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Helene Fullmer, M.A., Instructional Supervisor
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1202 Eleventh Avenue
Dorothy, NJ 08317
(609) 476-2412 – Phone (609) 476-3966 - Fax

Dear Parent/Guardian:

The Weymouth Township School District runs two (2) full-day pre-school programs for 3 and 4 year-old children. The class size is limited to 15 students (this is state-mandated); each class will have one teacher and one instructional aide. This Registration Packet contains the following required documents that need to be completed:

- Registration Form
- Language survey
- Health Assessment Record (completed by parent)
- Screening Inventory – Parent Questionnaire (completed by parent)
- Universal Health Record – (section 1 to be completed by a parent and section 2 to be completed and signed by a physician)

The following documents are also required at the time of registration:

1. Proof of Residency
    - Copy of Tax Bill
    - Copy of Lease
    - Utility Bill ***(must contain name and service location)***
    - Notarized Letter from Resident in which you are living with and a copy of their Tax Bill or Lease.
2. Birth Certificate
3. Proof of Immunizations – A list of shots required by the state is included in this packet.

We look forward to working with your child and your family for many years to come! If you have any questions, please do not hesitate to call us. Thank you.

Educationally yours,

Mary Lou DeFrancisco

Mary Lou DeFrancisco
Interim Superintendent

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Weymouth Township School District

Student Registration Form

Grade:	_____
504:	_____
IEP:	_____

STUDENT INFORMATION

Student's Legal Name: ____
Last Name *First Name* *Middle Name* *Preferred Name (Nickname)*

Physical Address: ____
Street *City* *State* *Zip*

Mailing Address (if different): ____
Street /P. O. Box (if applicable) *City* *State* *Zip*

BIRTH INFORMATION	RACE	ETHNICITY
Date of Birth: ____________________	☐ White ☐ Asian ☐ Multi-Racial	☐ Hispanic or Latino
Birth City/State: ____________________	☐ Black ☐ Indian ☐ Pacific	☐ Not Hispanic or Latino
Gender: ☐ Male ☐ Female ☐ Other		

PARENT OR GUARDIAN INFORMATION – In order of contact

1 **Name**: ______________________________

Select one
☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other________

Lives in home with student: ☐ Yes

☐ No ☐ Sole Custody ☐ Shared/Joint Custody

Email Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Employer: ______________________________

Work Phone: ____________________ext. _______

Address (if different from student):

____

Custody/Guardianship papers provided: __ Yes __ No

2 **Name**: ______________________________

Select one
☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other________

Lives in home with student: ☐ Yes

☐ No ☐ Sole Custody ☐ Shared/Joint Custody

Email Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Employer: ______________________________

Work Phone: ____________________ext. _______

Address (if different from student):

____

Custody/Guardianship papers provided: __ Yes __ No

EMERGENCY CONTACT INFORMATION (In case 1 & 2 cannot be contacted):

3 **Name**: ______________________________

Relationship to Student: ______________________

Home Phone: ______________________________

Cell Phone: ______________________________

4 **Name:** ______________________________

Relationship to Student: ______________________

Home Phone: ______________________________

Cell Phone: ______________________________

SIBLING INFORMATION – Other children living in the home

1.	Name: ______________________________	Age: ________	Grade: _______
2.	Name: ______________________________	Age: ________	Grade: _______
3.	Name: ______________________________	Age: ________	Grade: _______
4.	Name: ______________________________	Age: ________	Grade: _______
5.	Name: ______________________________	Age: ________	Grade: _______

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Language Services Form/Language Survey

Child's Name: ____

Child's First Language: ______________________________________

Mother's First Language: _____________________________________

Father's First Language: _____________________________________

Is your child fluent in English? (circle one): Yes / No

Language spoken by adult members of family: ________________________

Language spoken to children in the family: __________________________

Please list other children living in the home:

Name	Age	English Spoken Circle one	Other Language Spoken
		Yes / No	
		Yes / No	
		Yes / No	
		Yes / No	

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SCREENING INVENTORY-PARENT QUESTIONNAIRE

Child's Name: ____

Date of Birth: _______________ Age: _______ Sex: ________

Who is completing this Parent Questionnaire?

Name: ______________________________ Relationship to child: ____________________

FAMILY

With whom has the child lived for most of the past year? ______________________________

Other children in the family: How many older? ________ How many younger? ________

Other people living in the household: ______________________________________

What language(s) are spoken at home: ☐ English ☐ Other (specify) ____________________

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? ☐ Yes ☐ No

If yes, for how long? ☐ 6 months ☐ 1 year ☐ 2 years ☐ more than 2 years

Name of child's present or most recent preschool or day care: ______________________________

Please answer yes or no to the following questions:

MEDICAL HISTORY - BIRTH	Yes	No
Were there any significant problems during pregnancy?		
Was your child more than 3 weeks premature? If yes, how many weeks premature was the baby? _______________ Baby's birth weight _____________		
Did the baby stay in the hospital longer than the mother did? If yes, please explain:		
At the time of birth, did the baby have a seizure?		
At the time of birth, did the baby turn blue?		

CHILD'S HEALTH SINCE BIRTH

COORDINATION	Yes	No
Has your child ever had trouble walking, climbing, reaching, holding on to things?		
Has your child ever had any significant injuries or hospitalizations?		
Does your child have allergies?		
Is your child presently on any medication?		
Do you have any other health concerns about your child?		
If you answered YES to any of the above questions, please explain: ______________________ ______________________ ______________________		

EYES	Yes	No
Has your child ever had trouble seeing?		
Does your child hold books and objects close to his/her face		
Has your child's eyes ever looked crossed		
Have you ever suspected that your child has vision problems		
If you answered YES to any of the above questions, please explain: ______________________ ______________________		

EARS	Yes	No
Has your child had frequent ear infections?		
Has your child ever had trouble hearing?		
Have you ever suspected that your child has hearing problems?		
If you answered YES to any of the above questions, please explain: ______________________ ______________________		
CHILD'S DEVELOPMENT	Yes	No
Can your child:		
Feed him/herself using a spoon and/or a fork?		
Wash and dry his/her own hands?		
Help with dressing or dress with little assistance?		
Stay with a babysitter?		
Speak so that he/she can be understood by others?		
Express his/her thoughts and needs easily?		
Do you have any concerns about your child's appetite or willingness to try different foods? If yes, please explain:		
Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? If yes, please explain:		
Is your child: highly active?		
very quiet?		
toilet trained?		
in need of help with toileting?		
Does your child: play with blocks, boxes, cups, other construction toys without help?		
use crayons and/or markers to scribble or draw?		
listen to stories being read?		
turn pages of a book and look at pictures?		
recall stories or events?		
enjoy playing alone or with imaginary friends?		
talk with your friends/relatives who come to visit?		
follow simple, age-appropriate directions?		

What are your child's favorite activities?		
Does your child have opportunities to play with other children?		
How many hours a day does your child spend watching TV? ______________________________ Does he/she sit very close to the TV?		
Does he/she turn up the volume very high?		

Please use this area for other information that you would like to share with us:

____

____

____

____

____

____ ________________________
Parent Signature Date

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Health Assessment Record

To Parent(s):

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the "Universal Child Health Record" (Part 2).

State law requires complete primary immunization and a medical examination by a physician licensed to practice medicine or osteopathy or a certified registered nurse practitioner/clinical nurse specialist or licensed physician's assistant prior to school entrances in a New Jersey school district.

Kindergarten entrance physicals must be completed prior to the first day of school. All other children only need to provide proof of a physical. Students moving into the district are permitted up to 60 days from the date of registration to provide the school nurse with the completed Health Assessment Record. Transfer students must provide a complete Immunization record within 30 days of registration. This physical examination must be performed no more than 365 days prior to entry.

Please print:

Name of Student:	Birth Date: Sex:
Address:	Birth Country of child:
Address:	Phone Number:
Parent/Guardian Name:	

Part I – To be completed by parent – Important: Complete Part 1 before your child is examined.

Please check yes or no to the following questions (explain all "yes" answers in the space provided below).

	Yes	No
Do you have any concerns about your child's general health (eating & sleeping habits, weight, teeth, etc.)?		
Does your child have any other specific illness, physical deformity or problem (asthma, diabetes, Heart murmur, seizures, etc.)?		
Does your child have any restrictions on physical activity?		
Does your child have any allergies (food, Insects, medication etc.)?		

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	Yes	No
Does your child take any medication (daily or occasionally)?		
Does your child have any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?		
Has your child had any hospitalization, operation, or major illness (specify problem)?		
Has your child had any significant injury or accident (specify problem)?		
Are you claiming exemption from immunization guidelines?		
Have there been any recent changes in the family (relocation, death, divorce, etc.)?		
Would you like to discuss anything about your child's health with the school nurse?		
Does your child have health insurance coverage?		

This child is number _______ of _______ children.

Please explain any "yes" answers here. For illnesses/injuries/etc., include your child's age at the time.

____

____

____

____

I give permission for release of essential information on this form for confidential use in the school for meeting my child's health and education needs.

____ ____________________
Parent Signature Date

:lkq

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 ☐ 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	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam <u>that is being used to complete the form</u>. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis <u>should</u> be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

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Preschool Program Immunization and Health Requirements

A child must meet the following health requirements ***before*** being eligible for the Weymouth Twp. School Preschool Program:

1. Must present proof of the following immunizations, in accordance with the New Jersey State Department of Health.
   a. ***Diphtheria and Tetanus Toxoid and Pertussis*** (DTP/DTaP) Vaccine
   For those children less than five (5) years of age, minimum of four (4) doses of DTP are required.
   b. ***Poliovirus*** **Vaccine**
   For those children less than five (5) years of age, a minimum of three (3) doses of either oral polio vaccine (OPV) or enhanced inactivated poliovirus (IPV) is required spaced by a minimum of one month (28 days)
   c. ***Measles, Mumps, Rubella (MMR) Vaccine***
      - Measles Vaccine - One (1) does of a measles-containing vaccine, preferably MMR, given **on or after the first birthday.**
      - Mumps Vaccine One (1) dose of mumps vaccine administered on or after the first birthday.
   d. ***Haemophilus*** (Hib)
   One dose is required for children from 12-15 months of age to the fifth birthday.
   e. ***Hepatitis B (Hep B) Vaccine***
   f. ***Varicella (chickenpox) Vaccine***
   Children born on or after January 1, 1998 and entering preschool are required to receive one (1) dose of the varicella vaccine **on or after the first birthday**. The Department of Health and Senior Services has indicated that children that present laboratory evidence of immunity, a physician's or parental statement of previous varicella infection shall not be required to receive the varicella vaccine under this mandate.
   g. Pneumococcal Conjugate Vaccine (PCV, also known as Prevnar)
   Every child 12 months through 59 months of age and enrolling in or attending a child-care center or preschool facility shall receive at least one does **on or after their first birthday**.
   h. ***Influenza Vaccine***
   All children 6 months through 59 months attending any child-care or preschool facility shall annually receive at least one dose between September 1 and December 31 of each year.

2. Students are required to have a physical completed using the Universal Child Health Record, which can be found at www.state/nj/us/health/forms/ch-14.pdf. The form is also included in this registration packet. This examination must be done **no more than 365 days prior to entry** and must state what, if any, modifications are required for full participation in the school program. The physical form must be signed by your child's **healthcare provider**. (No office stamp of office staff initials will be accepted.) You may bring the completed immunization record and physical exam form to the school during business hours. Your doctor may also fax the documents to (609) 476-3966.

3. **Confidential Health History Form**: To be completed by parent/guardian.

It is requested that all immunizations be on the New Jersey Immunization Information System form. Your child's physician can print this out from the NJIIS website. All physicians were required to participate in the NJIIS as of January 2012.

Links to various vaccine requirements, charts, and FAQs can be found at http://nj.gov/health/cd/imm.shtml.

If you have any questions, please feel free to contact the school or myself.

Sincerely,

Alice M. Wheaton

Alice M. Wheaton
School Nurse

*****Please note: All medical information must be submitted to the school nurse before your child may attend the Preschool Inclusion Program.**

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