



Student may be released to anyone listed above (circle one)                      Yes                      No

Student MAY NOT be released to (copy of court order required): \_\_\_\_\_

Has your child been classified by the Child Study Team in your previous district?                      Yes                      No

Has your child previously been in a special education program or received special services (speech, OT, PT)?    Yes                      No

Race:                      Indian                      Asian                      Black                      Pacific                      White

Ethnicity (circle one only)                      Latino                      Non-Latino

Nationality \_\_\_\_\_ Primary Language \_\_\_\_\_

**HOME LANGUAGE SURVEY**

1. Does your child speak English?                      Yes \_\_\_\_\_                      No \_\_\_\_\_

2. What language did your child first learn to speak at home? Please be specific (for example Hindi rather than Indian language)  
\_\_\_\_\_

3. What language do you (his/her parents) use most often when speaking to you child at home? \_\_\_\_\_

4. What language does your child most often use when speaking to you (his/her parents)? \_\_\_\_\_

5. What language does your child use most when speaking to his/her brothers and sisters at home? \_\_\_\_\_

6. What language does your child most often speak to other relatives? \_\_\_\_\_

The State of New Jersey asks that various information about a student's medical status also be collected. This information will be used to assist students in receiving health benefits. (Submission of this information is optional.)

Health Insurance (circle one)    Yes    or    No    Health Insurance Provider: \_\_\_\_\_

Please note: NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online.

You may release my name and address to the NJ FamilyCare 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).

Date of Last Medical Exam: \_\_\_\_\_

**PRIVACY POLICY:** The Butler School District is committed to the safeguarding of any information collected by the district related to students, families and staff. Only designated staff will access your information as appropriate.