Student Registration for 20-21 during Covid – 19 restrictions

1. All registrations begin with the parent/guardian visiting our website http://www.paulsboro.k12.nj.us and pre-registering their child(ren) online.
2. Registrar will contact the parent/guardian via phone, email, etc., to review procedures and documentation needed to process registration.
3. A Registration Packet will be sent either via email or USPS for the parent/guardian to complete **OR** parents may download the fillable forms from our web site, http://www.paulsboro.k12.nj.us , fill them out, save to your device, attach them to an email and return with the other necessary documentation (below) to tcroce@paulsboro.k12.nj.us . DO NOT Email PICTURES (scanned or Microsoft documents only)
4. Upon completion of the Registration Packet, the parent/guardian must return all forms to the Paulsboro Public School Administration Building ***along with copies of: DO NOT DROP OFF ORIGINAL DOCUMENTS***
   a. Proof of Residency:
      - Owners:
        Copy of property tax bill/water sewer bill *from Borough Hall* **AND** an OFFICIAL mail item with their name and address (electric bill, phone bill, etc.) or a copy of their mortgage statement.
      - Renters:
        Original, up to date, *signed lease with **ALL** persons living in home listed & copy of the Certificate of Occupancy from Borough Hall with **ALL** persons listed* – **NO EXCEPTIONS**

   b. Shot Records **- UP TO DATE**
   c. Original Birth Certificate (must be original with raised seal) – (*during Covid -a copy with raised seal visible)*
   d. Custody or Court papers stating you have residential custody of this above student.
   e. **(Grades K-12)** Copy of transcripts and or last report card
   f. Transfer Card from last school of attendance (NJ residents)
   g. **(Grades 7-12 ONLY)** NJSIAA Transfer Form
   h. **(Grades 9-12 ONLY) Greenwich Twp. residents** must first register in Greenwich Twp. prior to coming in to Paulsboro Jr. / Sr. High School for transportation.
   i. **(PRESCHOOL ONLY)** Copy of any documents if receiving service from State of New Jersey (SSI, TANF, SNAP, county benefits/assistance, etc.) **AND** copies of last two pay stubs or copy of last income tax returns.
   j. copy of drivers license of person registering student

   This documentation can either be mailed to:

   Paulsboro Public Schools - Registrar
   662 North Delaware Street
   Paulsboro, NJ 08066

   Email: tcroce@paulsboro.k12.nj.us

   OR

   Dropped off Monday – Friday between the hours of 7:30a.m. – 2:30 p.m. at the Administration Building in a blue bin located outside the building doors.

Upon receipt and review of all documentation by the Registrar, students will be enrolled under a *provisional status in PPS. These students will be placed into our student database (Genesis) to begin school in the appropriate building within 24 hours.

Since, regulations require the district to view original documents of certain items to complete registration, (birth certificate, driver's License, custody/court papers, transfer card(s), etc.), once school reopens, an **appointment must be made** with the Registrar to show the original documents listed above to finalize the enrollment process. Questions - Terry Croce: (856)-423-5515x1236

ALL REGISTRATION IS *PROVISIONAL* UNTIL ALL DOCUMENTS ARE OBTAINED AND VIEWED BY REGISTRAR

Paulsboro Public Schools
662 North Delaware Street
Paulsboro, NJ 08066

Phone 856-423-5515
Fax 856-423-4602

TO THE PRINCIPAL - STUDENT RECORDS DEPARTMENT:

Name and address of Previous School: _____

fax #: _____ _____

phone#: _____ _____

Student's Name	DOB	Grade

The above named student(s) has/have registered in the Paulsboro School district. Please forward a complete transcript of the student(s) academic records, including health and confidential records. **Please include their SID#(s)**

ACADEMIC AND HEALTH RECORDS ARE FORWARDED TO:

☐ Paulsboro Jr.-Sr. High School
670 North Delaware Street
Paulsboro, NJ 08066
FAX: 856-423-2443

☐ Billingsport Elementary School
441 Nassau Avenue
Paulsboro, NJ 08066
FAX: 856-423-8912

☐ Loudenslager Elementary School
100 Baird Avenue
Paulsboro, NJ 08066
FAX: 856-423-8914

CONFIDENTIAL RECORDS ARE FORWARDED TO:

☐ Child Study Team Office
Paulsboro Public Schools
662 North Delaware Street
Paulsboro, NJ 08066
FAX: 856-423-4602

Parental Permission

I hereby give permission for the above named school to release the academic, health, test results and confidential records of my child/children to the Paulsboro Public School District.

_____ _____ _____
Parent / Guardian Signature | Date | phone #

PAULSBORO PUBLIC SCHOOLS
Paulsboro, New Jersey 08066
REGISTRATION FORM

Name of Student _____

Male ☐ Female ☐ Date of Birth _____ Place of Birth _____

School to Attend _____ Grade _____ Registration Date _____
Address: _____ Phone No. _____
Email: _____ Cell No. _____
Residing With: Father ☐ Mother ☐ Both ☐ Guardian (please attach proof of guardianship) ☐
**Guardian(s) email address: _____
Father _____ Employer _____ Work Phone _____
Mother _____ Employer _____ Work Phone _____
Guardian _____ Employer _____ Work Phone _____
Emergency Contact/Address 1. _____ Phone No. _____
2. _____

Ethnicity: White ☐ Black ☐ Hispanic ☐ American Indian/Alaskan ☐ Asian ☐ Hawaiian native pacific islander ☐

***LIST ALL CHILDREN IN FAMILY – PLEASE NOTE THE SCHOOL THE CHILDREN ARE ATTENDING:

NAME	DATE OF BIRTH	SCHOOL PRESENTLY ATTENDING

Last School Attended _____ Address _____
Was student enrolled in a **special education** class in the previous district? YES ☐ NO ☐
Has the student ever attended Paulsboro Public Schools? YES ☐ (School: _____) NO ☐

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

FOR OFFICE USE ONLY
☐ Home Language Survey Attached ☐ Transfer Card ☐
☐ Medical Information Attached ☐ Birth Certificate Attached ☐ Other _____

PLACE OF RESIDENCE (CHECK ONE):
(Parent MUST show registering official one of the following and attach copy to this form)

☐ Student lives with his/her family in their own house or apartment
Proof attached: (current) ☐ Tax Bill and/or Water Bill ☐ Lease

☐ Student domiciled with another family
Proof attached: ☐ Affidavit of Support of Minor and ☐ Statement of Parent/Guardian

☐ Student was placed in Paulsboro by an agency or court order
Proof attached: ☐ Letter from Agency or ☐ Court Order

☐ Student living with his/her family, but in someone else's house or apartment
(Please see the Residency Questionnaire for additional information)
☐ McKinney Act ☐ Letter from Homeowner ☐ Letter from Landlord

_____ _____ _____ _____
Signature of Registrar ***Date*** ***Principal*** ***Date***

_____ _____
Signature of School Nurse ***Date***

Preschool Expansion Grant Eligibility Verification

1. Child's Name: _____

2. Child's date of birth: _____

3. This child is eligible to participate in the program: ☐ Yes ☐ No

4. Check the application category of eligibility for this child:

   ☐ SSI
   ☐ Free/Reduced Meals
   ☐ Homeless
   ☐ Foster Care
   ☐ Public Assistance (TANF/WFNJ or other)
   ☐ None of the above

5. What documentation was used to determine eligibility:

   ☐ Income Tax Form 1040 (current or previous year)
   ☐ Written statement from employer
   ☐ W-2
   ☐ SSI documentation
   ☐ TANF/WFNJ documentation
   ☐ Free/Reduced Meals application
   ☐ Pay Stubs
   ☐ If other, Please explain: _____
   ☐ Unemployment documentation

Documentation of no income: _____

Staff name: _____ Date of eligibility verification: _____

Staff signature: _____ Title: _____

PAULSBORO PUBLIC SCHOOLS
PAULSBORO, NEW JERSEY 08066

HOME LANGUAGE SURVEY

HOME INFORMATION

Student's Name _____ Telephone _____

Student's Address _____

_____

Date of Birth _____

Place of Birth _____

Parent/Guardian's Name _____

LANGUAGE INFORMATION

1. What language did your **child** speak first?	English ☐	Spanish ☐	Other _____
2. What language do **you** speak most often to your child at home?	English ☐	Spanish ☐	Other _____
3. What language does your **child** most often use when speaking to you at home?	English ☐	Spanish ☐	Other _____
4. What language does your **child** most often use when speaking to brothers and sisters?	English ☐	Spanish ☐	Other _____
5. What language does your **child** speak most often with other family members?	English ☐	Spanish ☐	Other _____

In which language do you wish the school to send you communications? _____
Indicate Language

_____ _____
Parent/Guardian Signature Date

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

ENROLLMENT RESIDENCY CHECKLIST

To be completed by district enrollment clerk

In accordance with New Jersey State Law (N.J.S.A. 18A:38-1 and 18A: 7B-12), it is necessary to determine the residence of students entering the school district by answering the following question:

1. Does the student reside in any of the following facilities? (Please check where applicable.)

☐ Home the parent/guardian owns or is renting ***(Skip remaining registration procedures.)***

☐ Domestic Violence Shelter

☐ Living with family or friend's home out of necessity.
(* grandparent, aunt, uncle, brother, sister, cousin, etc.)

☐ Home For Adolescent School-Age Mothers

☐ Hotel/Motel/Apartment

☐ Migrant Family Dwelling

☐ Runaway Youth Shelter

☐ Shelter (other - identify):_____

☐ Transitional Housing Facility

☐ Other (identify):_____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Student's Name _____ Grade _____

Parent's Name _____ Date _____

School District Staff: Forward this completed checklist and the Declaration of Residency Form to the Paulsboro School District's Homeless Liaison within two days.

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

DECLARATION OF RESIDENCY FORM

To be completed at time of enrollment by parent/guardian

This is to inform the Paulsboro Board of Education that my child(ren)

_____

_____

and I _____ (Parent/Guardian)

are ☐ temporarily or ☐ permanently residing at the following address:

_____

We are living with _____ Telephone # _____.

Complete all sections that apply to your current situation:

☐ I am currently in a homeless situation and living out of necessity with the person(s) listed above.

☐ I am not actively pursuing housing and permanently residing with the person listed above.

☐ I have found permanent housing and no longer wish to be considered homeless.

My last district of permanent residence was _____.

My last address was _____.

My child(ren) attended _____School.

The causes of my becoming homeless are:

_____

_____

☐ I request to register my child(ren) in the Paulsboro School District.

☐ I prefer for my child(ren) to attend school in the former school district.

Name of former district _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

PARENT/GUARDIAN AFFIDAVIT

To be completed and returned to the school by the parent/guardian

I, _____, of full age, being duly sworn upon my oath, depose, and say:

1. I am domiciled at the following address:

   _____

   _____

2. I affirm that my child(ren) _____

   _____ is/are temporarily residing in the residence of relatives or friends named here:

   _____

   because my family lacks a regular or permanent residence of our own in accordance with N.J.A.C. 6A:17-2.3(A)(3).

3. I certify that I am not capable of supporting or providing care to my child/children due to family or economic hardship, and my child(ren) is/are not residing with relatives or friends solely to receive a free and/or better education per N.J.A.C. 6A:28-2.4(A)(2)(I)(2).
4. I understand that my child(ren)'s eligibility may be subject to re-evaluation, and that tuition may be sought in the event that my child/children are determined not to be eligible as a result of fraud or untruthful information.
5. I have been consulted and understand that the district of residence will make the decision regarding the educational placement of my child/children, and if I disagree with that decision, I have the right to appeal to the County Superintendent of Schools.
6. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-I and N.J.A.C. 6A;17.
7. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

_____
Parent/Guardian Signature

Sworn and subscribed to before me the _____day of _____.

_____
Signature of Registrar

Paulsboro School District

662 North Delaware Street, Paulsboro, NJ 08066
Phone (856) 423-5515 Fax (856) 423-4602

RESIDENT AFFIDAVIT

To be completed and returned to the school by the homeowner

I, _____, of full age, being duly sworn upon my oath, depose and say:

1. I am domiciled at the following address within Paulsboro:

   _____

   _____

2. I affirm that the school aged child(ren):

   _____

   is(are) residing in my residence temporarily out of necessity because the child(ren)'s family lacks a regular or permanent residence of their own in accordance with N.J.A.C. 6A:17-2.3(a)(3).

3. This affidavit is made in order to satisfy the requirements of N.J.S.A. 18A:38-I and N.J.A.C. 6A:17.
4. This statement is made under oath. I am aware that if any of the foregoing statements made in the Affidavit are willfully false, I may be subject to punishment.

_____
Signature of homeowner

Sworn and subscribed to before me this _____ day of _____, 20___.

_____
Signature of Notary Public

PARENT CONSULTATION

I, the parent/guardian of the above named child(ren) understand that the district of residence will make the decision for his/her/their educational placement based upon the best interests of the child(ren) after consulting with me. If I disagree with that decision, I know that I may appeal to the county Superintendent of Schools.

Parent/Guardian agrees with placement: Yes: ☐ No: ☐

Parent/Guardian Signature:_____ Date: _____

PAULSBORO PUBLIC SCHOOLS
RESIDENCY INFORMATION FORM

To be completed by the person registering the child for school.

Name of Student(s): _____

_____

_____

Name of Parent/Guardian: _____

Address of the Parent _____

Phone Number _____ Cell _____

Name of person registering the student(s)t if other than the parent: _____

Relationship to student(s): _____

Address of person registering the student(s): _____

Phone Number _____ Cell _____

Address where the students(s) will reside: _____

Type of residence:

Rental	☐ Yes	☐ No
Purchase/Own	☐ Yes	☐ No
Temporary	☐ Yes	☐ No

If temporary, please explain: _____

_____

_____

Other (please explain): _____

_____

_____

The Paulsboro Public School will investigate all new registrants in order to verify legal residency for the purposes of students attending schools.

Signature of the person registering the student(s): _____
(I attest the above statements and information are true.)

_____
Date

PAULSBORO PUBLIC SCHOOLS

Billingsport Early Childhood Center ☐
Phone: 856-423-2226
Fax: 856-423-8912

Loudenslager School ☐
Phone: 856-423-2228
Fax: 856-423-8914

Paulsboro Jr. High School ☐
Phone: 856-423-2225
Fax: 856-423-2443

Paulsboro Sr. High School ☐
Phone: 856-423-2222
Fax: 856-423-2443

HEALTH HISTORY

PLEASE RETURN THIS FORM WITHIN 30 DAYS OF YOUR CHILD'S FIRST DAY OF SCHOOL. If not returned, your child will be excluded from school.

Child's name _____ Date of Birth _____

Address _____ Phone & Cell _____

Parents' / Guardians' Names _____

PERINATAL

1. Child's Birth — Weight _____ Height _____
2. Complications of Pregnancy or Delivery _____
3. Gestation / Prematurity _____
4. Breathing Problems _____
5. Feeding Problems _____
6. Congenital Defects _____
7.

DEVELOPMENTAL

1. At what age did the child — Walk _____ Talk _____
2. At what age was child toilet trained _____
3. Hand preference _____

MEDICAL HISTORY -(DO NOT LEAVE ANY AREA BLANK, PLACE "N/A" IF NOT APPLICABLE).

	Type	Date
1. Allergies (seasonal/food and non-food)		
2. Drug Sensitivities		
3. Hepatitis		
4. Neuromuscular Diseases		
5. Asthma(indicate if student will have medication in school)		
6. Chicken Pox		
7. Seizures (Date of most recent seizure)		
8. Diabetes		
9. Heart Disease		
10. Middle Ear Infections(chronic/frequent)		
11. Rheumatic Fever		
12. Strep Infections(chronic/frequent)		
13. Operations or Injuries		
(please explain)		
14. Present Medications		
15. Limitations of activities		
16. Foods restrictions		
17. Other		

FAMILY

Recent changes in family life _____

Chronic diseases in family history _____

_____ _____

Parent / Guardian Signature — Date

MUST BE RETURNED TO SCHOOL NURSE WITHIN 30 DAYS

PAULSBORO PUBLIC SCHOOLS

Billingsport Early Childhood Center ☐	Loudenslager School ☐	Paulsboro Jr. High School ☐	Paulsboro Sr. High School ☐
Phone: 856-423-2226	Phone: 856-423-2228	Phone: 856-423-2225	Phone: 856-423-2222
Fax: 856-423-8912	Fax: 856-423-8914	Fax: 856-423-2443	Fax: 856-423-2443

PHYSICAL EXAM

THIS FORM SHOULD BE COMPLETED BY THE CHILD'S DOCTOR AND RETURNED TO THE SCHOOL WITHIN 30 DAYS OF YOUR CHILD'S FIRST DAY OF SCHOOL. If not returned, your child will be excluded from school.

Child's name _____ Date of Birth _____

Grade _____ Age _____

Parents' / Guardians' Names _____

Address _____

Height _____
Weight _____
Blood Pressure _____
Vision Acuity:
OD _____
OS _____
Hearing:
Right _____
Left _____
Ears (otoscopic) _____
Eyes _____
Lymph Glands _____
Thyroid _____
Nose _____
Throat _____
Teeth-Mouth _____

Heart _____
Lungs _____
Abdomen _____
Hernia _____
Genito-Urinary _____
Orthopedic:
Structural _____
Posture _____
Feet _____
Skin _____
Nutrition _____
Nervous System _____
Speech _____
Other _____
General Appearance _____

Please explain below any deficiencies / recommendations: _____

Physician Name _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____

PAULSBORO PUBLIC SCHOOLS
Screening

PK and K only

Developmental History

Date: _____

Child's Name:_____ M☐ F☐

Date of Birth:_____ Age: _____ y _____ m - in Sept.

Place of Birth: City _____ State: _____

Code: _____ (1= Am Indian/Alaskian 2 = Asian 3= black 4= Hispanic 5 = White 6=Native Hawaiian/Pac Isl)

Language Spoken at Home _____

Child Care Experience

1. Is the child or has the child been in any other early childhood program?

_____

_____

2. Any difficulties?_____.

Speech / Language

1. Does the child speak in words? _____.
2. Does the child speak in sentences?_____.
3. Is the child's speech clear?_____.
4. Do you have any concerns with your child's speech and language skills?

_____.

5. Does the child ask questions (who, what, when, where, why)? _____.
6. Does your child understand questions asked of him/her?_____.

7. Can the child name objects in pictures?_____.

8. Can the child name actions in pictures?_____.

Social / Emotional

1. Does the child separate easily from parent or guardian? _____.

2. Has the child had experiences playing with other children?_____.

3. Is the child friendly? _____Aggressive?_____Shy?_____.

4. Does the child enjoy playing with others?_____ Alone?_____.

5. Does the child share? _____.

6. Does the child demand a lot of attention from adults? _____.

7. How does the child handle discipline?_____.

8. Can the child follow simple rules (walk, stop,look,etc.)?_____.

9. How long can the child sit for an activity?_____.

Self-Help

1. Is the child toilet trained?_____.

2. Can the child take care of bathroom needs independently?_____.

3. Can the child feed him or herself independently?_____.

4. Can the child pick up after him or herself?_____.

5. Can the child dress him or herself?_____Zip?_____Button?_____.

Motor Development

1. Can the child maintain his or her balance on tiptoes?_____.

2. Can the child balance on one foot?_____.

3. Can the child run smoothly?_____.

4. Can the child hop?_____.

5. Can the child throw and catch a ball?_____.

6. Can the child kick a ball?_____.

7. Can the child pedal a bicycle or tricycle?_____.

8. Can the child climb steps independently?_____.

9. Can the child hold a pencil/crayon properly?_____.

10. Can the child scribble?_____.

11. Can the child draw simple shapes?_____.

12. Can the child use scissors properly?_____.

Cognitive Development

1. Does the child know his or her name?_____Age?_____.

2. Does the child enjoy listening to stories?_____.

3. Can the child match colors?_____.

4. Name colors?_____.

5. Can the child match shapes?_____.

6. Names shapes?_____.

7. Does the child understand positional concepts?

Over?☐	Big?☐
Under?☐	Little?☐
On Top?☐	Long?☐
Next To?☐	Short?☐
More?☐	Less?☐

8. Can the child rote count? _____.

9. Can the child count objects?_____.

10. Does the child enjoy being read to?_____.

11. Can he or she answer simple questions about stories?_____.

Please add any other pertinent information that will help us know your child better.

_____

_____

_____

_____

Screener's Observations:

_____

_____

_____

_____

New Jersey Department of Education

Household Information Survey 2020–2021

County: District: School:

Please complete, sign, and return this form to your child's school.

Part A. Household Members

Fill in the information for every person living in your household (adults & children). For help determining who should be included in the household, see instructions on the second page.

List all who live in the household: Names (*Last Name, First Name*)	Date of Birth XX-XX-XXXX	Name of School the Student Attends (if applicable)	Grade Level	Student Information (mark as applicable)			
				Migrant	Homeless	Foster	In Head Start
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

*** If household size is greater than 8,** list additional household members on a separate paper, and **follow special instructions in Part C.**

Part B. Benefits Received (if applicable)

1) If anyone in the household receives FDPIR, TANF, or SNAP, check the appropriate box(es) ☐ FDPIR ☐ TANF ☐ SNAP
2) If you checked a box, write the full name (Last, First) and 10-digit case number of any one person receiving the benefit and skip to Part D.

Name:_____ Case #:_____

Part C. Household Size and Gross Income (before deductions). For help determining your annual income, see page 2 of the survey.

- Households with 8 or fewer people: Check a box below for the Annual Income Range that reflects your total annual household income.
- If Household Size is greater than 8, DO NOT check an income range, but follow the special instructions below boxes 1 through 17.

Annual Household Income Ranges*

1 ☐ $0–$16,588	5 ☐ $28,237–$31,894	9 ☐ $40,183–$45,708	13 ☐ $56,759–$57,356
2 ☐ $16,589–$22,412	6 ☐ $31,895–$34,060	10 ☐ $45,709–$48,470	14 ☐ $57,357–$65,046
3 ☐ $22,413–$23,606	7 ☐ $34,061–$39,884	11 ☐ $48,471–$51,532	15 ☐ $65,047–$73,334
4 ☐ $23,607–$28,236	8 ☐ $39,885–$40,182	12 ☐ $51,533–$56,758	16 ☐ $73,335–$81,622
			17 ☐ $81,623+

*** Special Instructions for households with more than 8 people:** DO NOT check the boxes above. Instead, fill in items below:

Household size (# people):_____ Total annual Income: $_____

Part D: Certification - The head of household or adult designee who completed this form must complete this certification section. I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

Sign Here: X_____ Print Name:_____ Date:_____

Last Four (4) Digits of Social Security Number (Optional): XXX-XX-__-__-__-__ (may be used to verify the accuracy of the information provided)

Address:_____ City:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Email (optional):_____

Do **NOT** fill out this section. This is for school use only.

Status: F☐ R: ☐ N: ☐

Reason for ineligibility:

Determining Official's Signature:_____ Date:_____

Confirming Official's Signature:_____ Date:_____

PAULSBORO SCHOOL DISTRICT

CHILD STUDY TEAM
662 North Delaware Street
Paulsboro, NJ 08066
Telephone: (856) 423-5515, Ext.1245

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI) PARENTAL CONSENT FORM

Dear Parent / Guardian:

Our school district is participating in the Special Education Medicaid Initiative (SEMD 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).

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Please fill in the information below, sign the form, and return it to the address indicated

Child's Name: _____

(First) (Middle Initial) (Last)

Child's Date of Birth: _____/_____/_____

(Month) (Day) (Year)

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.

As a parent / guardian of the child named above, I voluntarily give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Educational Plan (IEP).

My authorization is good for as long as my child receives special education services, unless I decide to withdraw from the program.

Signature: _____ Date _____

(Parent or person in parental relationship) (Month/Day/Year)

Revised July 2018