Montague Township School District

STUDENT REGISTRATION FORM
SCHOOL YEAR: 2020 - 2021

MONTAGUE RESIDENTS:

Elementary:
- 1st Grade
- 2nd Grade
- 3rd Grade
- 4th Grade
- 5th Grade
- 6th Grade
- 7th Grade
- 8th Grade

- Full Day Preschool
- Full Day Kindergarten

NON RESIDENTS:

- Full Day Preschool --- $750/month

Child’s Information
Last Name _____________________________________________________________
First Name ___________________________ Middle Name ___________________________
PO Box ___________________________________ Physical Address _______________________
City ___________________________ State ___________________________ Zip Code ________
Date of Birth ___________________________ Gender ______ Male ______ Female ______
City, State & Country of Birth ________________________________________________
Race: American Indian ___ Asian ___ Black ___ Hispanic ___ White ___ Other ____
Language spoken at home ______________________________________________________

Parent/Guardian Information
Last Name ___________________________ First Name ___________________________
Relationship to child __________________________________________________________
Does child live with you? Yes _____ No ______
If no, Physical Address ________________________________________________________
Mailing Address ______________________________________________________________
City, State & Zip ___________________________ Home Phone _______________________
Cell Phone ___________________________ Work Phone _________________________
Email ___________________________________________
Last Name _________________________ First Name _________________________________

Relationship to child ___________________________________________________________________

Does child live with you?    Yes _____     No ______

If no, Physical Address _________________________________________________________________

Mailing Address ______________________________________________________________________

City, State & Zip ______________________________________________________________________

Home Phone ______________________________ Cell Phone _________________________________

Work Phone ______________________________  Email _____________________________________

Mail Information to each parent/guardian?   Yes ____   No ____

Is there a court ordered:

Temporary Restraining Order?     Yes _____ No _____    Dated: __________________

Permanent Restraining Order?      Yes _____ No _____    Dated: __________________

Child Custody Order?                   Yes _____ No _____    Dated: __________________

Guardianship?                               Yes _____ No _____    Dated: __________________

If yes, a copy must be attached to this form.

Does this child have any siblings in this school?    Yes ____  No _____  If Yes, please complete below.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Grade/Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Emergency Contact/Closing Information (other than parent)

Please notify your emergency contacts that they may be contacted by the school.

1st Contact Name ______________________________________________________________________

Relationship to child ___________________________________________________________________

Phone ____________________________________ Cell Phone _________________________________

Work Phone ______________________________ Does this person live with student? Yes ___ No ___

2nd Contact Name _____________________________________________________________________

Relationship to child ___________________________________________________________________

Phone ____________________________________ Cell Phone _________________________________

Work Phone ______________________________ Does this person live with student? Yes ___  No ___

Children will be sent home on their daily/regular bus, unless a parent/guardian calls and notifies the school of different arrangements for that day due to the emergency closing. Due to the critical nature of an early closing, please do not request bus changes in these situations.

All after school programs will be cancelled!

Children that have brought in bus notes to stay after school for an activity will be sent home on their regular buses, unless the school is notified otherwise by a parent/guardian.

In an emergency closing:

(   ) My child(ren) has permission to go directly home on his/her regular bus.

(   ) Please hold my child(ren) at school (parent/guardian must arrange pick up).

Please list all persons to whom the child(ren) may be released:

Name: __________________________________ Phone: _________________ Relationship: ______________

Name: __________________________________ Phone: _________________ Relationship: ______________

Name: __________________________________ Phone: _________________ Relationship: ______________

Student Registration Form -- Page 2 of 2
MONTAGUE NEW STUDENT REGISTRATION

Please provide the requested documents to ensure timely and proper registration of your child.

1. Completion of an entire application packet and medical forms.
2. Current immunization records including hepatitis “B” series record.
3. Copy of Birth Certificate (a certified copy of birth certificate or other proof of a student’s identity must be provided within 30 days of initial enrollment).
4. Two (2) proofs of residency with physical street address, which may include:
   - 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; and
   - Any other form of documentation relevant to demonstrating entitlement to attend school.
5. Physical Examination Form completed or date of appointment.

Please remember to complete a transfer card with your current school (if applicable). If you have any questions regarding the registration process, please contact the Montague Township School District at 973-293-7131.
MONTAGUE TOWNSHIP RESIDENCY

So as not to delay the registration process we are accepting the information you are supplying at the time of registration. This information may or may not be sufficient for us to satisfy our residency requirements. This form, along with your registration form, will be forwarded to my office and given to an administrator for further research and verification, if necessary.

Please check one.

☐ I reside within the Montague Township boundaries. The student I am registering is a full-time resident at that address.

☐ I am not a resident of Montague Township.

If, for any reason, you choose not to sign this form, your son/daughter will not be registered.

If our verification reveals that the address you supplied is not within our boundaries, or you are not living full-time within this District, you understand that you will be notified, the student will be removed from our program, and you will be personally liable for the full tuition payment.

Thank you and welcome to the Montague Township School District.

Signature: ________________________________________

Parent/Guardian

Address: __________________________________________

Date: ______________________________________________
REQUEST FOR STUDENT RECORDS

Former School Name _____________________________
Address _____________________________
Phone and Fax Number _____________________________

Student’s Name _____________________________ Date of Birth _________________

Please forward all mandated records for the above-named student who has enrolled in the _____
grade in the Montague Township School District, including the student’s State I.D. Number.

In addition, we would appreciate receiving copies of all permitted records, as per parent release
below. Please include Federal Lunch Program Application or verification of eligibility, if
applicable.

Thank you for your prompt attention to this matter.

____________________________
Signature of Parent/Guardian

____________________________
Relationship to Student

I authorize the release of all permitted records of the above-named student; this includes all CST,
IEP’s, Speech, health and birth certificates.
CONSENT AND RELEASE FORM

I am the Parent or Guardian of
Student Name: _______________________________________
Class: ______________________________________________

By signing this form, I give Montague School District permission to publish/display my child’s name, image, and schoolwork on school website, World Wide Web, a part of the Internet, newsletters, newspapers, and/or magazines. I understand that copyright and ownership of the work or writing remain my child’s property. I also understand that the publication/display of image and schoolwork may include personally identifiable information about my child, such as my child’s name, grade level, name of class, and name of school.

I also understand that information published in the newsletters, newspapers, magazines, or Internet may be accessed and distributed by parties over whom Montague School District has no control, and I agree, on myself and my child’s behalf, to release Montague Township School District, its board members, administrators, teachers, and employees, from and against any and all claims, damages, or liability arising from or related to the aforementioned publications/displays of my child’s name, image, and/or schoolwork.

I have read this Consent and Release form before signing it and I fully understand that my child will not be penalized academically or otherwise if I do not sign it.

Parent/Guardian’s Full Name (please print) _______________________________________________________

Parent/Guardian’s Signature __________________________________________________________ Date ____________
Grades PreK-8 Acceptable Use Policy

Student Name: ___________________________ Date: __________________

I understand that, as an Internet user, I am responsible for acting considerately and appropriately in accordance with the following rules when using the Montague School technology resources:

- I will not send, show, or download inappropriate messages or pictures.
- I will not use bad language.
- I will not insult, annoy, or hurt others.
- I will not damage computers, networks, or other technology equipment.
- I will obey all copyright laws.
- I will not use other users’ passwords.
- I will not go into other users’ work or files.
- I will not intentionally waste resources like paper, power, or ink.
- I will not access any instant messaging programs like AIM© or Yahoo© instant messenger.
- I will not access any social networking sites like Myspace© or Facebook©.

I understand that any or all of the following could be imposed if I violate any of the policies and procedures regarding the use of Montague School technology resources, including the Internet.

1. Loss of access.
2. Additional disciplinary action taken by the elementary teacher and administration in line with existing district policy.
3. Legal action, when applicable.

My child has my permission to access the Internet under the supervision of a certificated member of the Montague School faculty.

Parent Name: _______________________
Parent Signature: _____________________

Student Signature (Grades 2-8 only): ____________________
CHILD CUSTODY INFORMATION FORM

(Please complete only if applicable)

The parent with whom the child resides will be considered the custodial parent; however the non-custodial parent has many rights in the absence of an explicit Court Order that limits those rights. It is the responsibility of the custodial parent to provide the school with a copy of any Court Order that limits the custodial rights of the non-custodial parent. Unless specified in the Court Order, the child may be released from school to the non-custodial. It is also expected that the custodial parent will provide the non custodial parent with academic progress information such as report cards or other academic information.

Child’s Full Name __________________________________________________________

School child will be attending ________________________________________________

Name of custodial parent with whom child resides ______________________________

_________________________________________________________________________

Do you, as the custodial parent, have legal custody through a Court Order?

___ Yes    ___ No    ____ Pending*

*Date finalization is expected: ________________________________________________

(If pending, please inform the school when finalized)

If there is a Court Order, does it limit the non-custodial parent’s access to school records?  ___ Yes*  ___ No

*If Yes, a copy of the order must be given to the school office.

Please provide any additional information regarding custody of which the school should be aware: _________________________________________________________________

_______________________________________________________________________

_________________________                ________________________________
Date                                Signature of Custodial Parent
Roster Card

Name:

___________________________

Home (  ) __________________________

Cell (  ) __________________________

Office (  ) __________________________

Other (  ) __________________________

Please fill in and return. By returning this card, you give permission to receive calls.
From the School Nurse:
No child may begin school without documentation of immunizations and a current physical within the last six months. The school nurse clears all students to begin school. Please call the school nurse at 973.293.7131 ext 214, to schedule an appointment to review immunization documents and health records.

Absence:
Your child is expected to be on time and in school every day that school is in session. If your child is sick and cannot attend school you must call the school nurse at 973.293.7131 ext 214, and report the child’s name, grade, teacher, and reason for absence. When the child returns to school, a written reason of absence is needed. Please have doctor’s notes given to the school.

Attendance:
Consistent attendance at school is a strong predictor of student achievement and success.
1. Children are expected to be in attendance every day school is in session.
2. Every absence from school will be documented and recorded.
3. If a child is in school less than four hours, the day is considered an absence.
4. Parents/guardians will be notified of their child’s absences approximately every fifth day’s absence.
5. Upon notification, parents/guardians will work to correct the absence pattern and may be required to meet with the Assistant Principal regarding attendance.
6. Parents/guardians of each absent child must call the nurse to explain the reason, or the school will call.
7. Two days after an absence a note must be brought to school explaining the cause, with a note from the doctor if that applies.
8. Any student absence without an acceptable note or at the accumulation of ten days will be considered truant. State mandates regarding truancy issues will be followed.
9. All absences are cumulative regardless of parent or physician notes.
10. If a child is ill and will be home longer than two days, parent may request the child’s teacher prepare missed work after two day’s absence.
11. After an absence of twenty days, retention is possible.
12. If school is required to close for extended periods, the legally required attendance of 180 days may lead to an extension of the school year, including attending on Saturdays or scheduled holidays.

Medication Policy:
It is the policy of the school board that all children’s medication be administered by the parent whenever possible. If a child is required to take medication during school hours, the school nurse will administer the medication in compliance with the regulations that follow:
1. A prescription written by a physician stating child’s name, diagnosis, name of medication, dosage, and time to be given.
2. This policy includes prescription and over-the-counter medications (i.e. Tylenol, Motrin, etc.)
3. Medication must be in a prescription labeled bottle.
4. Written permission signed by the parent.
5. The PARENT must deliver the medication to the school nurse.

NO medication will be dispensed without the physician and parent written authorizations.
MEDICAL HEALTH HISTORY AND EMERGENCY CONTACT FORM

Student Name ________________________________ Grade & Teacher ___________ DOB ________________
Mailing Address ____________________________________________________ PO Box _________________

Mother/Guardian _______________________________________ Home ________________________________

Work __________________________________ Work __________________________________

Cell ______________________

Father ________________________________ Home _____________________ Home ________________

Work __________________________________ Work __________________________________

Cell ______________________

Parent Email Address ______________________________________________
Emergency Contact #1_______________________________________ Phone ________________________

#2_______________________________________ Phone ________________________

Does your child have health insurance?
Yes _____ Name of Insurance Company or NJ FamilyCare Insurance Provider:
No_____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low
income parents. For more info 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 __________________________________ Date ________________________

MEDICAL HISTORY (Most recent)

Allergies: _____Plants_____Animals_____Food_____Mold_____Drugs_____Bees _____ Date of reaction ________________
Life threatening? _____Yes _____ No

Please describe the reaction & treatment __________________________________________________________________

Documented Medical Condition & Restrictions if any: __________________________________ Date ________________

Daily Medications & Dosages: __________________________________________________________ Date ________________

Recent Surgeries or Injuries __________________________________ Date ________________
Physical Exam Date ________________________ Doctor & Phone ________________________
Dental Exam Date ________________________ Dentist & Phone ________________________
Eye Examination Date ________________________

There should be a meeting with the School Nurse to discuss medication or treatment orders.
***REMINDER***

Please be advised that physicians recommend that a child have a physical examination at least once during each of the student’s developmental stages: early childhood (preschool-grade 3), pre-adolescence (grades 4-6), and adolescence (grades 7-12). When your child receives a physical examination, please submit a copy of the report to the School Nurse so that your child’s health history can be updated.

I am aware that my child will participate in the following School Health Services where applicable:

1. Vision & hearing screening
2. Scoliosis screening every 2 yrs starting at age 10
3. Height, weight & blood pressure
4. Periodic head lice checks

Have you ever been told by a physician or health care professional that your child has:

- _____ Asthma
- _____ Seizure Disorder
- _____ Bleeding Disorder
- _____ ADD/ADHD
- _____ Diabetes
- _____ Bone/Muscle Disorder
- _____ Skin Condition
- _____ Heart Condition
- _____ Mental Health Condition (i.e. depression, anxiety, eating disorder)
- _____ Learning Disability

Does your child experience any of the following:

- _____ Nose Bleeds
- _____ Frequent Earaches
- _____ Overweight for Age
- _____ Underweight for age
- _____ Physical Disability
- _____ Poor Appetite
- _____ Frequent Stomachaches
- _____ Frequent Headaches
- _____ Fainting Spells
- _____ Tires Easily
- _____ Emotional concerns

Do any of the above condition(s) limit/effect your child at school? Yes_____ No_____

Describe ____________________________________________________________________________________

Hearing: Does your child wear hearing aids?  _____ Yes  _____ No

Vision: Does your child wear glasses or contacts?  _____ Yes  _____ Distance  _____ Reading

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _______________________________ Date ________________
MONTAGUE TOWNSHIP SCHOOL DISTRICT

Growth and Development

Registration ___________________________
Date

Child's Last Name _____________________ First Name __________ Middle Name _______ Date of Birth ________

Address (Number, Street, Town) ______________________________________ Phone Number _______________________

Mailing Address (if different than street address)

Father's Name __________________________ Mother's Name __________ Last School Attended _________

Is your child subject to: (Please circle Yes or No) Has your child had:

Frequent Colds  Yes  No  Poor eating habits  Yes  No
Bronchitis      Yes  No  Eye Disease      Yes  No
Frequent sore throats Yes  No  Head Injury Yes  No
Speech Difficulties Yes  No  A severe fall Yes  No
Ear Aches       Yes  No  Difficulty sleeping Yes  No
Development:
Age Walked _______________ Eyeglasses Prescribed Yes  No
Age Talked _______________ Hearing Loss Yes  No

Has your child had a history of (Please circle and give dates)

Allergy:
Medication _____________ Hernia
Other ________________ High Fever

Chicken Pox Mononucleosis Operations:
Enuresis (bed wetting) Pneumonia Appendectomy:
Epilepsy Tonsillitis Hernia Repair
Heart Disease Tuberculosis Tonsillectomy:
Hepatitis            Whooping Cough Ear Surgery

Other

Please list any childhood diseases, accidents or problems: ________________________________________________________________

Medication: Please list medications your child takes both at home and in school. If your child must take prescription or
over-the-counter medication (i.e. Tylenol, Motrin, etc) in school, a medical authorization form must be completed and
signed by the parent/guardian and physician.

Please list my child and his/her health concern on your confidential list to be distributed to teachers and cafeteria
staff  ____ Yes  ____ No

Parent/Guardian Signature __________________________ Date ____________

475 Route 206 Montague, NJ 07827 Phone 973.293.7131
Rev 03/19 Fax: 973.293.3391
School Year: 2020-2021

PHYSICAL EXAMINATION – To be completed by a medical doctor

Name ____________________________  DOB __________  Grade __________

Height ______  Weight _____  Blood Pressure ________  Pulse __________

Significant Medical/Surgical History: ________________________________
_________________________________________________________________
_________________________________________________________________

Allergies:  Insects  Food  Environmental ______________________________
_________________________________________________________________

Medications: _______________________________________________________
_________________________________________________________________

Vision Screening ___________  Hearing Screening ___________

Examination Findings

Ears ___________________________  Abdomen ___________________________
Eyes ___________________________  Hernia _____________________________
Nose ___________________________  Scoliosis __________________________
Throat __________________________  Skin _____________________________
Heart __________________________  General Appearance _____________
Lungs __________________________  Neurological ______________________
Other ___________________________

Summary of Findings
_________________________________________________________________
_________________________________________________________________

Immunization History: PLEASE ATTACH UPDATED IMMUNIZATION RECORD

__________________________________________  _______________________
Physician Signature                Date of Exam

MONTAGUE TOWNSHIP SCHOOL DISTRICT
475 Route 206, Montague, NJ 07827  *  Phone (973) 293-7131  *  Fax (973) 293-3391
MEDICAL AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN

Student’s Name __________________________ Age _____ Grade ________

Diagnosis ________________________________________________

Medication ______________________________________________

Dosage ___________________________________________________

Time of Administration ___________________________________

Possible Side Effects _______________________________________

Restrictions on Activities __________________________________

Physician’s Name (Printed) ___________________ Date ___________ Physician’s Signature ___________

TO BE COMPLETED BY PARENT

I request that my child __________________________ receive the medication prescribed by his/her physician. The medication is to be provided by me as required by School Board Policy. I understand that the district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse, or substitute school nurse, will administer the medication.

NOTE: All medication, prescribed and over-the-counter, must be brought to the school by the parent, in the original, labeled bottle or container.

______________________________________________ Date ___________
Parent/Guardian’s Signature
**Required Immunizations for Preschool Enrollment**

**DTaP**  
Diphtheria, Tetanus and Pertussis: 4 doses

**Polio**  
Inactivated Poliovirus: 3 doses

**Hib**  
Haemophilus Influenzae type B: at least 1 dose given on or after the first birthday

**PCV**  
Pneumococcal conjugate: at least 1 dose given on or after the first birthday

**MMR**  
Measles, Mumps and Rubella: 1 dose

**Varicella**  
Chicken Pox: 1 dose

**Influenza**  
1 dose yearly for flu season, must be given by Dec. 31, 2019

*required at time of enrollment between Jan 1, 2020-March 31, 2020

**Required Immunizations for Kindergarten Enrollment**

**DTaP**  
Diphtheria, Tetanus and Pertussis: A total of 4 doses with the 4th one being after the 4th birthday or any 5 doses

**Polio**  
3 doses with the 3rd one being after the 4th birthday or any 4 doses

**Hepatitis B**  
3 doses (one usually at birth, the second dose one month later and the third one at least 5 months after the second one)

**PCV**  
Pneumococcal conjugate: at least 1 dose given on or after the first birthday

**MMR**  
Measles, Mumps and Rubella: 2 doses

**Varicella**  
Chicken Pox: 1 dose yearly for flu season, must be given by Dec. 31, 2019

*required at time of enrollment between Jan 1, 2020-March 31, 2020

*optional if already 5 years old

**Required Immunizations for Sixth Grade Enrollment**

**Meningitis**  
1 dose at 11 years of age. (can be given any time after 10 years old)

**Tdap**  
1 dose at 11 years of age. (can be given any time after 10 years old)

Students **transferring** into a NJ school, preschool, or child care facility from out of state/out of country shall be allowed a 30 day grace period in order to obtain past immunization documentation.
HOME LANGUAGE SURVEY*

Date: ____________________

School District: ________________________________

School: ___________________________ Grade: __________

Student’s Name: ________________________________

1. What was the student’s first language? ________________________________

2. Does the student speak a language other than English? ___ Yes ___ No
   If yes, specify language: ________________________________

3. What language(s) is/are spoken in your home? ____________________________

4. Has the student ever received English as a second language (ESL) services?
   ___ Yes ___ No If yes, when? ____________________________
   And from what school district? ____________________________

5. Has your family ever received migrant services? ___ Yes ___ No
   If yes, please list the dates service was received: ____________________________
   ____________________________

6. Do either of the parents/guardians work in any field pertaining to agriculture?
   ___ Yes ___ No If yes, please specify where: ____________________________
   ____________________________

Person completing this form, if other than parent/guardian: ____________________________

Parent/Guardian Signature

* The school district/charter school has the responsibility under the federal law to serve students who are
  limited English proficient and need English instructional services. Given this responsibility, the school
district/charter school has the right to ask for the information it needs to identify English Language
Learners (ELLs). As part of the responsibility to locate and identify the ELL’s, the school district/charter
school may conduct screenings or ask for related information about students who are already enrolled in
the district as well as from students who enrolled in the school district/charter school in the future.
In summary, this form allows us to bill Medicaid for Speech, OT, PT, Counseling, School Nursing services, Transportation (if this applies) and IEP services. It DOES NOT give consent to speak to your physicians or outside services. It DOES NOT affect your benefits or cost to you at all. It DOES NOT sign you up for any type of insurance or Medicaid. It allows the school to get reimbursed for services, helping to generate income for the school system.

**Medicaid Annual Notification**

**Regarding Parental Consent**

Dear Montague Parents:

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 our Business Administration office at 973-293-7131 ext. 218 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 meet _____ Hand Delivered
Dear parents of Montague School:

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.

Revised September 2013 SEMI Parental Consent
To:   Parents/Guardians of Montague Students
Re:   Afternoon Bus Stops for KINDERGARTEN & ELEMENTARY students

Students will be dropped off at their assigned bus stop **only if**:

1. The student is met by a parent or legal guardian, 18 years or older.
   
   **OR**

2. A written request designating a responsible person to meet the student at the stop has been submitted and approved by the transportation office.

If there is no parent or approved designated person to meet the student, the student will be returned to the school by the bus driver. There must be visual contact of the parent or designated person by the bus driver or the student will be returned to the school.

Thank you for your cooperation.
**Definition of Household Member:** “Anyone who is living with you and shares income and expenses, even if not related.”

- Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read How to Apply for Free and Reduced Price School Meals for more information.

**Are you unsure what income to include here?** Flip the page and review the charts titled “Sources of Income” for more information.

**Sources of Income for Children** chart will help you with the Child Income section.

**Sources of Income for Adults** chart will help you with the All Adult Household Members section.

---

**2020-2021 Household Application for Free and Reduced Price School Meals**

Complete one application per household. Please use a pen (not a pencil).

---

**STEP 1** List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

<table>
<thead>
<tr>
<th>Child’s First Name</th>
<th>MI</th>
<th>Child’s Last Name</th>
<th>Grade</th>
<th>Student?</th>
<th>Foster Child</th>
<th>Homeless, Migrant, Runaway</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STEP 2** Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

If NO > Go to STEP 3.  
If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

**Case Number:**

Write only one case number in this space.

**STEP 3** Report Income for ALL Household Members (Skip this step if you answered ‘Yes’ to STEP 2)

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write ‘0’. If you enter ‘0’ or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)  
Earnings from Work  
Weekly  Bi-Weekly  2x Month  Monthly  
Public Assistance/Child Support/Alimony  
Weekly  Bi-Weekly  2x Month  Monthly  
Pensions/Retirement/All Other Income  
Weekly  Bi-Weekly  2x Month  Monthly

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member

---

**STEP 4** Contact information and adult signature.  
Mail Completed Form To: MONTAGUE TOWNSHIP SCHOOL DISTRICT

“[I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.]”

---

Printed name of adult signing the form  
Signature of adult  
Today’s date
### Sources of Income for Children

<table>
<thead>
<tr>
<th>Sources of Child Income</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Earnings from work</td>
<td>- A child has a regular full or part-time job where they earn a salary or wages</td>
</tr>
<tr>
<td>- Social Security</td>
<td>- A child is blind or disabled and receives Social Security benefits</td>
</tr>
<tr>
<td>- Disability Payments</td>
<td>- A Parent is disabled, retired, or deceased, and their child receives Social Security benefits</td>
</tr>
<tr>
<td>- Survivor’s Benefits</td>
<td>- Income from person outside the household</td>
</tr>
<tr>
<td>- Income from any other source</td>
<td>- A child receives regular income from a private pension fund, annually, or trust</td>
</tr>
</tbody>
</table>

### Sources of Income for Adults

<table>
<thead>
<tr>
<th>Sources of Adult Income</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings from Work</td>
<td>- Salary, wages, cash bonuses</td>
</tr>
<tr>
<td></td>
<td>- Net income from self-employment (farm or business)</td>
</tr>
<tr>
<td></td>
<td>If you are in the U.S. Military:</td>
</tr>
<tr>
<td></td>
<td>- Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)</td>
</tr>
<tr>
<td></td>
<td>- Allowances for off-base housing, food and clothing</td>
</tr>
<tr>
<td>Public Assistance / Alimony / Child Support</td>
<td>- Unemployment benefits</td>
</tr>
<tr>
<td></td>
<td>- Worker’s compensation</td>
</tr>
<tr>
<td></td>
<td>- Supplemental Security Income (SSI)</td>
</tr>
<tr>
<td></td>
<td>- Cash assistance from State or local government</td>
</tr>
<tr>
<td></td>
<td>- Alimony payments</td>
</tr>
<tr>
<td></td>
<td>- Child support payments</td>
</tr>
<tr>
<td></td>
<td>- Veteran’s benefits</td>
</tr>
<tr>
<td></td>
<td>- Strike benefits</td>
</tr>
</tbody>
</table>

### Categorical Eligibility

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- **mail:** U.S. Department of Agriculture
  Office of the Assistant Secretary for Civil Rights
  1400 Independence Avenue, SW
  Washington, D.C. 20250-9410
- **fax:** (202) 690-7442; or
- **email:** program.intake@usda.gov.

This institution is an equal opportunity provider.

### Optional Children’s Racial and Ethnic Identities

We are required to ask for information about your children’s race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children’s eligibility for free or reduced price meals.

**Ethnicity (check one):**  
- Hispanic or Latino  
- Not Hispanic or Latino

**Race (check one or more):**  
- American Indian or Alaskan Native  
- Asian  
- Black or African American  
- Native Hawaiian or Other Pacific Islander  
- White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

### Determining Official’s Signature

- **Date:**
- **Confirming Official’s Signature:**
- **Date:**

### Verifying Official’s Signature

- **Date:**

### Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24 Monthly x 12

<table>
<thead>
<tr>
<th>How often?</th>
<th>Weekly</th>
<th>Bi-Weekly</th>
<th>2x Month</th>
<th>Monthly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Total Income</th>
<th>$</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Categorical Eligibility</th>
<th>Eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Free</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Determining Official’s Signature</th>
<th>Date</th>
<th>Confirming Official’s Signature</th>
<th>Date</th>
<th>Verifying Official’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**INSTRUCTIONS**

**Sources of Income**

- **Total Income**
  - Annual Income Conversion:
    - Weekly x 52
    - Every 2 Weeks x 26
    - Twice a Month x 24
    - Monthly x 12

**INSTRUCTIONS**

**Determining Official’s Signature**

**Confirming Official’s Signature**

**Verifying Official’s Signature**

**Total Income**

**Income from person outside the household**

**Income from any other source**

**Example(s)**

- A child has a regular full or part-time job where they earn a salary or wages
- A child is blind or disabled and receives Social Security benefits
- A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
- A friend or extended family member regularly gives a child spending money
- A child receives regular income from a private pension fund, annually, or trust

**INSTRUCTIONS**

**Social Security**

- **Earnings from Work**
  - **Salary, wages, cash bonuses**
  - **Net income from self-employment (farm or business)**
- **Public Assistance / Alimony / Child Support**
  - **Unemployment benefits**
  - **Worker’s compensation**
  - **Supplemental Security Income (SSI)**
  - **Cash assistance from State or local government**
  - **Alimony payments**
  - **Child support payments**
  - **Veteran’s benefits**
  - **Strike benefits**

**INSTRUCTIONS**

**Pensions / Retirement / All Other Income**

- **Social Security (including railroad retirement and black lung benefits)**
- **Private pensions or disability benefits**
- **Regular income from trusts or estates**
- **Annuities**
- **Investment income**
- **Earned interest**
- **Rental income**
- **Regular cash payments from outside household**