Sandman Consolidated School
838 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9410
Fax: (609) 884-9412

Memorial School
2600 Bayshore Road
Villas, NJ 08251
Telephone: (609) 884-9430
Fax: (609) 886-0515

LOWER TOWNSHIP ELEMENTARY SCHOOL DISTRICT
905 SEASHORE ROAD
CAPE MAY, NEW JERSEY 08204

TELEPHONE: (609) 884-9400
FAX: (609) 884-1821

Maud Abrams School
714 Townbank Road
Cape May, NJ 08204
Telephone: (609) 884-9420
Fax: (609) 884-9421

Carl T. Mitnick School
905 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9470
Fax: (609) 898-9481

Preschool Appointment Reminder

Memorial School
2600 Bayshore Road
Villas, NJ 08251
(609) 884-9430

_____'s appointment is _____a.m.

On _____

Please indicate how you heard about our Preschool program - (social media, district website, school flyers, word of mouth, etc.) _____

Please complete the attached forms and return them to Memorial School along with:

___ Completed registration packet ___ Original Birth Certificate with the raised seal

___ Immunization Record ___ Court Documents (if applicable)

___ (2) **Two** current Proofs of Residency are required:

Please submit (1) **one** of the following: Lower Township Tax Bill, Deed **or** Lease

AND

(1) **One** of the following: Electric Bill, Sewer Bill, Cable Bill, Solar Bill or Gas Bill, etc.

LOWER TOWNSHIP SCHOOL DISTRICT

Cape May, New Jersey 08204

STUDENT REGISTRATION FORM

FOR OFFICE USE ONLY	
Teacher:	
Bus:	
Grad Year:	
Start Date:	
State ID (SID):	
(*If transferring from a NJ school)	

Registration Date: _____ Grade: _____

School: ☐ MEMORIAL ☐ MITNICK ☐ MAUD ABRAMS ☐ SANDMAN

PLEASE PRINT

Student has previously attended this district? ☐ **Yes** ☐ **No** **Student ID #**

PERSONAL

Student's Legal Name: _____
Last *First* *Middle*

Name you wish your child to be called (if different from above): _____

Home Address: _____
Street *City* *State* *Zip*

Home Phone: (area code and number) _____ Cell Phone: (area code and number) _____

Phone Notification Number for school closings, emergencies, etc: (area code and number) _____

Age: _____ Date of Birth: _____ Gender: Male: ☐ Female: ☐
Month *Day* *Year*

The following ethnicity information is utilized for compliance with federal and state reporting requirements.

Ethnicity: ☐ African American ☐ White ☐ Hispanic ☐ American Indian/Alaskan ☐ Asian Pacific Islander

City and State of Birth: _____ Country of Birth: _____

PARENT

Student is Living With: (Check one) ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Mother and Stepfather ☐ Father and Stepmother ☐ Guardian

All phone numbers must contain area code and number. *Please provide home and cell numbers if different from above.

Father's Name: _____ Home: _____ Cell: _____

Father's Employer: _____ Work: _____

Mother's Name _____ Home: _____ Cell: _____

Mother's Employer: _____ Work: _____

Guardian's Name: _____ Home: _____ Cell: _____
(If applicable)

Guardian's Employer: _____ Work: _____

Guardian's Relationship: _____

*If parent is military connected please circle: Active Duty National Guard or Reserve *Indicate which parent: Father Mother

LEGAL

Legal Alert: (Note: **IF** there are custody issues, please complete this section and provide the school with documentation.)

Student lives with: _____ Relationship to student: _____

Please circle one: Joint Custodial Parent Non-Custodial Parent

Name: _____ Relationship: _____

Address: _____ Phone Info: _____
Home *Cell*

EMERGENCY CONTACTS

Name: _____ Home: _____ Cell: _____

Relationship: _____ Work: _____

Name: _____ Home: _____ Cell: _____

Relationship: _____ Work: _____

Name: _____ Home: _____ Cell: _____

Relationship: _____ Work: _____

" FOR OFFICE/NURSE USE IN THE EVENT OF AN EMERGENCY"

Please complete both pages of the Student Registration Form. Thank you.

PREVIOUS SCHOOL

Please provide the following information **IF** the student is transferring from another school.

Name of School: _____ Grade: _____

Address: _____ Phone: _____

Please check if child was enrolled in any of these programs:

☐ Preschool Handicapped ☐ Speech ☐ Special Education ☐ Enrichment

☐ Remedial Reading ☐ Remedial Math ☐ Remedial Language Arts ☐ ESL/English Lang. Services

FAMILY

Native Language of Parent/Guardian: _____

IF native language is not English, is English spoken and understood by the parent/guardian? ☐ Yes ☐ No

Please list all children in your family including the child you are registering. Please list from oldest to youngest.

First Name	Last Name	Grade	School Attending	Date of Birth	Gender
					☐M ☐F
					☐M ☐F
					☐M ☐F
					☐M ☐F
					☐M ☐F
					☐M ☐F

OTHER

Health Insurance Info: This is required by the State of New Jersey

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

☐ Yes ☐ No Name of Company:

Please list any other pertinent information needed by school office below.

Email

Please provide an email address and indicate who it is for:

Contact Name:	Email:
Contact Name:	Email:

TRANSPORTATION

PLEASE NOTE

In order to provide an efficient and safe transportation system, it is imperative that routes and passengers remain consistent. We are required by the State of New Jersey (18A:39-1) to provide transportation to students living at least 2.0 miles from their school of attendance. The Lower Township Board of Education provides courtesy busing to all students from their place of residence to school. However, **if it is necessary for your child to be picked up and/or dropped off EVERY DAY of the week, at a location other than home, please fill in below. We DO NOT honor requests for daily stop changes, except in emergency situations.**

PICK UP Address: _____ *Bus # _____ Nearest Intersection _____

DROP OFF Address: _____ *Bus # _____ Nearest Intersection _____

Responsible Person at this Address: _____ Cell Phone Number at this Address: _____

Home Phone Number at this Address: _____

* Bus # will be provided by Transportation.

Rev. 3/3/2017

Original – Office Copy to Nurse Copy to Transportation Copy to Attendance Officer

Please complete both pages of the Student Registration Form. Thank you.

Lower Township Elementary School District
Confidential Health History

This information will be kept strictly CONFIDENTIAL and is for the exclusive use of school officials on a "need to know" basis.

NAME: _____

_____

☐ M ☐ F Birthdate: ____/____/____

Pediatrician: _____

Dentist: _____

Eye Doctor: _____

AT BIRTH:

- Did mother have any medical concerns during this pregnancy?
  If yes, please explain: ☐ YES ☐ NO

_____

_____

- Were there any difficulties during labor or delivery?
  If yes, please explain: ☐ YES ☐ NO

_____

- Was your child premature? ☐ YES ☐ NO

DEVELOPMENTAL PATTERNS:

- Were there any medical problems during the child's first year?
  ☐ YES ☐ NO
- At what age did your child walk? _____
- Does your child stumble, fall or bump into things frequently?
  ☐ YES ☐ NO
- Has this child or any family member had back curvature (scoliosis)?
  ☐ YES ☐ NO
- Does your child have trouble seeing or does he/she squint or have crossed eyes?
  ☐ YES ☐ NO

  Are glasses worn?
  - For seat work ☐ YES ☐ NO
  - At all times? ☐ YES ☐ NO
  - For TV only ☐ YES ☐ NO
- Do you have any concerns with your child's speech?
  ☐ YES ☐ NO
- Does your child have a history of frequent ear infections?
  ☐ YES ☐ NO
- Does your child have any trouble hearing? (ie: Does he/she have the TV turned up loudly?)
  ☐ YES ☐ NO

HAS YOUR CHILD HAD:

	YES	NO	DATE
Chicken Pox	☐	☐	
Head Injury	☐	☐	
Heart Problems	☐	☐	
Lyme Disease	☐	☐	
Nosebleeds	☐	☐	
Pneumonia	☐	☐	
Scarlet Fever	☐	☐	
Seizure Disorder	☐	☐	
Strep Infections	☐	☐	
Tonsillectomy	☐	☐	

DOES YOUR CHILD HAVE:

	YES	NO	DATE
Asthma	☐	☐	
Bedwetting	☐	☐	
Frequent Colds	☐	☐	
Frequent Headache	☐	☐	
Frequent Sore Throat	☐	☐	
Juvenile Diabetes	☐	☐	
Skin Rash/eczema	☐	☐	
Temper Tantrums	☐	☐	

MEDICAL INFORMATION:

List dates of hospitalizations, operations and serious accidents:

_____

_____

- Is your child presently under the care of a physician?
  Explain present condition ☐ YES ☐ NO

_____

_____

- List any medications your child takes:

_____

_____

_____

- List any other helpful information:

_____

_____

_____

PARENT/GUARDIAN (PRINT NAME)

_____

PARENT/GUARDIAN SIGNATURE

DATE:

Lower Township Elementary School District
Cape May, New Jersey

Allergy Information

Child's Name: _____

☐ M ☐ F Birthdate: _____ / _____ / _____

Does your child have any allergies? ☐ YES ☐ NO

Does your child have an EPI-PEN? ☐ YES ☐ NO

What is your child allergic to?

- ☐ Bees/ wasps
- ☐ Peanut Butter Is a peanut-free table required in cafeteria? ☐ YES ☐ NO
- ☐ Tree nuts
- ☐ Fish/shellfish
- ☐ Wheat
- ☐ Soy
- ☐ Cheese OK as ingredient in cooking? ☐ YES ☐ NO
- ☐ Eggs OK as ingredient in cooking? ☐ YES ☐ NO
- ☐ Milk ☐ Lactose intolerant ☐ Milk allergy
- ☐ Other _____

When was your child's first reaction? What treatment was sought? When was your child's most recent reaction?

_____

_____

What are your child's symptoms when in contact with allergy?

_____

_____

How knowledgeable is your child about his/her allergy and treatment?

_____

_____

Are there any special accommodations your child will need with regard to this allergy?

_____

- Monthly school menus are available on the District Website for your convenience when selecting lunches appropriate for your child with regard to his/her allergies.
- For the safety of your child, all names of children with allergies will be posted in each classroom as well as the lunchroom. **Your signature below indicates your agreement with this procedure.**

Parent/Guardian Signature: _____ *Date:* _____

Parent Input Form 2025-26

Child's Name:	**Date of Birth:**
Parent(s) Name:	**Phone Number:**
Name(s) of Siblings in District & Upcoming Grade:	

Please complete the questions below to allow us to best meet your child's needs.

A = Always S = Sometimes N = Never

Health & Physical Status

	Ear Infections		Picky eater
	Toilet trained		Takes naps
	Sleeps through the night		

Readiness Skills

	Follows two step directions		Keeps trying with difficult tasks
	Completes tasks		Speaks in three or four word sentences
	Can name five body parts		Talks about pictures in books
	Child can say first and last name		Uses imaginary play

Fine & Gross Motor Skills

	Clumsy or falls easily		Capable of stringing beads
	Feeds self with utensils		Able to walk up and down 3 steps

Social/ Emotional/ Behavioral Skills

	Gets along well with adults		Difficulty separating from parent
	Gets along well with other children		Appears sad, angry, moody
	Hits others		Takes turns/shares with others
	Must be reminded to do things		Upset child can calm down within 15 minutes
	Talks back defiantly		Verbalizes needs
	Gets angry when told no		Yells or screams

	Restless		Tries new things
	Verbally fights with others		Affectionate
	Constantly seeks attention		Makes new friends easily
	Listens when given directions		Can play independently
	Offers to help others		Becomes upset easily
	Plays gently with toys		Adjusts well to changes

Please indicate Yes or No to the Questions Below	Yes	No
Do you think your child talks like other children his/her age?		
Can you & others understand most of what your child says?		
Do you think your child walks, runs, and climbs like other children his/her age?		
Has there recently been a death in the family?		
Has your family recently experienced a relocation or move?		
Has your child & family had exposure to violence?		
Have there been any recent changes within the home or family environment?		
Do you have concerns regarding your child's behavior?		
Does anything about your child worry you?		

Please use the box below to provide any additional information:

Please indicate the language(s) currently used in your home.

How many hours of screen time does your child engage in daily? (ex. TV, Tablet and phone)

Has your child attended daycare?: If yes, for How Long? Please have provider complete Daycare Input Form

Does your child receive outside Speech, Occupational or Physical Therapy services? If so, who is the provider?

Was your child evaluated by Early Intervention Services? If so, what services did they qualify for?

Please indicate if there are any medical or health concerns for your child at this time:

Revised 2.9.25

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Preschool Home Language Survey
Parent/Guardian Questionnaire

PLEASE PRINT

Child's name: _____ Date of birth: _____
(first) (middle) (last)

Date of school entrance: _____

1. Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent [ ] Guardian [ ] Other
2. Please tell us about your child: _____

   _____
3. What language did the child learn when he/she first began to talk? _____
4. What language does the family speak at home most of the time? _____
5. What language (s) does the primary caregiver (s) speak to the child most of the time? _____
6. What language (s) does the child speak to his/her primary caregiver (s) most of the time? _____
7. What language (s) does the child speak to his/her brothers and sisters most of the time? _____
8. What language does the child speak to his/her friends most of the time? _____
9. Please list any preschool program(s) your child attended before coming to our program: _____
10. In which language do you wish to receive information from the school? _____
11. What name do you use for your child (if different from above)? _____

Sources:
Questions 1 – 8 are based on the NJ DOE Home Language Survey that was adapted from the sample survey in A Manual for Community Representatives of the Title VI Steering Committee, published 9/76 by the Institute for Cultural Pluralism, Lau General Assistance Center, San Diego University, San Diego, CA 92182

Question 9 was adapted from the Parent Questionnaire in One Child, Two Languages 2nd Edition published 2/2008 by Patton O. Tabors, Paul H. Brookes Publishing

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PRESCHOOL TRANSPORTATION REQUEST

Please return to the Transportation Department
Shannon Feltwell, Transportation Supervisor

Student Name:_____

Parent/Guardian(s) Name: _____

Home Address: _____

Phone: _____

Transportation Preference - Please indicate if your child will be riding the bus or if you will be transporting.

_____ LTES Bus Transportation or _____ Parent Transportation To/From

For bus transportation - Pickup/dropoff address (if different location than home- i.e., daycare facility)

_____

_____

Office use only:

*Memorial school received on:*_____

*Transportation received on:*_____

*Notified school:*_____ *Notified parent/guardian:*_____

*Bus stop am*_____ *Bus stop pm:*_____

*Supervisor:*_____