Asbury Park Board of Education

DISTRICT ENROLLMENT FORM

- ☐ Barack Obama Elementary School
- ☐ Bradley Elementary School
- ☐ Thurgood Marshall Elementary School
- ☐ Asbury Park Middle School
- ☐ Asbury Park High School

PLEASE PRINT

Student's Name: _____

Parent/Guardian: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____

Emergency Phone: _____ Ethnicity: _____

Date of Birth: _____ Age: _____

Place of Birth: _____

U.S. Entry Date (if applicable) _____ First Entry to U.S. Schools _____

Last School Attended: _____ Last Grade Completed: _____

Name of Father: _____

U.S. Citizen: Yes_____ No_____ Occupation: _____

Employer's Address: _____ Work Telephone: _____

Name of Mother: _____

U.S. Citizen: Yes_____ No_____ Occupation: _____

Employer's Address: _____ Work Telephone: _____

Does either parent work in a government institution? Yes_____ No_____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Phone: _____

Address: _____

LIST OTHER PUBLIC OR PRIVATE SCHOOLS ATTENDED BY THIS STUDENT:

School/District: _____ Address: _____

School/District: _____ Address: _____

School/District: _____ Address: _____

CENSUS INFORMATION – LIST OTHER CHILDREN IN FAMILY (OLDEST FIRST)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Asbury Park Board of Education

Authorization for Release of Records

Student's Name _____ Date of Birth _____

Current Grade _____

Records to be released (check appropriate items)

_____ Cumulative Record Folder

_____ Test Scores

_____ Transcript of Grades

_____ Health Records

_____ Attendance and Discipline Information

_____ Child Study Team Records (Educational, Psychological, and Social History Eval)

_____ NJ State ID Number

_____ Other: **NJ HSPA Score & ISR**

The Record(s) indicated above is/are to be released to:

___ **Barack H. Obama Elementary**
1300 Bangs Avenue
Asbury Park, NJ 07712
ATTN: Felecia Smith

___ **Bradley Elementary**
110 Third Avenue
Asbury Park, NJ 07712
ATTN: Tishell Bellamy

___ **Thurgood Marshall Elementary**
600 Monroe Avenue
Asbury Park, NJ 07712
ATTN: Tyhesha Prince

___ **Asbury Park Middle School**
1200 Bangs Avenue
Asbury Park, NJ 07712
ATTN: Yvose Damour

___ **Asbury Park High School**
1001 Sunset Avenue
Asbury Park, NJ 07712
ATTN: Diana Ervin

I hereby grant permission for the release of the above record(s):

_____ _____ _____

Parent/Guardian Signature **Date** **Student Signature (18 years or older)**

Asbury Park Board of Education

Academic History

In order to provide a highly educational instructional program, please answer the following questions:

I. ENGLISH AS A SECOND LANGUAGE/BILINGUAL

1. What Language did your child first learn to speak? _____
   _____
2. What Language do you use most often when speaking to your child at home?
   _____
3. What language does your child use most often when speaking to parent/guardian at home?
   _____
4. What language does your child use most often when speaking to brother or sister?
   _____
5. What language does your child use most often when speaking to other relatives?
   _____
6. What Language does your child use most often when speaking to friends at home?
   _____

II. PROGRAM INFORMATION

Please check any of the following programs in which your child has participated:

PROGRAM	GRADE LEVEL		
_____ ESL, Bilingual	_____	504	_____
_____ Talented and Gifted	_____	Homeless	_____
_____ Special Education Services	_____		
_____ None of the above	_____		

III. ADDITIONAL INFORMATION

Please provide the date that your child entered the country:_____

<u>SOCIAL HISTORY</u>: Please write any information about your child which you think the teacher should have in order to understand and help your child:

_____
_____
_____
_____
_____

Asbury Park Board of Education

Health Services Information

In order to provide the best possible health services for your child, the school nurse needs to know your child's history and current health status. Please indicate below if your child has had any of the following:

____ Asthma or breathing problems

____ Allergies/ (to what) _____ Type of reaction_____Epi Pen _____

____ Recent Hospitalization/Reason

____ Seizure Disorder, (type) _____ Medication _____

____ Frequent ear infections _____

____ Daily Medications - Name of medication _____

Dose _____ Frequency _____

____ Diabetes & Treatment _____

____ Any other health condition _____

_____

Doctor's Name _____ Telephone Number _____

Name of Health Insurance _____Identification Number _____

I give permission to the school to share information concerning my child's health to those faculty/staff members who may need to know. I recognize that sharing the information is important to my child's well-being and safety while attending school.

I give permission to the school nurse to contact my child's health providers to obtain necessary information to provide care to my child. This includes, but is not limited to Immunization Records and Medications Health Information, but also includes information from Mental Health care providers

Child's Name _____

_____ _____

Parent's Signature **Date**

School Based Nurse Practitioner Health Services Program

Dear Parent/ Guardian:

The School Based Nurse Practitioner Health Services Program (Health Services Program) provides Comprehensive preventative, medical, and health education services for students in our Schools. The Health Services Program is operated by the Visiting Nurse Association of Central New Jersey at no cost to the students.

The Health Services Program offers primary health care services provided by a Nurse Practitioner (or advanced Practice Nurse). A Nurse Practitioner, in collaboration with a physician, is licensed to diagnose and treat individuals within the school setting. These services will include examination and evaluation of health complaints or problems.

You will be informed of the findings, and treatment will be offered or recommendations made that your child see his/her own health care provider. At your request and consent, treatment will be provided and follow up visit scheduled. Your primary health care provider will be informed of any treatment offered at the health office via fax and phone in order to maintain professional comprehensive care for your child. Kindly provide the following necessary information.

Please complete the consent form below:

- I give consent for my child_____ to be examined and evaluated by a Nurse Practitioner in the case of illness or a health problem that may interfere with the child's progress in school. **Yes_____ No_____**
- **I do ____/do not___** want the Nurse Practitioner to administer basic care. Basic care may include giving Tylenol for high fevers

PLEASE NOTE: We are not an emergency room. If further care is needed, we will call 911. There is no cost to you for these services, whether your child is covered by a health insurance policy or not.

I hereby release this Asbury Park school, the Board of Education and the visiting Nurse Association of Central Jersey, and any other of their agents, elected officials or employees from any and all liability, claims, damages, costs and expenses, which result or may result from any action, accident, omission, or incident in condition in connection with or related to my child's use of the School- Based Nurse Practitioner Health Services Program.

I certify by signing that I am also releasing any claims for my child. As a condition and consideration for being able to use the School-Based Nurse Practitioner Health Services Program, I agree, to the fullest extent permitted by law, not to commence, encourage, facilitate or participate in any action or proceeding for damages, injunctive or any other type of relief, in any state, federal or local court or before any administrative agency on behalf of myself, my child or any other person relating to the School-Based Nurse Practitioner Health Services Program.

Parent /Guardian Signature _____ Date _____

Parent/ Guardian Print Name _____ Date _____

Medical Home Form

Student's Name _____ Date of Birth _____

Students Address _____

City _____ State _____ Zip Code _____

School _____ Grade _____ Homeroom# _____

Homeroom Teacher _____Parent/ Guardian Name_____

Please Check/complete one of the following:

1. My primary care Physician or clinic (medical home) is_____

   Address _____

   Phone Number _____

2. I **Do Not** have a Primary Care Physician

Check the lines below that apply to you:

_____ I do not have Medicaid
_____ I do not have NJ KidCare

_____ _____

Parent Signature **Date**

Title I - Parent Involvement Survey

Dear Parent/Guardian,

Title I parents are to be involved in the decisions regarding how the 1% reserved funds will be used for parental involvement. Our school believes your input regarding school information and parental involvement activities is crucial. Please complete the following survey by checking the kinds of resources and services you would like to see made available in the district.

This survey will be used to develop our school's Parental Involvement Policy and Activities.

Please check all that apply:

Listed below are opportunities we would like to offer. Please check any/all of those that you would like to see and or be involved in:

□ District-wide Parent Enrichment Conference

□ English as a second language

□ Resume writing workshop

□ Strategies for improving Student achievement in reading and writing

□ Basic Computer Skills

□ Resources for Grand Parents Raising Children

□ Ensuring your child does well on the NJ ASK Test

□ Understanding ADHD and doing something about it

□ Helpful Hints for single Mothers raising boys

□ Developing a Home Learning System

□ Monitoring your child's us of technology

□ Discovering your child's hidden Talent

□ PTO (Parent Teacher Organization)

□ Other

□ Improving your child's self-image

□ Drug and Gang Prevention workshops

□ GED prep classes

□ Chess Club

□ Stress Management for Today's parent

□ The 411 on HIB (Harassment, Intimidation and Bullying)

□ Preparing Children for school

□ Improving Communication with the Child's Teacher

□ Finding Mentors for children

□ Diagnosing Depression and other Mental health issues

□ Navigating The American Education System (Spanish and Creole)

□ Talking with youth about sex

□ PAC (Parent Advisory Council)

□ Other

Time of meetings *(Check one):* ____ AM ____PM /___Mon ___Tues ___Wed ___Thurs ___Fri ___Sat

Parent/Guardian Name: _____

Best Contact Number: _____Email Address: _____

Child's School: _____Grade: _____

School-Parent/Guardian Compact

The Asbury Park School District , and the parents of the students participating in activities, services, and programs funded by Title I, Part A of the Elementary and Secondary Education Act (ESEA) (participating children), agree that this compact outlines how the parents, all school staff, and the students will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children achieve the State's high standards.

This school-parent compact is in effect during school year of 2014-15.

School Responsibilities

The Asbury Park School District will:

1. Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the State's student academic achievement standards.

2. Hold parent-teacher conferences during which this compact can be discussed as it relates to the individual child's achievement.

3. Provide parents with frequent reports on their children's progress. Specifically, the school will provide reports as follows.

4. Provide parents reasonable access to staff. Specifically, staff will be available for consultation with parents upon request and on an as needed basis.

5. Provide parents opportunities to volunteer and participate in their child's class, and to observe classroom activities upon request and on an as needed basis.

Parent/Guardian Responsibilities

I (We), as parent(s), will support my child's learning in the following ways:

- Monitoring attendance.
- Making sure that homework is completed.
- Monitoring amount of television my child engages in.
- Volunteering in my child's classroom.
- Participating, as appropriate, in decisions relating to my child's education.
- Promoting positive use of my child's extracurricular time.
- Staying informed about my child's education and communicating with the school by promptly reading all notices from the school or the school district either received by my child or by mail and responding, as appropriate.
- Serving, to the extent possible on policy or advisory groups.

Student Responsibilities

I, as a student, will share the responsibility to improve my academic achievement and achieve the State's high standards. Specifically, I will:

- Do my homework every day and ask for help when I need to.
- Read at least 30 minutes every day outside of school time.
- Give to my parents or the adult who is responsible for my welfare all notices and information received by me from my school.

The Asbury Park School District will:

1. Involve parents in the planning, review, and improvement of the school's parental involvement policy, in an organized, ongoing, and timely way.

2. Involve parents in the joint development of any school-wide program plan, in an organized, ongoing, and timely way.

3. Hold an annual meeting to inform parents of the district's participation in Title I, Part A programs, and to explain the Title I, Part A requirements, and the right of parents to be involved in Title I, Part A programs. The district/schools will convene the meeting at a convenient time to parents, and will offer a flexible number of additional parental involvement meetings, such as in the morning or evening, so that as many parents as possible are able to attend. The district/schools will invite to this meeting all parents of children participating in Title I, Part A programs (participating students), and will encourage them to attend.

4. Provide information to parents of participating students in an understandable and uniform format, including alternative formats upon the request of parents with disabilities, and, to the extent practicable, in a language that parents can understand.

5. Provide to parents of participating children information in a timely manner about Title I, Part A programs that includes a description and explanation of the school's curriculum, the forms of academic assessment used to measure children's progress, and the proficiency levels students are expected to meet.

6. On the request of parents, provide opportunities for regular meetings for parents to formulate suggestions, and to participate, as appropriate, in decisions about the education of their children. The district/schools will respond to any such suggestions as soon as practicably possible.

7. Provide to each parent an individual student report about the performance of their child on the State assessment in at least math, language arts and reading.

8. Provide each parent timely notice when their child has been assigned or has been taught for four (4) or more consecutive weeks by a teacher who is not highly qualified within the meaning of the term in section 200.56 of the Title I Final Regulations (67 Fed. Reg. 71710, December 2, 2002).

Signature of District/School Representative _____ **Date**_____

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

Signature of Student _____ **Date** _____

Parental/Guardian Media Consent Form

Dear Parents/Guardians:

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personally identifiable information to be published by media outlets or used on the district and/or school's web site and/or social media.

As you are aware, there are potential dangers associated with the posting and sharing of personally identifiable information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as a parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, email address, phone numbers and locations and times of class trips. If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

Check ONE of the following choices:

☐ I /We GRANT permission for a photo/image/video that includes this student without any other personal identifiers to be published or used on the school and/or district's public Internet site.

☐ I /We GRANT permission for this student's photo/image/video and name to be published or used on the school and/or district's public Internet site.

☐ I /We GRANT permission for this student's photo/image/video and all other personal identifiers listed above to be published or used on the school and/or district's public Internet site.

☐ I /We DO NOT GRANT permission for photo/image/video that includes this student to be published or used on the school and/or district's public Internet site.

Student's Name: (please print) _____

Print name of Parent/Guardian: (print) _____

Signature of Parent/Guardian: (sign) _____

Relationship to student: _____ Student's Grade: _____ Date: _____

Student Agreement for Internet Access Account

By signing this agreement, I/we are signifying that I /we have read the Asbury Park Acceptable Use Policy and agree to abide by its terms. I/we understand that the computers, networks and technologies are to be used solely for educational purposes and that there is no expectation of privacy with respect to the use of the same.

When this contract is complete, it must be returned to the principal's office. If there are any questions regarding this policy, please contact a sponsoring teacher, technology coordinator, or an administrator.

Last Name:_____ **First Name:** _____

Home Address: _____

Home Phone: _____ **Age:** _____

Expected Year of Graduation: _____

User Signature: _____ **Date**: ___/___/_____

Parent or Guardian (If the applicant is under the age of 18, a parent or guardian must also read and sign this agreement):

As the parent or guardian of this student I have read the policy in its entirety and agree to its terms on behalf of my child. I hereby give my permission to issue an account for my child and certify that the information contained in this application is correct.

Parent or Guardian's Name (please print): _____

Parent or Guardian Signature: _____

Date: ___/___/_____

Daytime Phone: _____ **Evening Phone:** _____

Asbury Park School District Emergency Card

ID # _____

Last Name _____ First _____ Initial _____ Date of Birth (MM/DD/YYYY) _____
Address _____ School _____
City _____ Zip _____ Grade _____
Home Phone (_____) _____ Teacher/H.R. _____ Email_____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.

Parent/Guardian 1: Name _____ Relationship _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

Parent/Guardian 2: Name _____ Relationship _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

List four neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name _____ Address _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

Neighbor/Relative 2 Name _____ Address _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

Neighbor/Relative 3 Name _____ Address _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

Neighbor/Relative 4 Name _____ Address _____
Phone Numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Email _____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

_____ _____ _____
_____ _____ _____
_____ _____ _____

☐ **Please check this box if there has been a name change of parent/guardian, address or telephone number.**

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

☐ **NO**. My child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about Health Insurance.

Signature: _____ **Printed Name:** _____**Date:** _____

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

- NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ **YES.** My child has health insurance.

List any medical/surgical care your child has received during the past year: _____
_____

Dental Exam: Date:_____ Braces ☐Yes ☐No
Allergy Kind:_____ Medications ☐Yes ☐No
Immunizations/Tetanus: Date:_____ Type: _____
Doctor _____
Dentist _____
Eye Exam Date:_____ Glasses/Contacts ☐Yes ☐No
Allergic Reaction:_____
Restrictions: Type:_____ _____
Phone _____
Phone _____
Hospital (Hospital Name)_____ Phone _____
Hospital (Address) _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____
Signature of Parent(s) / Guardian(s) **Date**

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 ☐ 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		

☐ ***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.***

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

New Jersey Required Immunizations: School Age Children

Student Name:_____ Birth Date:_____

The Asbury Park School District, in compliance with New Jersey law, requires that a child receive the following immunizations prior to entering school. Please have your doctor record the dates below.

1. Diptheria, Tetanus, and Pertussis (DTaP):
Minimum four (4) doses with one dose given on or after the fourth birthday OR any five (5) doses.

1. _____
2. _____
3. _____
4. _____
5. _____

2. Polio:
Minimum three (3) doses with one dose given on or after the fourth birthday OR any (4) doses.

1. _____
2. _____
3. _____
4. _____

3. Measles, Mumps, Rubella:
Minimum two (2) doses of live measles-containing vaccine given on or after the first birthday.

1. _____
2. _____

4. Hepatitis B:
Minimum three doses hepatitis B vaccine.

1. _____
2. _____
3. _____

5. Varicella:
Every pupil born after Jan. 1, 1998, shall have received one dose of Varicella before entering Kindergarten.

1. _____
2. _____

6. Haemophilus Influenza B (HIB):
(Required for day/child care enrollees 2 months to 5th birthday only)
Age 2 - 11 months: 2 doses minimum
Age 12 - 59 months: 1 dose minimum given after the first birthday

1. _____
2. _____
3. _____

7. Pneumocooccal:
(Required for day/child care enrollees 2 months to 5th birthday only)
Age 2 - 11 months: 2 doses minimum
Age 12 - 59 months: 1 dose minimum given after the first birthday

1. _____
2. _____
3. _____

8. A physical exam performed within the last 365 days is also required. Please attach a copy of this exam.

If the pupil has had any other immunization, please provide the type and date:_____

Place Physician's stamp below: Physician's Signature:_____ Date:_____

_____

_____

_____

In order to register your child for school, you will need to bring in the following documents:

Proof of Residency: Three (3) of the items listed below are needed:

- ☐ Current **Utility bill** including gas, electric, water, phone or cable bill
- ☐ **Certificate of Occupancy** from Asbury Park
- ☐ **Rent receipt** or **lease**
- ☐ **Mortgage statement, sewer bill**, or **tax bill.**

* PLEASE NOTE: the items listed above are the *only* ones that will be accepted as proof of residency.

Additional Documents:

- ☐ **Withdrawal Form/Transfer Card/Transcripts** from previous school
- ☐ **IEP** (if applicable)
- ☐ **Original Birth Certificate** with raised seal.
- ☐ **Updated Immunization Record**
- ☐ **Physical Exam** within the past 12 months.
- ☐ **Health Insurance Card**
- ☐ **Letter of Guardianship** (if not living with parent)

In addition, you must click on the link below that corresponds to your child's grade level and complete the specified documents. Once all the information is completed, please call Chanta L. Jackson at (732) 776-2606, ext. 2233 to schedule an appointment.

SEMI Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).
The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.
In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent .

Is there a cost to you?
No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?
- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Asbury Park Middle School
Child Study Team
1200 Bangs Avenue
Asbury Park, NJ 07712

PHONE 732-776-2559
FAX 732-869-9561
WEB SITE asburypark.k12.nj.us