

**South Hackensack
Memorial School**

Dyer Avenue, South Hackensack, NJ 07606

Telephone: (201) 440-2782

Fax: (201) 440-9156

"A tradition of caring"

Superintendent/Principal: Mr. Gregorio Maceri

Website: www.shmemorial.org



You will need the following:

- ✓ **Completed Registration Application**
- ✓ **Physical Exam Form**
- ✓ **Proof of Residency**
Owner - Current Tax Bill
Renter - Notarized Affidavit of Landlord - to be completed by the Landlord, listing all occupants of rental premises, with his or her signature notarized
AND
Residential Rental Property Certificate of Inspection
- ✓ **Immunization Card / Record**
- ✓ **Proof of Student's Birth** - Original Birth Certificate and/or Passport
(MUST be translated if not in English)
- ✓ **Last Report Card and any other available academic documentation**

Registrar use only

School Start Date: _____ Grade: _____ LID: _____ SID: _____

SOUTH HACKENSACK MEMORIAL SCHOOL
REGISTRATION APPLICATION



Student's Name: (Please print your child's name the way it appears on their birth certificate)

_____ Last First Middle

Gender: Male Female Age: _____

Place of Birth: _____ Date of Birth: _____
City State or Country Month Day Year

Home Address:

_____ Street Apt. / PO Box City State Zip

Home Telephone: _____

Parent/Guardian Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Parent / Guardian Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Ethnic Group: (Please circle)

- | | | |
|----------------------------------|------------------------------------|----------|
| White (not of Hispanic Origin) | Black/African American | Asian |
| American Indian / Alaskan Native | Native Hawaiian / Pacific Islander | Hispanic |

If student is foreign born - Date Entered United States: _____

Date enrolled into a United States school: _____

Student Language Spoken Most Often: _____ Other Languages: _____
Primary

*If any of the above information changes please
send written updates to the Main Office or
e-mail office@shmemorial.org*

EDUCATIONAL INSTITUTION HISTORY

Student Name: _____

Please detail all schools attended beginning with Prekindergarten; list in chronological order from oldest to current.

Dates Attended	School	City	State or Country

Please indicate the programs in which student has participated:

- ESL/LEP Speech Services Child Study Team Evaluation
- Gifted and Talented Special Education (IEP) Individualized Education Program
- ADA / Section 504

If ESL/LEP has been checked please insure that ESL/WIDA test scores are provided. Provide any 504 or I&RS documentation if applicable.

HEALTH HISTORY

Student's Name _____ Grade _____

Date of Birth _____ Place of Birth _____

Communicable Disease History – Please indicate month and year

Chicken Pox _____ German Measles _____ Strep Throat _____

Measles _____ Scarlet Fever _____ Other _____

Disease History – Please indicate month and year of onset / episode

Diabetes _____ Urinary Tract / Kidney _____

Rheumatic Fever _____ Ear Infection _____ Heart Disease _____

Convulsive Disorder _____

Growth Development Problems (type) _____

Skeletal / Joint Problems (type) _____

Asthma / Allergic _____ Exercise Induced _____

Allergies _____

Problems with Hearing _____ Speech _____

Vision _____ Glasses: yes _____ no _____

Hospitalization (reason and date) _____

Is your child receiving treatment for any condition? _____

Does your child require medication? _____

Is there any health concern you would like known in the health office? _____

Signature of Parent: _____ Date: _____