Dear Parent/Guardian,

1) Please complete the attached forms and upload them to the hyperlinks that will be provided to you upon submission of your online registration. Hyperlinks will be sent to the primary email listed in the online pre registration in two separate emails. Hyperlinks do expire. If you receive notification that a link is expired, please email registrar@motsd.org and fresh hyperlinks will be emailed to you. Please include your child's full name in the request.

   Contact Information: Please be sure that all contact information you enter is correct. The main number is the first number that will be called in case of an emergency and therefore it is important that the number listed is one that will readily be answered. All future changes to your contact information should be updated immediately in the parent portal for emergency purposes.

   Email: The first email you list in preregistration will become your primary email. All important emails and hyperlinks will be mailed to the primary email address. Please list an email that you check regularly to ensure receipt of all email correspondence.

2) Health forms - These forms must reflect a physical that has been completed 365 days prior to entry into our district and must be compliant with all required immunizations for your child. Specific instructions regarding the health forms are provided in this packet. For students entering the US for the first time, please visit: https://nj.gov/health/cd/imm_requirements for a complete list of required immunizations.

   In addition to uploading the health forms, please submit the originals to the health office at the high school. The originals must be on file in the nurse's office if your child will participate in sports or to request working papers from the school.

3) School Records (Transcripts) - Records to include all years of high school (secondary) education completed up until date of registration. For a student entering the 9th grade - please submit completed records from 7th and 8th grades. If the student is from another country, we ask that the academic records be professionally translated by an accredited translation agency. School Records should include transcripts, report cards, current schedule, and standardized test scores (IEP or 504 if applicable).

4) Your child's registration is not complete until the necessary documents have been uploaded, reviewed and approved by the registrar's office. You can upload documents at any time and do not need to upload them all at once. Reminder: Hyperlinks do expire. If this occurs, please email registrar@motsd.org and fresh hyperlinks will be emailed to you. Please include your child's full name in the request.

5) Once the registrar has reviewed and accepted the submitted documents, the high school guidance department will be in contact with you. They will provide you with a start date and schedule for your child.

(High School Grades 9-12)

6) All questions regarding registration should be emailed to registrar@motsd.org

Checklist of required documents for grades 9-12:

- ☐ **Proof A Residency**: Current Lease/Deed/Tax record
- ☐ **Proof B Residency**: Current Utility Bill (within 30 days), driver's license, auto insurance, voter registration, or other expenditure demonstrating personal attachment to a particular address
- ☐ **Child's Birth Certificate**
- ☐ **Immunization Records** - from physician's office with stamp
- ☐ **Transcripts** - (Transcript, report cards, current schedule, standardized test scores) School records to include all years of (secondary) education that have been completed up until date of registration. If the student is from another country, we ask that the academic records be professionally translated by an accredited translation agency.
- ☐ **Request for Records Form** - completed by parent and uploaded to the hyperlink for our staff to act upon
- ☐ **Physical Forms** - see directions included in this packet
- ☐ **IEP / 504** - *If applicable*. Please submit the current copy of these documents.
- ☐ **Transportation Form** - completed by parent and uploaded to hyperlink
- ☐ **Transfer Card** - *If applicable.* (You may have received this when you signed your child out of their prior school.)

MOUNT OLIVE TOWNSHIP SCHOOL DISTRICT
227 US Route 206, Suite 10
Flanders, NJ 07836
(973) 691-4008

REQUEST FOR TRANSFER OF RECORDS

Former School Name _____ Date _____

Former School Address _____ Grade _____

City, State, and Zip Code _____ School Phone Number _____

Contact at Former School _____ School Fax Number _____

As the Parent/Guardian of _____, I am authorizing **the school listed below** to request all academic and health records for my child from **the school listed above**.

The above student has enrolled in our school. Please send all school records (transfer card, transcripts, report cards, current schedule, standardized test scores, special services (IEP/504), health records, discipline, future course projections and or teacher recommendations) to the school checked below. Thank you for your prompt attention to this matter.

☐ **Chester M. Stephens Elementary School**
99 Sunset Drive
Budd Lake, NJ 07828
Att: Kelly Lippe, Secretary to the Principal
kelly.lippe@motsd.org
Ph: 973-691-4002 Fax: 973-691-4030

☐ **Mountain View Elementary School**
118 Clover Hill Drive
Flanders, NJ 07836
Att: Theresa Basciano, Secretary to the Principal
theresa.basciano@motsd.org
Ph: 973-927-2201 Fax: 973-927-2202

☐ **Sandshore Elementary School**
498 Sandshore Road
Budd Lake, NJ 07828
Att: Joanne Robinson, Secretary to the Principal
joanne.robinson@motsd.org
Ph: 973-691-4003 Fax: 973-691-4027

☐ **Tinc Road Elementary School**
24 Tinc Road
Flanders, NJ 07836
Att: Angela Aaron, Secretary to the Principal
angela.aaron@motsd.org
Ph: 973-927-2203 Fax: 973-927-2200

☐ **Mount Olive High School**
18 Corey Road
Flanders, NJ 07836
Att:Tammy Grossberndt, Guidance
tammy.grossberndt@motsd.org
Gloria Longo, Guidance
gloria.longo@motsd.org
Ph: 973-927-2208 Fax: 973-927-2204

☐ **Mount Olive Middle School**
160 Wolfe Road
Budd Lake, NJ 07828
Att: Sandy Remshifski, Guidance
sandra.remshifski@motsd.org
Ph: 973-691-4006 Fax: 973-691-4029

_____ _____
Parent/Guardian PRINT Parent/Guardian SIGNATURE

Mt. Olive Township Schools - Transportation Office
Office: (973) 691-4005

Transportation Request Form - SY 2022/23

Type of request: ☐ New — Fill in General Information and Section 2
☐ Change — Fill in General Information and Section 1,2
☐ Daycare — Fill in General Information and Section 2,3 (Subject to space availability on bus & Daycare approval)

General Information:

Students Name: _____ Grade: _____ Birth Date: _____

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Moms Work Phone: _____ Fathers Work Phone: _____

Moms Cell Phone: _____ Fathers Cell Phone: _____

EMERGENCY CONTACT: (other than parent)

NAME _____ PHONE NUMBER _____

School Attending: ☐ High School ☐ Middle School ☐ Sandshore ☐ Tinc ☐ Mountain View ☐ CMS Elementary

What is the date that the information on this transportation request form becomes effective?:

Section 1:

New Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Nearest Intersection: _____

New Home Phone: New Work Phone:

Section 2 if Applicable:

Student has: ☐ Pending IEP ☐ Active IEP ☐ Pending 504 ☐ Active 504

Section 3:

Daycare Provider Name: _____

(Daycare must located within your home school boundary)

Daycare Provider Address: _____ City: _____ State: _____ Zip: _____

Daycare Phone Number: _____

Daycare Provider Approval Signature: _____ Date: _____

Please indicate daycare transportation status:

☐ Pick up/Drop off, 5 days/week ☐ Drop off only, 5 days/week ☐ Pick up only, 5 days/week

Comments:

Parent/Guardian Signature: _____ Date Signed: _____

School Representative: _____ Date Signed: _____

NOTICE: IF APPROVED, ALLOW MINIMUM OF 3-5 SCHOOL DAYS TO IMPLEMENT

Tips for Completing Health Forms

- Use **pen** to complete all forms

- **Page one** - Complete all demographics and emergency contact information

- **History Form** - Complete the entire form. Any questions that are answered “yes” must be explained in the lined portion on hte bottom right corner of the form

- **Special Needs Form** - Complete if applicable. If not applicable, draw a line through the page and still sign at the bottom.

- **Physical Examination Form** - Fill out Name and Date of Birth only. The Physician completes the rest.

- **Clearance Form** - Fill out name, sex, age, and date of birth only. The Physician will complete the rest.

  Upload these forms to the hyperlinks and submit the originals to the health office at the high school.

Mount Olive Department of Athletics

Home

Of

The

Marauders

_____AD
_____Credits
_____ATC
_____Nurse
_____ for official use only

_____Eligible
_____Ineligible
_____Probation
_____Red Shirt
For official use only

Today's Date:_____ **Date of Last Physical:** _____

Student's Name: _____ **Sex: M F (circle one) Age:** _____ **Place of Birth**_____
(City & State)

Address: _____

City/State/Zip:_____

Date of Birth: _____ **Sport:** _____ **Home Phone:** _____

Grade: _____ **School:** _____ **District:** _____

Physician: _____ **Phone:** _____ **Fax:**_____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship to student:** _____

Phone (work): _____ **Phone (home):**_____ **Phone (cell):** _____

***It is required that if your child goes to their private physician, the physician must sign and stamp stating completion of the cardiac module on the physical form. ***

Mount Olive Nurse's Office To Complete Information Below

Date of Physical _____

Physical performed by _____

ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? Yes No If yes, please identify specific allergy below.
Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: High blood pressure A heart murmur High cholesterol A heart infection Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues

- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed, or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
- During the past 30 days, did you use chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet, and use condoms?

Date of Physical Exam _____

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	Male Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected Y N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b]Consider GU exam if in private setting. Having third party present is recommended. [c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Mount Olive High School

COREY ROAD, FLANDERS, NEW JERSEY 07836
Telephone Number (973) 927-2208 Nurse Fax Number (973) 927-2210

Kevin Moore, Principal
Sue Pasqualone, Vice Principal
David P. Falleni, Vice Principal
Robert Feltmann, Vice Principal of Student Affairs
Colleen Suflay, Director of Athletics

Robert Zywicki, Ed.D, Superintendent of Schools

Dear Parent/Guardian:

This letter serves as written notification that your son/daughter _____, can/cannot (circle one) participate in _____sports for the 20__20__ school year pursuant to N.J.A.C. 6A:16-2.2. Please be advised that this letter reflects the recommendation of the examining physician who **completed and signed** the Athletic Pre-Participation Examination Form (Parts A and B) submitted to the school on behalf of your son/daughter.

If your child is deemed unable to participate based on an incomplete form, please ensure that the original examining physician completes the form and returns it to the school to be reviewed for eligibility.

Remarks: _____

_____

Thank you for your cooperation.

Sincerely,

Physician's Stamp _____

Physician's Signature _____