Classical Academy Charter School of Clifton — GRADES 6-8
APPLICATIONS MUST BE SUBMITTED BY JANUARY 14TH, 2022
SUBMIT ONE APPLICATION FOR EACH APPLICANT STUDENT

Student Name: _____
(Last) (First) (Middle)

Gender: _____ **Age:** _____ **Date of Birth:** _____

Current Grade: _____ **Expected Grade for Next Year:** _____

Address: _____
(Number/Name of Street) (Apt.#) (City/State) (Zip Code)

Mailing Address: _____
(If different from above) (P.O. Box # or Number/Name of Street) (City) (Zip Code)

Home Phone #: _____ **Alternate Phone #:** _____

PARENT/GUARDIAN INFORMATION:

Check One: ❑ Parent ❑ Step Parent ❑ Legal Guardian

Full Name: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Check One: ❑ Parent ❑ Step Parent ❑ Legal Guardian

Full Name: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Sibling Policy: Preference is given to siblings of enrolled students pursuant to N.J.S.A. 18A:36A-8(c). Please list any siblings (brothers/sisters) enrolled at Classical Academy Charter School in 2021-2022.

Sibling Name: _____ **Current Grade** _____ **Grade in 2021-2022** _____

Sibling Name: _____ **Current Grade** _____ **Grade in 2021-2022** _____

Signature of Parent/Guardian: _____ **Date:** _____

lassical Academy is a free, open-enrollment public charter school. Classical Academy is open to all students on a space availabl basis and does not discriminate in its admission policies or practices on the basis of intellectual or athletic ability, measures of ıchievement or aptitude, special education status, proficiency in the English language, or any other basis that would be illegal i used by any school district.

❑ New ❑ Address Change ❑ Re-admit
❑ Special Attention ❑ Test ESL Language

Classical Academy Charter School of Clifton

This information is required to be completed by School staff:

Neighborhood School: _____ **Enrolled/Magnet School:** _____

Student ID: _____ **Grade:** _____ **Hr#** _____

❑ **Legal proof of birth** ❑ **Two pieces of identification showing residency** ❑ **Immunization record**

❑ **Physical Exam** ❑ **Signed request for school records/transfer card**

If appropiate: ❑ **Sworn Statement** ❑ **Guardianship document** ❑ **Provisional Enrollment**

Signature of School Staff: _____ **Date:** _____

Signature of Nurse: _____ **Date:** _____

NJSID#: _____ **Start Date:** _____

Student Name: (Last Name) _____ (First Name) _____ (Middle Initial) ____

Address: _____ Apt. #_____ City: _____

Nine Digit Zip Code _____ Home Phone #:_____ Sex: ❑M ❑F

Birth Date: _____ Birth City _____ Birth State _____

Country of Birth _____ Date entered US (if applicable): _____

Date entered into US School System (if applicable):_____

Language spoken at home: _____

Ethnic Origin*: ❑White (not of Hispanic origin) ❑ Black (not of Hispanic origin) ❑ Hispanic
❑ Amer.Indian/Alaskan Native ❑ Asian/Pacific Islander *(This information is optional & for statistical purposes only)

CHECK ONE Pupil lives with: ❑Parents ❑Father ❑Mother ❑Guardian ❑Self

CHECK ONE Parents Marital Status: ❑Married/Civil Union ❑Separated ❑Widow/er ❑Divorced ❑Single

Father: (Last) _____(First) _____ Cell #: _____

Employer Name/Address: _____ Work # _____

Email Address _____ Allowed to pick up Student ❑

Mother: (Last) _____(First) _____ Cell# _____

Employer Name/Address: _____ Work # _____

Email Address: _____ Allowed to pick up Student ❑

****Guardian(s)[** other than child's Natural parent <u>you must</u> attach proof of legal custody or complete *Application for Admission]*

Name: _____ Cell #:_____

Employer Name/Address:_____ Work # _____

Email Address _____

Name: _____ Cell #:_____

Employer Name/Address:_____ Work # _____

Email Address _____

Emergency Contact#1:_____ Phone # _____ ❑Allowed to pick up Student

Emergency Contact#2:_____ Phone # _____ ❑Allowed to pick up Student

Family Doctor Name:_____ Phone #: _____

Family Dentist Name: _____ Phone#: _____

Health Problems (check all that apply):

❑Asthma ❑Diabetes ❑Hearing ❑Speech ❑Cardiac ❑Epilepsy ❑Vision ❑Orthopedic ❑Other (describe):

❑Hospitalized or treated within the last year for other than routine medical problems? ❑Yes ❑No

(if yes, describe)

Name & Address of Last School Attended:

_____

_____

Length of time at previous school:

❑ Received special services from the previous school district?

Previous home address: _____ City: _____

How did you hear about us?_____

Previous Institutions Attended:

Siblings (Brother or sister) **Name**	**Sex**	**DOB**	**School Attended (give city if not Clifton)**

I certify that the information provided in this form is true and accurate. I understand that misrepresenting myself as a legal resident of Clifton may result in *criminal prosecution or legal attempts to collect tuition.* CHANGES IN INFORMATION (ADDRESS, TELEPHONE NUMBERS, GUARDIAN) MUST BE REPORTED WITHIN 5 DAYS! Depending upon the circumstances of this registration, additional forms may be required.

_____ _____

Signature of Parent/Guardian Date

CHILD HEALTH RECORD

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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 lifethreatening 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.

Classical Academy Charter School
Clifton, NJ

STUDENT HEALTH INVENTORY

Name _____ _____Grade_____

(Last) (First)

Gender _____ Birth date_____

Parent's Names:

Father_____

Mother_____

Student's Medical Doctor_____

Is your child under the care of an orthodontist? Yes____No_____

If yes, Orthodontist's Name_____

DOES YOUR CHILD HAVE:

1. Allergies: Yes_____No_____If yes, to what_____
2. Does he/ she takes medication routinely? Yes_____No_____ If yes, what Medication_____3.
3. Asthma:_ Yes____No___ Medication used _____
4. Diabetes: Yes____ No_____Take insulin?_____How often?_____
5. Frequent ear infections: Yes_____No_____Explain_____
6. Frequent sore throats: Yes_____No_____Explain_____
7. Frequent headaches: Yes_____No_____Explain_____
8. Epilepsy or convulsions: Yes_____No_____Explain_____
9. Heart murmur / condition: Yes_____No_____Explain_____
10. Orthopedic problem: Yes_____No_____Explain_____
11. Muscular problem: Yes_____No_____Explain_____
12. Drug sensitivities: Yes_____No_____Explain_____ 13. Congenital Defects: Yes_____No_____Explain_____

HAS YOUR CHILD HAD :

1. Chicken pox Yes_____No_____Date_____
2. Measles Yes_____No_____Date_____
3. Mumps Yes_____No_____Date_____
4. German measles Yes_____No_____Date_____
5. Bronchitis Yes_____No_____Date_____

6. Pneumonia Yes_____No_____Date_____

7. Tuberculosis Yes_____No_____Date_____
8. Rheumatic Fever Yes_____No_____Date_____
9. Mononucleosis Yes_____No_____Date_____
10. Hepatitis Yes_____No_____Date_____
11. Serious illness Yes_____No_____Date_____
Explain_____
12. Serious injury Yes_____No_____Date_____
Explain_____
13. Operations Yes_____No_____Date_____
Explain_____

DOES YOUR CHILD:

Wear glasses ? Yes_____ No_____
Have contact lenses ? Yes_____ No_____
Have trouble seeing close work? Yes_____ No_____
Have trouble seeing at a distance? Yes_____ No_____
Have trouble hearing? Yes_____ No_____
Wear a hearing aid ? Yes_____ No_____
Have difficulty with speech? Yes_____ No_____
Have tendency to bleed easily ? Yes_____ No_____
Have frequent nosebleeds ? Yes_____ No_____
Have frequent vomiting or diarrhea? Yes_____ No_____ Occasionally wet his/ her pants? Yes_____ No_____
Occasionally have bowel movements in his/ her pants ? Yes_____ No_____ Take daily medication ? Yes_____ No_____
What for?_____
Take emergency medication ? Yes_____ No_____
What for?_____
Have a condition, which prevents participation in regular physical education activities? Yes_____ No_____

Explain_____
Any other Health Problems of which we should be aware? Yes_____ No_____

Explain_____

Parent's Signature_____Date_____

PLEASE NOTIFY THE SCHOOL NURSE of any medical problems, serious illnesses, or communicable diseases that arise while the student is enrolled at this school.
PLEASE NOTIFY THE SCHOOL NURSE of any immunizations received by your child. 09/07

BILINGUAL/ENGLISH AS A SECOND LANGUAGE
HOME LANGUAGE SURVEY

Name of Student: _____

Age of student: _____ Highest grade completed: _____

Last school attended: _____ (please include location)

Please respond to each of the questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

1. Which language(s) did your child learn when he/she first began to talk?

   _____

2. Which language(s) do you use most often at home? _____

3. What language(s) did/do the child's parents/guardians use to speak to the child most of the time?

   _____

4. What language(s) is/are spoken most often by adults (parents, guardians, grandparents, or any other adults) in your home?

   _____

5. In what language do you prefer to receive correspondence from the school?

   _____

6. What language(s) was used at your child's school? _____

7. What language(s) can your child read and write in? _____

8. Do you have a report card from your child's previous school? (please include with your child's records) _____

- The person(s) completing this survey must sign and date this document below.
- This survey must remain in the student's permanent file.
- If any language other than English is mentioned on this survey, the student must be referred to a qualified ESL specialist for additional language assessment.
- Submit an additional copy of this survey to the attention of the Supervisor of Bilingual/ESL at School 6.

Parent/Guardian:

_____ _____

Print Name Signature Date

Classical Academy Charter School of Clifton
1255 Main Avenue
Clifton, NJ 07011

STATE OF NEW JERSEY
COUNTY OF PASSAIC

I _____ of full age, and being duly sworn upon his or her oath, according to law deposes and says:

1. I am the owner of the property located at _____ in the city of Clifton, NJ.
2. _____ is a tenant and has been a tenant at the above said premises since _____ (month/day/year). A copy of this tenant's lease, if same is in written form, is attached hereto. In the event that tenant does not have a written lease the pertinent terms of said lease are as follows:
   a) Circle one of the following: Month to Month/ Year to Year
   b) Rental amount $ _____ per _____
   c) The names of permissible tenants are as follows:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

3. I am making this affidavit knowing that the Classical Academy Charter School of Clifton will rely on same in determining whether _____ will be considered a pupil who is entitled to an education free of charge.

I understand that if any of the above statements made by me are willfully false I may be subject to legal action.

_____
(Landlord)

Sworn and subscribed before me this _____ day of _____.

_____
(Notary Public)