ DOB: _____Birthplace: _____
Enrolling Grade:_____
4. Child's Name: _____
Sex: M F Age: _____ DOB: _____Birthplace: _____
Enrolling Grade:_____
Address_____
City_____State _____ Zip Code_____
E-Mail_____
Previous School(s)_____
Address:_____
Child(ren) resides with_____ Both Parents _____Mother _____Father _____ Guardian
Language (other than English) Spoken at Home: _____
How did you hear about our school? ____Newspaper Ad _____Referred by Family/Friend
_____Social Media ____Website _____Other Please explain:
_____
Parent Information: Father's Name_____
Mother's Name_____
Best Email address to use _____
Father Cell Phone _____Mother Cell Phone _____
Home Phone Phone_____
Mother Occupation _____
Father Occupation _____
Mother Work Phone_____Father Work Phone_____
Number of children in Family_____ Transportation to school: _____car _____bus _____walk

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Please submit this Registration Form to: ***Saint Mark Christian Academy*** *80 David Street South River, NJ 08882 Attn: Registration. Acceptance letters will be mailed to the parent(s) after the application is processed and approved.*

*PARENT SIGNATURE*_____*DATE*_____

The following information must be submitted upon acceptance: Immunization record, Birth Certificate,Physical Exam Form and Health History.

Please complete this section if you are registering a child into our Pre-Kindergarten 4 Program Pre-K Program Selection Please check which program you are interested in:

Pre-K 4-year-old programs (Child MUST be 4 years old by October 31)

____ 3 Full Days (Monday, Wednesday, Friday – 8:30 am –3:00 pm)

____ 5 Full Days (Monday through Friday – 8:30 am – 3:00 pm)

NEW JERSEY STATE DEPARTMENT OF EDUCATION
OFFICE OF STUDENT TRANSPORTATION

(B6T) APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION

Please submit a separate application for each child to the private school

SCHOOL YEAR _____ RESIDENT DISTRICT BOARD OF EDUCATION _____

STUDENT's NAME _____ (LAST FIRST MIDDLE) DATE OF BIRTH _____ (MONTH DAY YEAR)

GENDER _____ (M or F) PARENT/GUARDIAN NAME _____ DAYTIME PHONE _____ (AREA CODE + NUMBER)

HOME ADDRESS _____ CITY or TWP _____ ZIP _____

NEAREST INTERSECTION TO STUDENT'S RESIDENCE _____

MAILING ADDRESS _____ ZIP _____

FULL NAME OF SCHOOL TO BE ATTENDED _____ PHONE _____

ADDRESS OF SCHOOL _____

STUDENT'S GRADE FOR THE COMING YEAR _____ SHORTEST ONE-WAY MILEAGE BETWEEN HOME AND SCHOOL _____ (MILES TENTHS) (MEASURED VIA THE SHORTEST ROUTE ALONG PUBLIC ROADWAYS OR WALKWAYS IN MILES AND TENTHS)

DATE SCHOOL OPENS _____ CLOSES _____ SCHOOL HOURS FROM _____ AM TO _____ PM

NAME AND ADDRESS OF SCHOOL OF ATTENDANCE IN PRIOR YEAR _____

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE * FOR PUBLIC SCHOOL USE ONLY

YOUR APPLICATION HAS BEEN REVIEWED BY THE RESIDENT DISTRICT BOARD OF EDUCATION. THE FOLLOWING DETERMINATION HAS BEEN MADE:

_____ TRANSPORTATION WILL BE PROVIDED _____ YOU ARE ELIGIBLE FOR PAYMENT IN LIEU OF TRANSPORTATION

_____ INELIGIBLE _____ (REASON)

DATE _____ SIGNATURE _____ TITLE _____

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION (B6T) N.J.A.C. 6A:27-2.5

1. IT IS THE OBLIGATION OF THE PARENT OR GUARDIAN OF PRIVATE SCHOOL STUDENTS TO:

- ANNUALLY OBTAIN THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION FROM THE ADMINISTRATIVE OFFICE OF THE PRIVATE SCHOOL FOR EACH STUDENT FOR WHICH TRANSPORTATION SERVICES ARE BEING REQUESTED. SUBMIT A SEPARATE APPLICATION FOR EACH STUDENT.

NOTE:

- IF THERE IS A CHANGE OF HOME ADDRESS, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.
- IF THERE IS A CHANGE IN THE NONPUBLIC SCHOOL OF ATTENDANCE, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.

- COMPLETE THIS APPLICATION AND RETURN IT TO THE PRIVATE SCHOOL ON OR BEFORE MARCH 10TH PRECEDING THE SCHOOL YEAR IN WHICH TRANSPORTATION IS BEING REQUESTED.

LATE APPLICATIONS – ANY APPLICATION RECEIVED AFTER MARCH 10TH WILL BE A LATE APPLICATION AND MUST BE ACCOMPANIED BY A STATEMENT OF THE REASON FOR LATENESS. ELIGIBLE STUDENTS WILL RECEIVE TRANSPORTATION OR AID IN LIEU OF TRANSPORTATION BASED ON THE DATE THE APPLICATION IS RECEIVED BY THE PUBLIC SCHOOL.

2. IT IS THE OBLIGATION OF THE NONPUBLIC SCHOOL ADMINISTRATOR TO ANNUALLY COLLECT THE APPLICATION AND SUBMIT IT TO THE PUBLIC SCHOOL FROM WHICH TRANSPORTATION IS BEING REQUESTED PRIOR TO MARCH 15TH.

3. IT IS THE OBLIGATION OF THE PUBLIC SCHOOL ADMINISTRATOR TO NOTIFY THE PARENT OR GUARDIAN AS TO THE DETERMINATION OF EACH APPLICATION BY AUGUST 1ST.

A DISTRICT BOARD OF EDUCATION SHALL PAY AID IN LIEU OF TRANSPORTATION TO THE PARENT OR GUARDIAN OF AN ELIGIBLE STUDENT ONLY AFTER RECEIVING A SIGNED "REQUEST FOR PAYMENT OF TRANSPORTATION AID" VOUCHER AS PRESCRIBED BY THE COMMISSIONER OF EDUCATION.

PROOF OF RESIDENCY FORM

Dear Parent/Guardian,

Please complete the proof of residency form and return to school along with the B6T Transportation form (Application for Private School Transportation) and a copy of a photo driver's license with matching parent/guardian name and address. Proof of residency must also match the B6T and include your name and address. These forms will be transmitted to your sending school district. Bank mortgage statement for the current year, contract to purchase a home, current rental or lease agreement, current tax bill, or a copy of property deeds are acceptable. If there is a change of home address, a new application and B6T Transportation form must be submitted to the public school district.

STUDENT NAME: _____

STUDENT ADDRESS: _____

_____

STUDENT GRADE: _____
(If your child is registered for Kindergarten you **must** include a copy of their birth certificate)

SCHOOL TO BE ATTENDED: _____

PARENT/GUARDIAN NAME: _____
(If guardian, guardianship documentation is necessary)

COPY OF PHOTO DRIVER'S LICENSE _____

PROOF OF RESIDENCY ENCLOSED:
Please provide a **current** copy of ONE of the following documents

BANK MORTGAGE STATEMENT _____

PROPERTY TAX RECEIPT FOR CURRENT YEAR _____

LEASE ORRENTAL AGREEMENT FOR CURRENT YEAR: _____

CURRENT DEED: _____

New Jersey Department of Education
Office of Interdistrict Choice and Nonpublic Schools

Individual Student Request Form for Loan of Textbooks

Date: _____

Public School Information

Public School District: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Nonpublic School Information

Nonpublic School: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Student Information

Name of Student: _____ Grade: _____

Name of Parent/Guardian: _____

Parent/Guardian Ce[redacted]

Under the provisions of N.J.S.A. 18A: 58-37.1 et seq., I hereby request

_____ to loan textbooks to the
(Public School District)

_____ in which my child is enrolled.
(Nonpublic School)

I certify that my above-named child and I are residents of the State of New Jersey. I understand that the public school district in which the nonpublic school is located has oversight of the State funds designated for providing the loan of textbooks to nonpublic school students pursuant to law and regulations.

Signature of Parent/Guardian:

Date: _____

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Dear Parents,

Existing legislation provides certain nursing services and funding for full-time students in private schools. Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, and scoliosis screening. In addition, your child will receive emergency nursing services for any school related illness or injury. Please sign the form below and return to the health office as soon as possible. RE: Nursing Services Chapter 226-Laws of 1991

NONPUBLIC NURSING SERVICES I give permission for my child,

_____, in Grade _____ to participate in nursing services.

School District: South River School: St. Mark Christian Academy

Parent Name _____

Parent Signature_____ Date_____

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MEDICAL RELEASE

Date:_____

To:_____

Fr:_____

Student Name:_____

Re:_____

Dear Parent/Guardian:

It has come to our attention that your child has the following diagnosis:_____

_____.

We have been advised he/she is in need of a specific protocol:_____

_____ and required medication for emergency use. You have made a decision not to comply with the suggested protocol, and it is now necessary for you to sign this release of responsibility for St. Mark Christian Academy. Please understand, if he/she suffers an emergency due to this condition, 911 will be called as the immediate intervention.

Parent 1:_____

Parent 2:_____

School Nurse:_____

Principal:_____

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EMERGENCY CONTACT INFORMATION 2020-2021

Student Name:

_____

Parent/Guardian:

_____

Address:

_____

Phone Numbers At Which Parent Can Be Reached: 1) _____
2) _____ 3) _____

CONTACTS AND CUSTODY: NOTE: THIS SECOND MUST BE COMPLETED BY INDIVIDUALS WHO AGREE TO: 1) BE CONTACTED IN AN EMERGENCY 2) TAKE CUSTODY OF THE ABOVE NAMED STUDENT IN AN EMERGENCY

I/ We agree to be contacted in an emergency, to accept custody of the above named student and to provide information and assistance in resolving the emergency.

1) Name (Print)_____ Signature _____
Relationship _____ Phone _____
2) Name (Print)_____ Signature _____
Relationship _____ Phone _____
3) Name (Print)_____ Signature_____
Relationship _____ Phone _____
Family Physician/Pediatrician: _____
Address: _____
Phone: _____ Medical Insurance Provider:
_____
(e.g., Medicaid, Blue Cross/ Blue Shield) Address:
_____
Phone: _____ Name of Employer: _____
Address: _____ Phone: _____

I _____, the parent/guardian of _____
Grant permission for St. Mark Christian Academy staff to secure emergency medical, psychiatric and/ or other services should they be needed and school staff is unable to contact me. I understand that my personal insurance will be primary with respect to the payment of any insurance benefits. If I cannot be contacted, my child can be placed in the custody of the person(s) Identified in the "Contacts and Custody" second of this form. Parent Signature:

_____ Date: _____

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2022-2023 AUTHORIZATION FOR NURSE TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL (TO BE KEPT CONFIDENTIAL UPON COMPLETION)

NAME OF STUDENT: _____ GRADE: _____
DIAGNOSIS / ILLNESS: _____
MEDICATION: _____
DOSAGE: _____
FREQUENCY: _____
SPECIAL INSTRUCTIONS: _____
POSSIBLE SIDE EFFECTS: _____

I certify that the above information regarding this student is correct, and that the administration of the medication to this student is necessary.

_____ _____
Signature of Prescribing Physician Date

_____ _____

Stamp

Phone_____

****

I/We authorize the School Nurse, or in his/her absence, the Principal to administer the above medication as indicated. I/We understand and agree that the School, The School Nurse, and the Principal shall not be liable for any injury to the Student resulting from the administration of the medication as authorized by my signature below.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

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We have read the Tuition Payment Policies for St. Mark Christian Academy. We understand all policies and agree to abide by them.

Family Name (Print):_____

Parent 1 Name (Print): _____

Signature: _____

Parent 2 Name (Print): _____

Signature: _____

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Before/After School Registration Form

Family Registration Fees: A one-time registration fee of $25.00 per family is due with this registration form. No child will be allowed to stay for Before/Aftercare without a registration form on file in the school office, and the registration fee paid.

Family Name: _____ E-Mail: _____

Mother's Name: _____Father's Name: _____

Child's Name: _____ Grade:_____

Child's Name: _____ Grade:_____

Child(ren)'s Primary Address:

_____

Contact Information: Mother's Home/Cell/Work Phones (please indicate the order you would like to be contacted):
Home:_____ Cell:_____Work:_____ Father's Home/Cell/Work Phones: (please indicate the order you would like to be contacted):
Home:_____ Cell:_____Work:_____

Emergency Names and Numbers: Please list the adults who may be contacted in the event you can not be reached, and who have permission to pick up your child(ren). If at any time these names change, please send an updated contact list to the office. No child will be allowed to leave without written permission. We will Check ID.
Name:_____
Phone:_____
Name:_____
Phone:_____

Allergies/medical concerns:

_____
_____
_____

Please indicate which days your child(ren) will attend.. _____Monday _____ Tuesday _____Wednesday _____Thursday _____Friday
Parent Signature:_____Date:_____

Students in Before/After-Care are required to follow all policies and rules set forth in the Student Handbook.

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:

Weight *(must be taken within 30 days for WIC)*	
Height *(must be taken within 30 days for WIC)*	
Head Circumference *(if <2 Years)*	
Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS

☐ Immunization Record Attached
☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • *List medical conditions/ongoing surgical* concerns:	☐ None ☐ *Special Care Plan* Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. ***Behavioral/Mental Health issues*** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.