Grade 1-4 Registration Checklist

*Please call 201-391-2900 to schedule appt. for registration

Student Name: _____

☐ Deed or lease

☐ Utility bill

☐ Birth Certificate or Passport

☐ Most Recent Report Card

Medical

☐ Physical Exam Form (dated Sept. 2018 or later)

☐ Immunization Record

☐ Medical Information Form

☐ Health History Questionnaire

Forms

☐ Registration Form

☐ Student Data Form

☐ Home Language Survey

☐ Student Release Form

☐ Code of Conduct

☐ Acceptable Use of Technology Agreement Form

Montvale Public Schools
2019-2020

HEALTH OFFICE INFORMATION

- Medical Memo to Parents and Guardians
- Immunization Requirements for New Jersey Schools – Simplified
- Health Office Information and Procedures

HEALTH OFFICE REGISTRATION FORMS

- Health History Questionnaire
- Approved School Physical Examination Form
- Medication Permission Information Letter
- Medical Information Form

GENERAL REGISTRATION FORMS

- Student Data Report
- Student Registration Form
- Home Language Survey
- Student Release Form
- Code of Conduct
- Acceptable Use of Technology Agreement

To: Parents/Guardians

From: Mrs. Meghan Dugan, RN

Re: **Medical Requirements – Pre-K - 4**

In order for children to start school in Memorial School, the following are required:

PHYSICAL EXAMINATION and HEALTH HISTORY

Before entering school, each child must have a **complete medical examination**, which includes a vision and hearing screening conducted by your physician. This exam must be done **no more than 365 days before the child's first day of school**. ***No student is admitted without the physical form.*** The physical form in this packet should be completed with full results of the examination, blood pressure, height, weight, vision, hearing, recommendations and immunizations. The form must be **signed, dated and stamped** by the examining physician. If the doctors' office uses their own form, **all of the same information should be included** and it should be **signed and dated**.

Should there be any **absolutely unavoidable delay**, contact the school nurse (201-391-2900 ext. 3505) regarding possible provisional admission.

Parents/Guardians should complete the **Health History Questionnaire *prior to registration***.

We encourage a dental check-up before your child enters Kindergarten.

IMMUNIZATIONS

The State of New Jersey mandates that the following **immunizations** be required of all pupils starting public or private school in New Jersey.

- **DTP** - Every child less than seven years of age shall have received a minimum of four doses of diphtheria and tetanus toxoid and pertussis vaccine (DTP), or any vaccine combination containing DTP, such as DTP/Hib or DTaP, one dose of which shall have been given on or after the child's fourth birthday.
- **Polio** - Every child less than seven years of age shall have received at least three doses of live, trivalent, oral poliovirus vaccine (OPV), or inactivated poliovirus vaccine (IPV) either separately or in combination, one dose of which shall have been given on or after the child's fourth birthday.
- **Measles** - Every child is required to have received two doses of live virus vaccine administered on or after the first birthday separated by at least one month. Combined MMR or MR vaccine is recommended for these.
- **Mumps** - One dose of live mumps virus vaccine administered on or after the first birthday.
- **Rubella** (German Measles) - One dose live vaccine administered on or after the first birthday.
- **Hepatitis B** - Three doses of hepatitis B are required prior to Kindergarten entrance.
- **Varicella** – One dose of varicella vaccine, or any vaccine combination containing varicella virus, administered on or after the first birthday, prior to Kindergarten entrance.
- **NOTE: Mantoux Test for TB** – May be required for students entering from other states or from countries outside the United States.
- **NOTE, also: Pre-K immunization requirements are on the following page.**

Immunization Requirements for New Jersey Schools – (simplified)

REQUIREMENTS FOR KINDERGARTEN

Diphtheria, Tetanus, Pertussis	4 doses with one dose after 4th birthday **OR** any 5 doses (Sixth Grade Booster required as of 9/1/2008)
Inactivated Poliovirus or Oral Poliovirus	3 doses with one dose after 4th birthday **OR** any 4 doses at least 28 days apart
Measles	2 doses with the first dose on or after 1st birthday, and an interval > 1 month between doses
Rubella and Mumps	1 dose of each on or after 1st birthday
Hepatitis B	3 doses **OR** lab evidence of immunity >2 months after last dose, titer ≥ 10
Varicella	One dose on or after 1st birthday **OR** history of disease **OR** lab evidence of immunity

REQUIREMENTS FOR OTHER GRADE LEVELS

Pneumococcal	Required for Pre-K - (as of 9/01/2008) (1) Minimum of 2 doses of Pneumococcal vaccine needed if between the ages of 2-11 months. (2) Minimum of 1 dose of Pneumococcal vaccine needed after the first birthday.
Influenza	Required for Pre-K – (as of 9/01/2008) 1 dose given between September 1 and December 31 of each year.
Haemophilus Influenza type B (HIB)	Required for Pre-K only (1) Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months. (2) Minimum of 1 dose of Hib vaccine is needed after the first birthday.
Meningococcal	Required for Sixth Grade (as of 9/01/2008)
Hepatitis A	No Mandate yet

AGE APPROPRIATE VACCINATIONS FOR PRE-K CENTERS

18 Months – 4 Years New Requirements…... (as of 9/01/08)	4 doses DTaP or DTP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, plus 1 dose Pneumococcal Vaccine (PCV7), Annual Influenza between September 1 and December 31

Note:** ***All students entering Grades K-4 must meet the Kindergarten/First Grade requirements.

Also, ALL STUDENTS REGISTERING MUST SUBMIT A CURRENT PHYSICAL EXAM (Done within the 365 days prior to the first day of attendance).

HEALTH OFFICE INFORMATION AND PROCEDURES

The nurses of the Montvale School District would like you to be aware of procedures that are followed in helping to safeguard your child's health.

ACCIDENTS
The school attempts to provide an environment in which the student will be safe from accidents. Minor accidents such as abrasions and small contusions are cared for routinely, as are minor complaints such as stomach aches and tooth discomfort. If any accident or sudden illness which requires continued intervention and or observation occurs, first aid will be administered and the student's parent(s) or guardian(s) notified. No care beyond first aid will be given by the school nurse.

EMERGENCY DATA
An emergency form is distributed for parents and guardians to complete, sign, and return. The emergency form is used to update the emergency contact information for your child if he or she is ill or injured. It includes permission to transport your child to the hospital in case of an emergency requiring rapid response. It is also used for our telephone notification system. The following information must be included:
- The student's home phone number and parent(s) or guardian(s) cell phone numbers.
- Work phone numbers and email addresses for parents
- Two names and phone numbers of people who can care for your child in your absence

GUIDELINES FOR KEEPING A CHILD HOME
DO NOT SEND A STUDENT TO SCHOOL WHO IS COMPLAINING OF FEELING ILL, OR WHO HAS HAD A FEVER THE AFTERNOON OR NIGHT BEFORE SCHOOL. **Children must be fever-free (WITHOUT TYLENOL) for 24 hours before they return to school.** Children who feel unwell before school almost invariably feel ill in class and must be sent home. It is unfair for the other children in the class, as well as the teacher, to be exposed to a student with a possible contagious illness.

NOTIFICATION OF ABSENCE by TELEPHONE and/or NOTE
When a student will be out of school, **notify the school nurse at 201-391-2900, ext. 3164 by 9:00 a.m.** A note is requested for each absence and is required for admittance into class after an illness of three or more days. Please obtain a doctor's note when there is a possibility of contagious disease such as streptococcus (strep throat), influenza, conjunctivitis (pink eye), or impetigo.

MEDICATION
Administration of medication during school hours is not encouraged. However, if a physician determines that failure to take medication during school hours would jeopardize the health or school attendance of a student, **the medication will be given by the school nurse.** Only medications necessary for life threatening illness/conditions shall be administered on field trips.

The following procedures must be followed if any medication (including any inhaler) is to be administered during school hours:

1. A medication administration form, available on-line (on our website) and in the nurse's office, is required to be completed and signed by the student's physician. The request to administer the medication must be signed by the parent.
2. The above form and the container with the pharmacist's label designating patient's name, instructions, name of drug and name of physician must be given to the **nurse by the parent.**

Students will only be permitted to self-administer medication without the assistance of the nurse if it is deemed necessary for life threatening illness/conditions with special permission form(s) signed by the physician and parent. A student may be permitted to use inhalers for asthma without the nurse's assistance, but this requires a special set of permission forms**.** A student will be permitted to self administer insulin in school and on field trips, if so directed by the physician.

PHYSICAL EDUCATION

If a student cannot take physical education classes due to illness or injury, a note **stating the reason for the excuse** must be sent to the nurse by the parent or guardian. If a prolonged physical education absence (more than one week) is necessary, a note from a physician is required. This should state the length of time that the student is to be excused and the return date.

IMMUNIZATIONS

In order to attend school, state law requires that each student's immunizations be completed as determined by state mandate. These requirements are included in the school registration packet.

If you have any questions regarding any of the above information, please call the school nurse. The main thrust of our efforts is the well being of your child in a healthy school environment. Only through parent-school cooperation can this be accomplished.

HEALTH HISTORY QUESTIONNAIRE

Name:	Male/Female	Grade:

Directions: Please answer the following questions about your child's medical history. Explain "yes" answers at the bottom of the page. You should respond to all questions. If there are two parents or legal guardians, both are asked to sign.

1. Has your child had, or does he/she currently have: (*check ONE)*

	YES	NO	DON'T KNOW
a. A physical for this school year? (After September 1)			
b. An injury or illness since the last exam?			
c. A chronic or ongoing illness (such as diabetes or asthma)?			
1. An inhaler or other prescription medicine to control asthma?			
d. Any prescribed or over the counter medications taken on a regular basis?			
e. Surgery, hospitalization or any emergency room visit(s)?			
f. Any allergies to medications?			
g. Any allergies to bee stings, pollen, latex or foods?			
1. Type of reaction: rash, hives, skin condition, anaphylaxis? (circle)			
2. Any medication/epipen taken for allergy symptoms? (if yes, list below)			
h. Any anemia or blood disorders?			

2. Has your child had or does he/she currently have any of the following *head-related* conditions:

	YES	NO	DON'T KNOW
a. Concussion requiring a physician's evaluation?			
1. How many times and when? (Answer below)			
b. Memory loss or been "knocked out"?			
c. Any seizures?			
d. Frequent or severe headaches?			

3. Has your child had or does he/she currently have any of the following *heart-related* conditions:

	YES	NO	DON'T KNOW
a. Chest Pain? (When exercising?)			
b. Heart murmur?			
c. High blood pressure?			
d. Elevated cholesterol level?			
d. Restriction from sports for heart problems?			
e. Has any family member or relative:			
1. Died of a heart problem before age 35?			
2. Died of a heart problem before age 50?			
3. Died with no known reason?			
4. Died while exercising? During or after?			
5. Been diagnosed with Marfan's Syndrome?			

Explain "Yes" Answers Here (Include Dates):

_____

_____

_____

4. Has your child had or does he/she have any of the following *eye, ear, nose, mouth or throat conditions:*

	YES	NO	DON'T KNOW
a. Vision problems?			
1. Wear contacts, eyeglasses or protective eyewear? (Circle which type)			
b. Hearing loss or problems?			
1. Wear hearing aides or implants? (Circle which one)			
c. Nasal fracture(s) or frequent nose bleeds?			
d. Wear braces, retainer or protective mouth gear?			
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?			
f. Frequent ear infections?			

5. Has your child had or does he/she have any of the following *neuromuscular/orthopedic conditions*:

	YES	NO	DON'T KNOW
a. A burner, stinger or pinched nerve?			
b. A sprain diagnosed by a doctor?			
c. A strain diagnosed by a doctor?			
d. Swelling or pain in muscles, tendons, bones or joints?			
e. Dislocated joint(s)?			
f. Low back pain?			
g. Fracture(s), stress fracture(s)?			
h. Worn any protective braces or equipment for a prior injury?			

6. Has your child had or does he/she have any of the following *general or exercise related conditions:*

	YES	NO	DON'T KNOW
a. Difficulty breathing? (During Exercise)			
1. After running long distance (1 mile)			
2. Coughing, wheezing or shortness of breath in weather changes?			
3. Been diagnosed with exercise-induced asthma?			
i. controlled with medication? (List below)			
4. Experienced dizziness, passing out or fainting?			
b. Viral infections (e.g. mono, hepatitis)?			
c. Become tired more quickly than friends?			
d. Any of the following skin conditions:			
1. Eczema, contact dermatitis, ringworm, warts, acne, herpes?			
2. Sun sensitivity?			
f. Had feelings of depression?			
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?			
1. Heat exhaustion? (cool, clammy, damp skin)			
2. Heat stroke? (hot, red, dry skin)			

Explain "Yes" Answers Here (Include Dates):

The medical information contained in this HEALTH HISTORY QUESTIONNAIRE and on the student's PHYSICAL EXAMINATION may be shared with school personnel when applicable and necessary. I certify that the information provided herein is accurate as of the date of these signatures.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Signature:	**Date:**

Medication Administration At School

Occasionally, students require medications for a variety of reasons throughout the school day. With the appropriate paperwork, signed by both the physician and the parents, the school nurse may administer medication. All medications must be delivered to the school by an adult and handed off to designated school staff. Students may not carry, transport or self administer medication.

If your child will require medication at school, please contact Meghan Dugan, our school nurse, to discuss and obtain the appropriate forms. Thank you.

Meghan Dugan RN-CSN
mdugan@montvalek8.org
201-391-2900 x3505

APPROVED SCHOOL PHYSICAL EXAMINATION FORM
MONTVALE PUBLIC SCHOOLS
MEMORIAL SCHOOL (Pre-K - 4)

UNIVERSAL CHILD HEALTH RECORD

Endorsed by:
American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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		

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

CH-14 JAN 06 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

IMMUNIZATION RECORD

STUDENT:		DATE:				
	IMMUNIZATION	**#1**	**#2**	**#3**	**#4**	**#5**
	Diphtheria, Tetanus, Pertussis (DTP, DTaP)					
	Inactivated Poliovirus (IPV,OPV)					
	MMR (Measles, Mumps, Rubella)					
	Measles					
	Mumps					
	Rubella					
	Hepatitis B					
	Varicella					
	Haemophilus Influenza type B (HIB)					
	Hepatitis A (not mandated yet)					
	Pre-K: Pneumococcal Vaccine (PCV7)					
	Pre-K: Annual Influenza					

	TB Test – Mantoux					

Physician's Signature: _____ DATE:_____

MONTVALE PUBLIC SCHOOLS
STUDENT MEDICAL INFORMATION FORM
2019– 2020

Name: _____ **Grade:**_____

Gender: _____ **Birth Date:** _____

Street Address:_____ **City**: Montvale **State**: NJ **Zip**: 07645

Parent Name:_____ **Parent Name**: _____

Home Phone Number: _____ **E-Mail**: _____

Cell Phone Number(s):_____ **Work Phone(s)** _____

Birth City/State: _____, _____ **Country of Birth**: _____

Ethnicity: _____

Primary language spoken at home (circle): English Other:_____

In case of a medical emergency, contact the following person(s) if parents/guardians are NOT available:

Name: _____Phone: _____ Alternate Phone:_____
(work/cell phone)

Name: _____Phone: _____ Alternate Phone:_____
(work/cell phone)

Doctor Information:

Family Doctor: _____ Phone Number:_____

Health Information: ***Note: This medical information is stored in the nurse's office in hard (paper) copy only. These documents are restricted to authorized personnel.)***

Does the student have any of the following health problems?	*Yes*	*No*
Allergies		
Asthma		
Diabetes		
Convulsive (Seizure) Disorders		
Congenital Defects		
Other (Please Explain Below)		
Medications (at home or at school)		

Please explain any items if checked "*Yes*":

_____

_____

If emergency treatment is required, can the school authorities use their own judgment in sending the child to the hospital or doctor most easily accessible before parents/guardians are reached? Circle one: YES NO

Does your child have medical health insurance? Circle one: YES NO

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

12/2018

MONTVALE PUBLIC SCHOOLS
STUDENT DATA REPORT

Name: _____ Grade:_____

Gender: _____ Birth Date:_____

Street Address: _____ City: Montvale **State:** NJ **Zip:** 07645

Parent Name: _____ Parent Name:_____

Home Phone Number: _____ Email:_____

Cell Phone No.:_____ Birth City/State_____,_____

Country of Birth: _____ If born outside USA, US entry date:_____

Ethnicity_____ Primary (Native) Language_____Home Language: _____

I have reviewed my child's data and certify that the information is correct as submitted:

Parent/Guardian Name: _____Signature:_____Date:_____
Please Print Clearly

****Emergency Early Dismissal****

The phone number to be dialed by the automated calling system, Parent Link, is:_____

If a parent/guardian is not reached through the automated calling system, the following information is to be used:

Mother/Guardian Name: _____ Home Phone: _____

Work Phone: _____ (if part-time please specify days & hours) Cell Phone:_____

Father/Guardian Name: _____ Home Phone:_____

Work Phone: _____ (if part-time please specify days & hours) Cell Phone: _____

Two homes to which the student may go if parent/guardian cannot be contacted.

1. **Name: _____ Phone: _____**

   Address: _____

2. **Name: _____ Phone: _____**

   Address: _____

In case of an early dismissal, please check appropriate box:

- ☐ **I will pick-up or arrange to have my child picked up.**
- ☐ **My child has permission to walk home.**
- ☐ **My child, who rides the bus, has my permission to ride his/her assigned bus to designated stop.**

I have instructed my child in the procedure listed above and authorize him/her to be dismissed to either the child's home or one of the two homes listed.

_____ _____

Parent/Guardian Signature **Date**

MONTVALE PUBLIC SCHOOLS STUDENT REGISTRATION FORM

Today's Date: _____ Grade Entering: _____

NJ Entry Code: _____

****PLEASE PROVIDE A SMALL CURRENT PICTURE OF YOUR CHILD FOR OUR RECORDS****

Student Enrollment Information:

Name: _____ Gender M or F (circle)
(Last) (First) (Middle)
Street Address: _____ City: _____ Zip: _____

Home Phone Number (Area Code + Number): _____

Date of Birth: _____ Birth City: _____ Birth State: _____

Birth Country: _____ (if born outside USA) US entry date: _____

Ethnicity: (please circle) Hispanic White Asian Black American Indian Hawaiian Native

Primary (Native) Language: _____ Home Language: _____

Military Connected: ( ) Yes ( ) No If Yes: ( ) Active ( ) Not Active

Unusual home conditions affecting pupil i.e. death, divorce, separation, relatives living in home, etc.:_____

Previous school attended (name, address, city, state):

_____

_____

Parent/Guardian Information:

Parent/Guardian (Mother) Parent/Guardian (Father):

Name: _____Name:_____

Street Address: _____Street Address (if not same)_____

City: _____City:_____

State: _____ Zip_____State: _____ Zip: _____

Home Phone No.:_____Home Phone No.:_____

Cell Phone No.:_____Cell Phone No.: _____

- **Please check if you would like to be informed of Emergency School Closing by email.**
  E-Mail:_____

Proof of Residency:

As proof of domicile (residency), I am providing copies of the following (mark with "X"):

_____ 1. A lease effective during the current school year, showing residence within the Borough of Montvale (or Landlord Affidavit) Effective date: _____

OR

_____ 2. A recorded deed showing ownership of a residence within the Borough of Montvale. Residency since: _____

AND

3. The following additional documentation (mark one item below with "X")

_____ Bank Statement showing address (block out the figures)
_____ Property Tax Bill
_____ Utility or Phone Bill showing your address
_____ Other (i.e. moving company bill)

AND, if applicable:

_____ 4. A current signed affidavit form stating that the student listed above resides with you and is financially dependent upon you even though you are NOT his/her parent or legal guardian. (Documentation of financial dependency must be attached, i.e. IRS return showing student as dependent)

Reviewed and approved by (initials): _____

Other children in household:

Childs Name:	**Date of Birth:**
_____	_____
_____	_____
_____	_____

Registration Statement:
I, _____, affirm that I am the (please check one): _____ natural parent/legal guardian;_____ affidavit host of the student(s) listed above. I further state that this form and the attached documentation constitute true and accurate proof that the student(s) listed above reside(s) with me within the Borough of Montvale. If any student above stops living with me, or if I move my residence out of the Borough of Montvale, I will promptly notify the Montvale Board of Education in writing.

I certify that the forgoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punitive action.

Parent/Guardian Signature: _____ Print Name:_____Date:_____

Montvale Public Schools

53 W. Grand Avenue, Montvale, NJ 07645
David Collier, Principal

Home Language Survey

Dear Parents or Guardians:

In order to comply with N.J. State Law, we are required to survey all students entering the district's schools about language use background, in order to provide help if needed. We would appreciate your completing the form below and returning it to your child's school office. Thank you.

Student's Name: _____ Date of birth: _____

School: _____ Grade: _____

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent [ ] Guardian
[ ] Other:_____

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English_____ Other [specify]_____

2. If English was not your child's first spoken language, at what age was he/she first exposed to English? _____

3. What language does the family speak at home most of the time?

   English _____ Other [specify] _____

4. What language does the parent [guardian] speak to the child most of the time?

   English _____ Other [specify] _____

5. What language does the child speak to his/her parent [guardian] most of the time?

   English _____ Other [specify] _____

6. What language does the child speak to his/her friends most of the time?

   English _____ Other [specify] _____

7. Was this student in a school ESL program? YES NO
   If yes, what grade(s)_____ Where (school/city)_____

8. If yes, did this student exit the former ESL program? YES NO

9. In which language do you prefer to receive school communication?

   English _____Other [specify] _____

Phone:_____

Signature of Parent/ Guardian: _____ Date Completed: _____

Montvale Public Schools

Darren A. Petersen, Ed.D.
Superintendent of Schools

47 Spring Valley Road
Montvale, NJ 07645

STUDENT RELEASE FORM

Dear Parents/Guardians:

As part of their educational experience, students participate in special curriculum projects, a variety of contests, concerts, school plays, and field trips. Pictures/video of our students are often taken to capture these moments in time. We would like your permission to share some of the photographs/video of your child(ren) with the public for communication and/or publicity purposes.

Please read the following and complete the form, if this is acceptable to you.

I hereby grant permission to the Montvale Board of Education to use the name, photograph, or video of my son/daughter for communication and/or publicity purposes, including newspapers, Montvale School District newsletters, and MonTVale Access Group, Cable Channel 78. This use excludes the Montvale School District Internet Website. My permission shall remain in effect unless later withdrawn by me and communicated to you in writing.

_____ _____
Name of Student **Homeroom**

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

Please return this form to child's homeroom teacher. If you should have any questions or concerns, please do not hesitate to contact your principal's office.

Sincerely,

Darren A. Petersen
Darren A. Petersen, Ed.D.
Superintendent of Schools

Montvale Public Schools

Darren A. Petersen, Ed.D.
Superintendent of Schools

47 Spring Valley Road
Montvale, NJ 07645

Montvale Public Schools
Code of Conduct

Dear Montvale Parents/Guardians, Students, and Staff:

To ensure that all students and parents/guardians have read and understand the material presented in the Montvale Public Schools Code of Conduct, available online at www.montvalek8.org, **please sign and return this form** to your school office. We look forward to working with all members of the Montvale school community to accomplish the established goals. Please do not hesitate to contact your child's school if you have any questions or concerns regarding the information contained within the Code of Conduct.

Thank you for your continued cooperation and support.

Sincerely,

Darren A. Petersen, Ed.D.

Darren A. Petersen, Ed.D.
Superintendent of Schools

By signing this contract, I agree to work with all members of our school community to follow the guidelines presented within the Montvale Public Schools Code of Conduct.

STUDENT NAME (Please Print):_____ DATE:_____

By signing this contract, I agree to work with my child and all members of our school community to follow the guidelines presented within the Montvale Public Schools Code of Conduct.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

ACCEPTABLE USE OF TECHNOLOGY AGREEMENT: STUDENT/PARENT ACKNOWLEDGMENT

The agreement is available at www.montvalek8.org on the home page under "Important Information."

STUDENTS:

I have read and will abide by the "Acceptable Use of Technology Agreement" of the Montvale Public Schools. I further understand that any violation of the agreement is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action and/or appropriate legal actions may be taken.

PARENTS/GUARDIANS:

I have read and agree to assist my child in understanding and abiding by the "Acceptable Use of Technology Agreement" of the Montvale Public Schools. I understand that access to district technology equipment and its entire system of electronic communication is designed for educational purposes. I also recognize that some materials on the Internet may be controversial and objectionable and that, while every attempt will be made to block inappropriate sites, it is impossible for the Montvale School District to restrict access to all controversial and objectionable materials. I will not hold the Montvale School District responsible for the accuracy or quality of any materials acquired or viewed on its system by my child. I understand that improper or inappropriate use of technology equipment and the district system by my child may result in revocation of his/her technology privileges and the imposition of school discipline, criminal penalties, or civil penalties. I accept all financial and legal liabilities that may result from my child's use of the Montvale School District equipment and technology system.

I release the Montvale School District, its officers, employees, agents, representatives, and all organizations and individuals related to the Montvale School District's technology system from any and all liability or damages that may result from my child's use of the district's equipment and electronic communication system. I specifically agree to indemnify and hold the Montvale School District, its officers, employees, agents, and representatives harmless for any actions, claims, costs, damages, or losses, including, but not limited to, attorney's fees, incurred by the Montvale School District relating to, or arising out of my child's use of such equipment and system.

STUDENT NAME: _____
(Please Print)

PARENT/GUARDIAN NAME: _____
(Please Print)

Please check off the statement below which is applicable.

_____ I grant my child permission to use the district's technology equipment and electronic communication system.

_____ I DO NOT grant my child permission to use the district's technology equipment and electronic communication system.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

(August 8, 2011)