



49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

## Registration Requirements

Sadiq School is accepting student registration for Preschool (3 years old), Pre-kindergarten (4 years old), and kindergarten (5 years) for the academic year 2020-2021. The students need to turn 3, 4 or 5 years of age before October 31, 2020 to register to Preschool, Pre-kindergarten, and kindergarten, respectively. Tuition is \$ 5500 per year and there is a one-time yearly fee of \$ 250 to cover the cost of supplies for students. To register your child or children, please fill out the following information and return to school by August 15, 2020.

Please visit [Sadiqschool.com](http://Sadiqschool.com) for school calendar and other information.

We will need the following to complete registration of your child:

- o Copy of Child's Birth Certificate \*
- o Copy of updated immunization record \*
- o Physical/health history form- must be signed and stamped by your child's physician and dated within 1 year \*
- o Permission to administer medication \*
- o Emergency Contact Form \*
- o Photo/Video release \*
- o Technology agreement \*
- o ESL Waiver \*

**\*THESE REQUIREMENTS CANNOT BE WAIVED EXCEPT WITH THE EXPRESSED PERMISSION OF THE CHIEF SCHOOL ADMINISTRATOR OR HIS DESIGNEE AFTER CONSULTATION WITH THE BOARD ATTORNEY.**





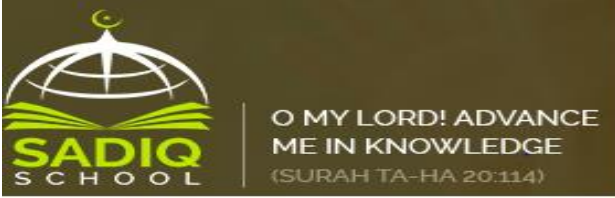
49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

**APPENDIX H**

**UNIVERSAL  
CHILD HEALTH RECORD**

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

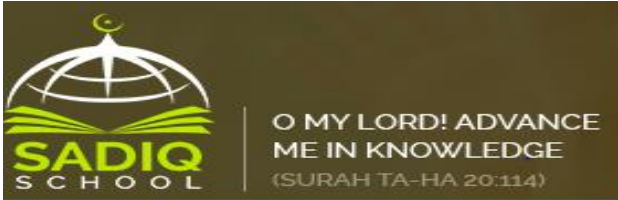
SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name (Last) _____	(First) _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's 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 ( ) - _____	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>			
Signature/Date _____	This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		
<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached		
	<input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS			
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	



49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <b><i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i></b>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

CH-14 OCT 17 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provide



49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

### EMERGENCY FORM

STUDENT'S NAME: \_\_\_\_\_  
(Last) (First) (MI)

Teacher's name \_\_\_\_\_

Student Birth Date \_\_\_\_\_ Gender \_\_\_M \_\_\_F

Mailing Address: \_\_\_\_\_

Name of Mother/Step-Mother/Guardian (circle one) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Number \_\_\_\_\_

Occupation \_\_\_\_\_

Name of father/Step-father/Guardian (circle one) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Number \_\_\_\_\_

Occupation \_\_\_\_\_

Student primarily lives with: \_\_\_Both Parents \_\_\_Mother \_\_\_Father \_\_\_Parent/Step-Parent  
\_\_\_Guardian(s)

If student's biological parents reside together, they are: \_\_\_Married \_\_\_Single/Living Together

If student's biological parents do not reside together, they are: \_\_\_Separated \_\_\_Divorced \_\_\_Single  
\_\_\_Widowed

If you are this student's guardian, indicate your relationship to student: \_\_\_\_\_



O MY LORD! ADVANCE  
ME IN KNOWLEDGE  
(SURAH TA-HA 20:114)

49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

Are there custody or guardianship documents for this student? \_\_\_\_Yes \_\_\_\_No

Please Note: If there are court documents regarding parental custody or guardianship, a copy must be on file with Sadiq School. Please call 732-844-3326 for more information

EMERGENCY CONTACTS: PLEASE LIST PERSONS OTHER THAN YOURSELF WHO YOU AUTHORIZE TO RECEIVE PHONE CALLS OR PICK UP THIS STUDENT IN THE EVENT THAT YOU CANNOT BE REACHED. WE **WILL NOT** ALLOW PERSONS OTHER THAN THOSE ON THIS LIST FOR PICK UP FROM SADIQ SCHOOL. PLEASE MAKE SURE TO CALL THE SCHOOL AHEAD OF TIME IF THERE ARE ANY CHANGES TO REGUALRY SCHEDULED PICK UP PERSONS. ALL NAMES AND IDS MUST MATCH.

\_\_\_\_\_  
Name Phone # Relationship to Student

\_\_\_\_\_  
Name Phone # Relationship to Student

\_\_\_\_\_  
Name Phone # Relationship to Student

Parent/Guardian Email Address \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone # \_\_\_\_\_

In case of emergency, I hereby give permission for this student to be taken to the hospital for treatment, if necessary. Please provide a preferred hospital name and address, if desired.

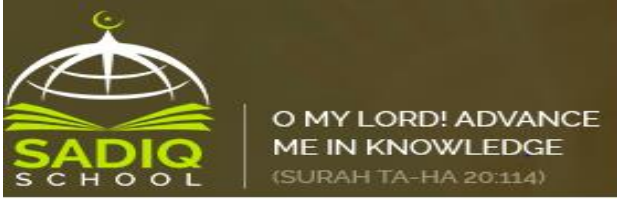
\_\_\_\_\_

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

Is this student covered by health insurance?

Yes Insurance Company \_\_\_\_\_ No \_\_\_\_\_ NJ FamilyCare provides free or low cost

health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online. I hereby give you permission to release my name and address to NJ FamilyCare



49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

## ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF MEDICAL EQUIPMENT IN SCHOOL

If your child requires medication at school, please request for administration of medication, treatments or use of equipment in school. Please remember school personnel will not administer any medication without signed document by child Physician **AND** parent/guardian's written approval. All medication administered at school must be kept in the original container. Medications will be administered by principal, or principal's designee. Non-prescription medicine will not be administered.

### For Physician

The below named student must take prescribed medication during school hours as it is required to be administered more than three times a day and cannot be given at home only.

Name of Student: \_\_\_\_\_  
(LAST) (FIRST) (MI)

Diagnosis: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Dosage required: \_\_\_\_\_

Time during school day to be given: \_\_\_\_\_

Duration of medication: \_\_\_\_\_

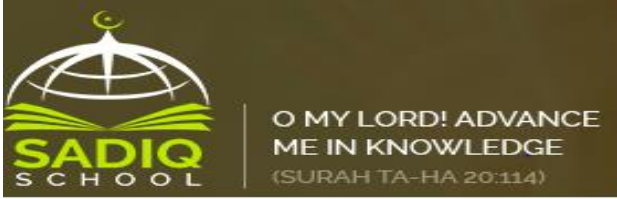
Possible side effects/adverse reaction: \_\_\_\_\_

Child is able to self-administer inhaler/EpiPen: \_\_\_\_\_

Physician's Name and Signature \_\_\_\_\_

Date: \_\_\_\_\_ Contact number: \_\_\_\_\_

Parent (guardian) name and signature: \_\_\_\_\_



49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

### **TECHNOLOGY/TABLETS/CELL PHONES FORM**

Sadiq School does not allow the use of personal tablets by students at any time during school hours. Please do not bring such items to school. Teachers may confiscate such items which will require parents to come to school to have items returned.

Cell phone use during school hours is prohibited, unless an emergency situation should arise or under special circumstances. Special permission must be obtained beforehand to avoid disciplinary action. All cell phones must be turned off during school hours.

Sadiq School is not responsible for, nor can be held liable for any activity on such devices before, during, or after school hours.

I have read & understood the above.

---

Parent/Gradian Signature

Date





O MY LORD! ADVANCE  
ME IN KNOWLEDGE  
(SURAH TA-HA 20:114)

49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

### HOME LANGUAGE/ESL & SPECIAL EDUCATION

I have discussed and acknowledged Sadiq School's policy regarding ESL & Special Ed. I do not hold Sadiq School liable for classes or support related to these services.

---

Parent/Guardian Signature

Date



O MY LORD! ADVANCE  
ME IN KNOWLEDGE  
(SURAH TA-HA 20:114)

49 Cedar Grove Lane Somerset, NJ 08873 Ph.: 732- 560-0191 Email: info@sadiqschool.com

### **PHOTOGRAPH/VIDEOTAPERELEASE Form**

Sadiq School may occasionally take pictures and video of children enrolled. Such material may appear in the School printed materials such as brochures, teacher training videos, and/or on the New Jersey Department of Education's (NJDOE) Web site.

Please check one of the following:

- I authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Sadiq School and / or NJDOE.
  
- I do not authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Sadiq School and / or NJDOE.

---

Parent/Guardian Signature

D

