

TOWNSHIP OF BYRAM BOARD OF EDUCATION

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February 2, 2012

Dear Parents and Guardians,

It is hard to believe that it's almost time for our 100th day celebration. More importantly it is time for KINDERGARTEN REGISTRATION!

This year, we are excited to announce some changes to our registration process. In order to streamline this procedure and to save time for all those involved, we have scheduled two dates, February 16th and 17th, as "Packet Pick up Days." If you have a child who will be entering kindergarten in the fall, please stop by the school and pick up a packet on one of those two dates. At that time, you will schedule your appointment for registration. Once you receive the information, please fill out the forms prior to your appointment date. The dates of registration will be March 5th and 6th.

Included in the packet you will find a checklist of documentation that you **MUST** bring with you to your appointment in order to register your child. No child will be registered without the completed packet and required documentation. On the day of registration, you will also be scheduling your date and time for our "Spring into Kindergarten" screening where the kindergarten teachers will be completing a variety of activities with your child in order to assess him/her. While the teachers work with your children, you will have the opportunity to meet with me to learn about the school and the kindergarten program, as well as ask any questions you may have.

You can also download the complete registration packet on our website at www.byramschools.org and click on Byram Lakes School. You will see the link on the homepage. If you download the packet, please call the school to set up an appointment for registration.

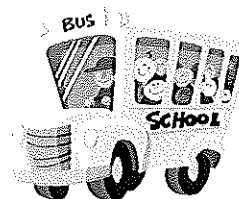
Dates	Events
February 16, 2012 & February 17, 2012	Pick up registration packet & Schedule registration appointment
March 5, 2012 & March 6, 2012	Kindergarten Registration (Please come at your scheduled time)
May 21, 2012 & May 22, 2012	Spring into Kindergarten (You will schedule this at registration)

If you do not have a child entering kindergarten, but know someone who does, please pass this information along. We hope that these changes will simplify the registration process. Should you have any questions, please feel free to call.

Sincerely,



Ed Abato
Principal
Byram Lakes Elementary School





Kindergarten Registration Checklist

Along with the forms included in this packet, below is a list of documentation that you must bring with you to register your child:

- Birth certificate with raised seal AND a copy
- Proof of residency (Please provide one of the following)
 - Lease, OR
 - Tax bill, OR
 - Notarized letter from homeowner with tax bill
- Current, official immunization record from a doctor
 - A physical exam from the pediatrician is NOT required for the registration process. It will be required prior to your child starting school in September.
 - Bus transportation information will be provided at a later time. Bus stops and morning/afternoon determination (based on address) will be completed by the bus company

**PACKETS WILL BE CHECKED PRIOR TO REGISTRATION.
IF ANY INFORMATION IS MISSING, REGISTRATION CANNOT TAKE PLACE.**

NOTES + QUESTIONS

BYRAM TOWNSHIP SCHOOLS

STUDENT REGISTRATION

Student Information

(Note: It is important for parents/guardians to inform the office, in writing, of any changes in address, phone numbers guardianship, emergency contacts, etc.)

First Name:		Middle Name:
Last Name:	Suffix Name:	Nick Name:

Birth Date (mm/dd/yyyy):	Gender	Male	Female
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Ethnicity	American Indian/Alaskan	Asian	African-American
	Hawaiian/Pacific Islander	Hispanic	White

Birth City:	Birth State (US only):	Birth Country:
Citizenship:	Primary Language:	Home Language:

Legal Residence Information

Street Address:		
City:	State:	Zip Code:
Mailing Address (if different):		
City:	State:	Zip Code:
Home Phone Number (xxx-xxx-xxxx):		
Parent/Legal Guardian	Name(s):	
	Signature:	
Custody Ruling (circle): Yes No If Yes, show Legal Custody status (circle): Joint Father Mother Guardian		

Emergency Contacts	List at least 2 contacts that will assume temporary custody of your child if you cannot be reached. Please ask prior permission from the contacts listed.
Name & Relationship	Phone Number (xxx-xxx-xxxx)
1.	
2.	
3.	

-----Office use only-----

Original Birth Certificate	Immunizations	Proof of Residency	
Registered – Grade Level	Homeroom	Year of Graduation/Class of	

Parent Information

(Note: It is important for parents/guardians to inform the office, in writing, of any changes in address, phone numbers guardianship, emergency contacts, etc.)

Marital Status (choose one)	Married	Divorced	Separated	Single
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Father's Information	Father resides with student (circle one)		Yes	No
	If not, parent is to receive copies of (choose)	Attendance Letters	Schedules	
		Report Card	Discipline Letters	
Father's Name:				
Mailing/Street Address:				
City:		State:	Zip Code:	
Phone Number Information (including area code xxx-xxx-xxxx)				
Home Phone:		Cell Phone:	Work Phone:	
Employer:				
Email Address:				

Mother's Information	Mother resides with student (circle one)		Yes	No
	If not, parent is to receive copies of (choose)	Attendance Letters	Schedules	
		Report Card	Discipline Letters	
Mother's Name:				
Mailing/Street Address:				
City:		State:	Zip Code:	
Phone Number Information (including area code xxx-xxx-xxxx)				
Home Phone:		Cell Phone:	Work Phone:	
Employer:				
Email Address:				

All Children in Family:

Birth date

Name	Month	Day	Year	In school (Y/N)	Grade
1.					
2.					
3.					
4.					
5.					
6.					

Additional Information concerning the Student (For example: Step-parent, Restraining Orders, etc.):

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Student Medical Information

Student Name:					
Disease History	Other info	Year	Disease History	Other Info.	Year
Allergies			Asthma		
Lyme Disease			Chicken Pox		
Hepatitis			Convulsive Dis.		
Neuromusc. Dis.			Diabetes		
Otitis media			Rheumatic Fever		
Strep Infections			Mononucleosis		
Drug Sensitivities			Heart Disease		
Congenital Defects					
Other					

Operations or Injuries	Year

Attention: If the student listed above has any Special Health Concerns, please indicate the concern and the procedure to follow and *CONTACT YOUR SCHOOL NURSE*:

Name	Telephone
Physician	
Dentist	
Orthodontist	

In Case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, the school may make whatever arrangements seem necessary.

Please **CROSS OUT** the following services that you **DO NOT** want done for your child:

1. Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
2. Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.

Signature of legal Parent/Guardian:	
Date:	Print name:

BYRAM SCHOOL DISTRICT

ELEMENTARY STUDENT HEALTH SURVEY

Name: _____ Birthdate: _____

Grade: _____ Sex: _____ Name of Local Doctor: _____

Has your child ever had or has now? (Please check at right of each item)

	Yes	No	Year		Yes	No	Year
High blood pressure				Excessive worry or anxiety			
Heart condition				Depression			
Asthma				Ulcer			
Sever Allergies				Severe or chronic abdominal pain			
Contact with tuberculosis				Excessive colds			
Positive tuberculin test				Speech Problem			
Tumor, growth or cancer				Eye trouble			
Diabetes or sugar in urine				Wears glasses			
Serious skin disease				Frequent ear infections			
Concussion				Hearing loss			
Frequent or severe headache				Frequent or painful urination			
Dizziness or fainting spells				Intestinal trouble			
Severe head injury				Wets or soils pants			
Epilepsy (convulsions)				Scoliosis in family			

Has your child had any orthopedic (bone or joint) problems? What? When? Explain: _____

Has your child had any operations? What? When? Explain: _____

Has your child ever had serious illnesses or injuries other than those already noted? What? When? Explain: _____

Has your child been diagnosed with Attention Deficit Disorder? Explain: _____

List any medications your child is allergic to: _____

Does your child have severe bee sting sensitivity? Local _____ or General _____ Explain: _____

Does your child have other health or behavior problems (learning, hyperactivity tantrums, coordination)? _____

Is your child under regular medical supervision for any of the above conditions? If yes, give name of physician: _____

Do you have any special question or concerns about your child's health? _____

If so, please contact the school nurse for a confidential conference.

BYRAM TOWNSHIP SCHOOLS

STUDENT EMERGENCY INFORMATION

School Year 20____
 Name & Number to call first _____
 Grade _____ Teacher _____

Student Name: _____ Sex (circle): Male Female
(Last) (First) (MI)

Home Address: _____ Birth date

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Mailing address: _____ City: _____ State: _____ Zip: _____
(MM) (DD) (YEAR)

Parent Information

Father/Guardian		Mother/Guardian	
Name: _____		Name: _____	
Address: _____		Address: _____	
Employer: _____		Employer: _____	
City, State: _____		City, State: _____	
Home Phone _____	Work # _____	Home Phone _____	Work # _____
Cell # _____		Cell # _____	

(Note: It is important for parents/guardians to inform the office, in writing of any changes in address or phone numbers.)

Child resides with: _____ Any Custody issues: _____

Emergency contacts: (List neighbors or nearby relatives who will assume temporary custody of your child if you cannot be reached. PLEASE ask permission to use these names.)

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

Note: It is important for parents/guardians to inform the Health Office, in writing of their child's health needs and/or changes during the school year.

My child receives regular care for the following medical conditions:

- No medical condition
- Yes, please check below:
- | | | |
|--|---|---|
| Allergy to (list): <input type="checkbox"/> Food _____ | Bee Sting _____ | |
| <input type="checkbox"/> Medications _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Rheumatic Heart _____ | <input type="checkbox"/> Sickle Cell Anemia _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Cancer/Leukemia _____ | <input type="checkbox"/> Chronic Cough/Wheezing _____ |
| | <input type="checkbox"/> Hearing Problems _____ | <input type="checkbox"/> Vision Problem _____ |
| | | <input type="checkbox"/> Hemophilia Seizures _____ |

Other: _____

Other health information:

- Operations or injuries (include date): _____
- Medications (list): _____
- Other health issues or concerns: _____

Brothers/Sisters Names _____

Date of birth _____

Physician (and number): _____

Dentist (and number): _____

Orthodontist (and number): _____

I, the undersigned, do hereby authorize officials of Byram Township Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Does your child have Health Insurance?

Yes _____ Name of 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.

Please CROSS OUT the following services that you DO NOT want done for your child:

1. Permission to share the above Special Health Concerns with the staff that meets the daily needs of my child.
2. Permission for the nurse to check that the child's spine is not curved (called Scoliosis) when they are in grade 5 and 7.
3. Permission to release my name and address to the NJ FamilyCare Program to contact me about health insurance. (Written consent required pursuant to 20 USC § 1232g (b)(1) and 34 CFR 99.30 (b).)

Signature of legal Parent/Guardian: _____

Date: _____ Print name: _____

BYRAM TOWNSHIP SCHOOLS

STUDENT EMERGENCY INFORMATION

School Year 20____
 Name & Number to call first _____
 Grade _____ Teacher _____

Student Name: _____ Sex (circle): Male Female
(Last) (First) (MI)

Home Address: _____ Birth date

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(MM) (DD) (YEAR)

Mailing address: _____ City: _____ State: _____ Zip: _____

Parent Information

Father/Guardian		Mother/Guardian	
Name: _____		Name: _____	
Address: _____		Address: _____	
Employer: _____		Employer: _____	
City, State: _____		City, State: _____	
Home Phone _____	Work # _____	Home Phone _____	Work # _____
Cell # _____		Cell # _____	

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1. _____		
2. _____		
3. _____		
4. _____		

Note: It is important for parents/guardians to inform the Health Office, in writing of their child's health needs and/or changes during the school year.
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- No medical condition
 Yes, please check below:
- | | | |
|--|--|---|
| Allergy to (list): <input type="checkbox"/> Food _____ | Bees Sting _____ | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Medications _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Heart | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sickle Cell Anemia |
| | | <input type="checkbox"/> Vision Problem |
| | | <input type="checkbox"/> Chronic Cough/Wheezing |
| | | <input type="checkbox"/> Hemophilia Seizures |

Other: _____
 Other health information:
 Operations or injuries (include date): _____
 Medications (list): _____
 Other health issues or concerns: _____
 Brothers/Sisters Names _____ Date of birth _____

Physician (and number): _____
 Dentist (and number): _____
 Orthodontist (and number): _____

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Signature of legal Parent/Guardian: _____
 Date: _____ Print name: _____