

## **ENROLLMENT REQUIREMENTS**

**STUDENTS ARE ELIGIBLE TO REGISTER FOR PISCATAWAY TOWNSHIP SCHOOLS IF THEY LIVE WITH A PARENT OR GUARDIAN WHO IS A LEGAL RESIDENT OF THE DISTRICT OR WITH ANOTHER LEGAL RESIDENT WHO PROVIDES FULL FINANCIAL SUPPORT OF THE STUDENT.**

### **PRE-REGISTRATION REQUIREMENTS**

**\*\*\*\*\*Complete steps 1-3 of the online pre-registration process prior to making an appointment for registration\*\*\*\*\***

#### **Step One**

Go to District Website [www.piscatawayschools.org](http://www.piscatawayschools.org)

- o Select District Information
- o Select Enrollment Center to Access Documents
- o Enrollment packets copies are available in the Enrollment Center if needed

#### **Step Two**

Complete the online registration packet, one packet completed per child being registered

- Health History/Record Update
- Previous Service Record
- Food Allergy Form
- Physical Exam Form
- Medication Administration Request
- Affidavit paperwork ( Only to be completed by: Parents who do not rent or own property in Piscataway and are living with another Piscataway resident)

#### **Step Three**

Call the Enrollment Center at 732-572-2289 x 2-2573 for an appointment

**\*\* PLEASE NOTE IF YOU DO NOT COMPLETE STEPS 1-3 YOU WILL NOT BE ABLE TO REGISTER YOUR CHILD\*\***

### **REGISTRATION REQUIREMENTS - REGISTRATIONS ARE BY APPOINTMENT ONLY**

**Proof of Residency - Must present EACH of the following:**

- Homeowners: current property tax/sewer bill *or* current mortgage statement *or* HUD US One Settlement with buyer's and seller's signatures
- Renters: current lease *or* notarized letter from the landlord
- Additional documentation (at least two (2) items) which include the parent's name and reflect the Piscataway address such as: PSE&G bill, cable bill, driver's license, passport, work ID, county ID, current medical bills, bank statement, voter registration card, state agency documents, etc.
- All bills/statements must be dated within 30 days of registration date
- Affidavit of Residency Forms (if applicable)

These forms are for parents who do not rent or own property in Piscataway but are residing in the home of a Piscataway resident. These forms are available on our website or at the Enrollment Center. **The homeowner must accompany the parent/guardian at the time of registration. For your convenience we notarize signatures at the time of your appointment**

**Original Birth Certificate and/or passport of your child(ren) – Copies will not be accepted**

**Proof of custody (if applicable) – Legal document for divorce, separation, single parent or guardianship**

**Immunization records (translated to English on a doctor's letterhead if in another language) for your child(ren)**

**Any additional required immunizations (not included on the record) MUST be completed by the first day of school.**

**Students from outside NJ or the USA have 30 days to fulfill these additional immunizations.**

**Physical Examination - from a physician or advanced practice nurse licensed to practice in NJ (if a copy is not provided at the time of registration, it MUST be submitted to the school nurse BEFORE the first day of school.)**

**\*\*\*PLEASE NOTE: ALL PRE-SCHOOL STUDENTS ARE REQUIRED TO SUBMIT A COPY OF THEIR MOST RECENT PHYSICAL AT THE TIME OF REGISTRATION\*\*\***

**Previous School Records if applicable:**

- For all students: copy of transfer card, report card, test scores, previous school phone number, mail and email address
- For High School students: an unofficial transcript
- For Special Education students: a current IEP

**Special Circumstances:** If for any reason you are unable to produce the above documentation, you may still be eligible to enroll. Please call the Enrollment Center at the telephone number listed above.



**PISCATAWAY**  
TOWNSHIP SCHOOLS

1515 Stelton Road  
Piscataway, NJ 08854

**Dr. Frank Ranelli**  
Superintendent of Schools

Dear Parents/Guardians:

If your child was enrolled in another school district, please indicate if he/she was receiving services through the Child Study Team and has an Individualized Education Plan (IEP), 504 Plan, or was enrolled in a Limited English Proficiency Program. Please sign this letter to certify the following:

Child's Name \_\_\_\_\_

Please mark an "X" next to the appropriate statements:

\_\_\_\_\_ Currently has an IEP Plan

\_\_\_\_\_ Does not have an IEP Plan

\_\_\_\_\_ Currently has a 504 Plan

\_\_\_\_\_ Does not have a current 504 Plan

\_\_\_\_\_ Enrolled in a Limited English Program (LEP)

\_\_\_\_\_ Not enrolled in a Limited English Program (LEP)

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent's Name

**Dr. Frank Ranelli**  
Superintendent of Schools  
**Deborah I. Dawson, Psy.D.**  
Supervisor of K-8 Counseling and Health Services

### Health History/Record Update

Pupil's Name \_\_\_\_\_  
Last First Middle Grade (as of September)

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

Guardian \_\_\_\_\_ Home Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

The information provided in this update takes the place of any previous information. Health information will be shared with essential staff to assist in your child achieving educational goals.

HEALTH HISTORY	DATE	HEALTH HISTORY	DATE	HEALTH HISTORY	DATE
Allergy - Specify	Y N	Eczema	Y N	Injuries/Broken Bones/Stitches (List)	
		Eyeglasses/Contacts	Y N		
		Hearing Aid	Y N		
		Hearing Difficulties	Y N		
		Heart Disease	Y N		
Asthma	Y N	Hepatitis	Y N		
Autism Spectrum Disorder	Y N	Hematological Disorder	Y N	Operations (List)	
Auto Immune Disorders	Y N	Juvenile Rheumatoid Arthritis	Y N		
Chronic Otitis Media (Ear Infection)	Y N	Lyme Disease	Y N		
Congenital Disorder	Y N	Mononucleosis	Y N		
Convulsive Disorder	Y N	Neuromuscular Disorder	Y N	Hospitalizations (List)	
Diabetes	Y N	Strep Infections	Y N		
Drug Allergies - Specify	Y N	Other Illnesses - Specify	Y N		

MEDICAL RESTRICTIONS (Attach Physician's Note)	CURRENT MEDICATIONS (Prescriptions, Inhaler, EpiPen, etc.)

List all Children in Family (Oldest to Youngest)

Last Name/First Name	Birthdate	Last Name/FirstName	Birthdate

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Any additional information can be attached to this form.



FOR SCHOOLS AND PARENTS: K-12 IMMUNIZATION REQUIREMENTS



**NJ Department of Health  
Vaccine Preventable Disease Program**

New Jersey Minimum Immunization Requirements for Kindergarten-Grade 12 Attendance

N.J.A.C. 8:57-4 Immunization of Pupils in School

**Guide for checking compliance**

Step 1: Each child attending/enrolling must present documentation of immunizations or valid medical or religious exemption to vaccines. In order to allow a child to enter school, he/she must have at least one dose of each age-appropriate required vaccine.

Step 2: Determine child's present grade level.

Step 3: Compare the child's record with the requirements listed on the chart below.

	Minimum Number of Doses for Each Vaccine						
	DTaP Diphtheria, Tetanus, acellular Pertussis	Polio Inactivated Polio Vaccine (IPV)	MMR (Measles, Mumps, Rubella)	Varicella (Chickenpox)	Hepatitis B	Meningococcal	Tdap (Tetanus, diphtheria, acellular pertussis)
<i>Grade/level child enters school:</i>							
<b>Kindergarten – 1<sup>st</sup> grade</b>	A total of 4 doses with one of these doses on or after the 4 <sup>th</sup> birthday <u>OR</u> any 5 doses*	A total of 3 doses with one of these doses given on or after the 4 <sup>th</sup> birthday. <u>OR</u> any 4 doses	2 doses <sup>†</sup>	1 dose	3 doses	None	None
<b>2<sup>nd</sup> – 5<sup>th</sup> grade</b>	3 doses <i>NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Tetanus, diphtheria (Td)</i>	3 doses	2 doses	1 dose	3 doses	None	None
<b>6<sup>th</sup> grade and higher</b>	3 doses	3 doses	2 doses	1 dose required for children born on or after 1/1/98 <sup>‡</sup>	3 doses <sup>§</sup>	1 dose required for children born on or after 1/1/97 <sup>§</sup> given no earlier than ten years of age	1 dose required for children born on or after 1/1/97 <sup>§</sup>



## FOR PARENTS: KINDERGARTEN-GRADE 12 IMMUNIZATION REQUIREMENTS

Additional vaccines are recommended by the Centers for Disease Control and Prevention (CDC). The chart above lists only the vaccines that are required for school attendance in NJ. Please note that unvaccinated children, including those with medical and/or religious exemptions, may be excluded from school during a vaccine preventable disease outbreak or threatened outbreak to ensure public health safety.

For the complete CDC Recommended Immunization Schedule, please visit <http://www.cdc.gov/vaccines/schedules/index.html>.

\* **DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5<sup>th</sup> dose) does not apply until the child attends Kindergarten. However, if one of these 4 doses was given after the 4<sup>th</sup> birthday, this child will not need an additional dose for Kindergarten. Children will need 5 doses if all doses were administered prior to the 4<sup>th</sup> birthday in order to enter Kindergarten.

**Polio:** Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4<sup>th</sup> dose) does not apply until the child attends Kindergarten. However, if one of these 3 doses was given after the 4<sup>th</sup> birthday, this child will not need an additional dose for Kindergarten. Children will need 4 doses if all doses were administered prior to the 4<sup>th</sup> birthday.

† A child is required to receive two doses of measles, one dose of mumps, and one dose of rubella once he/she enters Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.

The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit [http://nj.gov/health/cd/documents/antibody\\_titer\\_law.pdf](http://nj.gov/health/cd/documents/antibody_titer_law.pdf).

§ Varicella vaccine is only required for children born on or after January 1, 1998. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as a parent can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

† Two doses of hepatitis B vaccine is acceptable if child received the vaccine between 11 – 15 yrs. of age AND the vaccine is identified as Adolescent Formulation. Children who present documented laboratory evidence of hepatitis B disease or immunity, constituting a medical exemption, shall not be required to receive hepatitis B vaccine.

\*\* Tdap and Meningococcal vaccines are required for all entering 6<sup>th</sup> graders who are 11 years of age or older; 6<sup>th</sup> graders < 11 years must receive Tdap and meningococcal vaccines once age 11 is reached.

For the complete list of "NJ Immunization Requirements Frequently Asked Questions", please visit <http://nj.gov/health/cd/imm.shtml>.



FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS



**NJ Department of Health  
Vaccine Preventable Disease Program**

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance  
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit <http://www.cdc.gov/vaccines/schedules/index.html>.

At this age the child should have received the following vaccines:	2 months	4 months	6 months	12 months	15 months	18 months	19 months	20-59 months
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
<i>Haemophilus influenzae</i> type b (Hib)	Dose #1	Dose #2		1-4 doses (see footnote)		At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1 <sup>1</sup>			
Varicella (VAR)							Dose #1 <sup>§</sup>	
Influenza (IIV; LAIV)					One dose duc each year <sup>1</sup>			

**Interpretation:** Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.



## FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS

\* *Haemophilus influenzae* type b (Hib) and pneumococcal (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.

Please Note: The use of combination vaccines may allow students to receive the 1<sup>st</sup> birthday booster dose of Hib between 15-18 months of age.

† **MMR vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

§ **Varicella vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, a

child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. Documented laboratory evidence showing immunity (protection) from chickenpox, 2. A physician's written statement that the child previously had chickenpox, or 3. A parent's written statement that the child previously had chickenpox.

‡ The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective

NJ accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, N.J.A.C. 8:57-4. Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

**For more information, please visit “NJ Immunization Requirements Frequently Asked Questions”, at the following link:**

<http://nj.gov/health/cd/imm.shtml>. **Interpretation:** Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

**Dr. Frank Ranelli**  
Superintendent of Schools  
**Deborah I. Dawson, Psy.D**  
Supervisor of K-8 Counseling and Health Services

## NOTICE REGARDING PHYSICAL EXAMINATION

Dear Parent/Guardian:

New Jersey State law requires a medical examination for students **upon entry into a school district**. If your child had a recent physical examination, contact the nurse at your child's school to determine if it will meet the requirements. Physicals must be done by a medical provider (MD, DO, PA or NP) who is licensed to practice in New Jersey.

### **PRE-SCHOOL STUDENTS**

All Pre-School students are required to have a physical exam, and must be presented at the time of registration.

### **KINDERGARTEN STUDENTS**

All Kindergarten students registering for the 2019-2020 school year must present physicals dated on/after September 1, 2018 in order to be accepted. Physicals are strongly encouraged to be presented at the time of registration. Physicals must be submitted to the school nurse **BEFORE** the first day of school in order for the student to attend.

The primary responsibility for the total health needs of the school child rests with the family and the child's own healthcare provider. A physical examination by a private provider allows for a more thorough and individual approach. It also provides the opportunity for additional immunizations if needed.

Any questions or concerns can be directed to the nurse at your child's school.

Sincerely,

*Deborah Dawson*  
Supervisor of Counseling and Health Services





**PISCATAWAY  
TOWNSHIP SCHOOLS**

**Dr. Frank Ranelli**  
Superintendent of Schools  
**Deborah I. Dawson, Psy.D.**  
Supervisor of K-8 Counseling and Health Services

5205 Ludlow Street  
Piscataway, NJ 08854  
732 699-1563 x5481  
Fax 732 844-9407  
[www.piscatawayschools.org](http://www.piscatawayschools.org)

**PHYSICAL EXAMINATION FORM**

Pupil's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Immunizations DTP \_\_\_\_\_ DT \_\_\_\_\_ Td \_\_\_\_\_ Tdap \_\_\_\_\_

Polio \_\_\_\_\_ Meningococcal \_\_\_\_\_

MMR \_\_\_\_\_ MMR \_\_\_\_\_ Hep B \_\_\_\_\_ Heb B \_\_\_\_\_ Hep B \_\_\_\_\_

Varicella \_\_\_\_\_ HIB \_\_\_\_\_ PCV \_\_\_\_\_

Pneumococcal Conjugate \_\_\_\_\_ Influenza \_\_\_\_\_

Mantoux Tuberculin Skin Test: Date Administered \_\_\_\_\_ Date Read \_\_\_\_\_ Results \_\_\_\_\_ mm

Last Lead Test \_\_\_\_\_ Lead Test Results \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hearing \_\_\_\_\_ Vision \_\_\_\_\_

Nutrition \_\_\_\_\_ Skin \_\_\_\_\_ Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_

Oral (Teeth/Gums) \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_

Abdomen/Hernia \_\_\_\_\_ Genitalia \_\_\_\_\_ Extremities \_\_\_\_\_ Orthopedic \_\_\_\_\_

Scoliosis \_\_\_\_\_ Remarks \_\_\_\_\_ Neurological \_\_\_\_\_ CBC \_\_\_\_\_ Urinalysis \_\_\_\_\_

History of Illness/Injury \_\_\_\_\_

Medication \_\_\_\_\_

Participation in Physical Education/Sports/Activities \_\_\_\_\_

Remarks/Impressions/Summary \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date of Exam \_\_\_\_\_

**Physician's Stamp**

**Dr. Frank Ranelli**  
Superintendent of Schools

**Deborah I. Dawson, Psy.D.**  
Supervisor of K-8 Counseling and Health Services

Dear Parents/Guardians:

Food allergies affect children in many ways, with reactions ranging from itching or a rash to hives and difficulty breathing. If you notify us of your child's food allergy, food service personnel will be alerted when your child checks out in the food line.

Please complete the form below and return it to the school nurse, who in turn will send the form to Sodexo School Services at the High School (732-981-0700 ext. 2289). **A new form must be completed each school year.** Once the form is returned, the allergy information will be entered into the computer system by Sodexo's staff. The food allergy information will be entered onto your child's health record as well. **If your child cannot drink milk and you would like to substitute juice for milk, a doctor's note is required.** Please attach the note from your child's doctor to this form when you return it to the nurse.

When your child enters his/her ID number at check out a "Dietary Notice" of food allergies will appear. This alerts food service personnel that this food item should not appear on your child's tray. If it does, food service personnel will remove the food and talk with your child.

You should be aware, however, that this system may not identify allergens that are ingredients in other foods, such as chicken nuggets or baked goods.

It is hoped that this service will assist with the health and well being of your child. However, this service is not intended to replace parental responsibility for insuring that their child makes appropriate food selections from the school cafeteria.

Sincerely,  
*Deidre Ortiz*  
Director of Pupil Services

*Jim Giannakis*  
Sodexo Food Service Manager

***Complete and Return to the Nurse at Your Child's School***

**A new form must be completed each school year.**

\* \* \* \* \*

Child's Name	ID Number	School	Grade
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\_\_\_\_ My Child has the following **food allergies** (do not include personal, religious or cultural preference):

\_\_\_\_ My child has no food allergies.

I understand that this information will be entered into the Sodexo School Services system and onto my child's health record.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Dr. Frank Ranelli**  
Superintendent of Schools  
**Deborah I. Dawson, Psy.D.**  
Supervisor of Counseling and Health Services

**MEDICATION ADMINISTRATION REQUEST**

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Teacher/Homeroom \_\_\_\_\_

**TO BE FILLED OUT BY HEALTHCARE PROVIDER:**

Please administer the following medication  
to the above-named student as prescribed below:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Time to be Administered \_\_\_\_\_

Start Date \_\_\_\_\_ Stop Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

If PRN, for signs and symptoms \_\_\_\_\_

**Healthcare Provider Stamp below:**

\_\_\_\_\_  
Signature of Healthcare Provider

Date Effective \_\_\_\_\_

**TO BE FILLED OUT BY PARENT/GUARDIAN:**

\_\_\_\_\_ My child is to receive the prescribed medication on "half days".

\_\_\_\_\_ My child is **not** to receive the prescribed medication on "half days".

I request that the above medication be administered to my child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_ Date

This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. For safety and the prevention of errors, pupils may not carry medication with them during the school day. The medication must be in the original container and labeled by the pharmacy or medical provider if it is a prescription medication.

**REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE  
RENEWED ANNUALLY**

Only to be completed by: Parents who do not rent or own property in Piscataway and are living with another Piscataway resident.

PISCATAWAY TOWNSHIP SCHOOLS  
Piscataway, New Jersey 08854

VALID ONE SCHOOL YEAR ONLY  
\_\_\_\_ New      \_\_\_\_ Renewal

**AFFIDAVIT OF RESIDENCY OF STUDENT**

I, \_\_\_\_\_ hereby certify that  
(NAME OF PISCATAWAY HOMEOWNER OR LEASEHOLDER)

The following students and their parents reside at the residence address stated below:

NAME OF STUDENT(S)	RELATIONSHIP	GRADE	BUILDING	ID#
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parent/Guardian Name \_\_\_\_\_  
Mother and/or Father

Resident's Address \_\_\_\_\_  
LOT #                      STREET                      APT#

Type of Proof of Residency \_\_\_\_\_  
(COPIES ATTACHED)

Previous Address of Student \_\_\_\_\_

Submission of any knowingly inaccurate information on this form has serious legal implications and may expose you to criminal prosecution. Submission of a fraudulent document to a government agency is punishable by jail and fines in criminal court. In addition a tuition judgment may be imposed by a court or the Commissioner of Education for any services secured through submission of fraudulent information.

I UNDERSTAND IT IS MY RESPONSIBILITY TO IMMEDIATELY REPORT TO THE BOARD OF EDUCATION ANY CHANGE OF RESIDENCE, WHICH OCCURS FOR THE ABOVE MENTIONED INDIVIDUAL(S). THE LEGAL RAMIFICATIONS AND TUITION JUDGEMENT HAVE BEEN EXPLAINED BY A REPRESENTATIVE OF THE PISCATAWAY SCHOOL DISTRICT.

Sworn to and subscribed to before me

\_\_\_\_\_  
Signature of Piscataway Property Owner  
or Leaseholder

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
A NOTARY PUBLIC OF the State of New Jersey

\_\_\_\_\_  
Signature of Parent/Guardian

THE ABOVE INFORMATION IS REQUIRED FOR THE PISCATAWAY TOWNSHIP SCHOOL SYSTEM.  
THE CONTENTS WILL NOT BE MADE AVAILABLE TO ANY OTHER AGENCY.

SEAL

**PISCATAWAY TOWNSHIP SCHOOLS**  
**1515 Stelton Road**  
**Piscataway, New Jersey 08854**  
**(732)-572-2289 ext. 2-2573 Fax (732)-985-2969**  
**HOMEOWNER / TENANT AFFIDAVIT FORM**

<b>Homeowner</b>	<b>Applicant Family Residing with Homeowner/Tenant</b>
<b>Name of Homeowner/Tenant</b> _____	<b>Name of Family residing with Homeowner/Tenant</b> _____
<b>Street Address</b> _____ <b>Apt#</b> _____	<b>Street Address</b> _____ <b>Apt#</b> _____
<b>City</b> _____ <b>State</b> _____ <b>Zip Code</b> _____	<b>City</b> _____ <b>State</b> _____ <b>Zip Code</b> _____
<b>Home Phone</b> _____ <b>Cell Phone</b> _____	<b>Home Phone</b> _____ <b>Cell Phone</b> _____
<b>Property:</b> <input type="checkbox"/> Homeowner <input type="checkbox"/> Renting	

**Housing Information**

Please specify the type of building in which the applicant and resident live.

- Single Family House                       Three Family House                       Multiple Dwelling, No. of Apartments \_\_\_\_\_
- Two Family House                               Condominium                               Other: (Specify) \_\_\_\_\_

Please provide the following:

Relationship of family to Homeowner/Renter:  No Relation  Family Member(s) How many people will be living with you? \_\_\_\_\_

Does the applicant contribute to rent and utilities?  NO  YES If yes, how much? \_\_\_\_\_

How long do you expect the applicant's family to live with you? \_\_\_\_\_ (example – 3 weeks, 4 months, 1 year)

**List the Names of People Living in the Home**


**Knowingly permitting your name or address to be used in the registration of a non-resident student has serious legal implications and may expose you to criminal prosecution. Submission of a fraudulent document to a government agency is punishable by jail and fines in a criminal court. In addition, a tuition judgment from a court or the Commissioner of Education may be imposed for any services secured through submission of fraudulent information.**

**I attest that the information is true and correct and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.**

\_\_\_\_\_  
Signature of Homeowner / Tenant                      Date                      Sworn and subscribed before me

this \_\_\_\_ day of \_\_\_\_\_

Stamp and Seal Placed Here

\_\_\_\_\_  
Signature of Notary Public on New Jersey

Official Use Only: Request Date: \_\_\_\_\_ Received Date: \_\_\_\_\_ Requested by: \_\_\_\_\_