Kindergarten Registration
2024-2025 School Year

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 pre-registration will become your primary email. All important emails and hyperlinks will be sent to the primary email address. Please list an email that you check regularly to ensure receipt of all email correspondence.

2) KINDERGARTEN SCREENING will take place May 28-31, 2024. *It is imperative that you complete the kindergarten registration and upload of documents in a timely fashion.* Parents will be contacted at a later date by their child's school with regards to scheduling a date/time for the screening.

3) Universal Health Form - This form must reflect your child's 5 year checkup or one that has been completed 365 days prior to the start of school (8/28/2024). It must be compliant with all required immunizations.

   Immunization requirements:

   - DTap: a total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses.
   - Polio: a total of 3 doses with one of these doses given on or after the 4th birthday or any 4 doses.
   - MMR: (Measles, Mumps, Rubella)
     - Measles: 2 doses of Measles vaccine to enter Kindergarten.
     - Mumps: 1 dose of the mumps vaccine required.
     - Rubella: 1 dose of the rubella vaccine required. ➢ Most children will have 2 MMR vaccines.
   - Varicella (Chickenpox): 1 dose on or after 1st birthday OR laboratory evidence of immunity, physician's statement or parental statement of previous varicella disease is acceptable.
   - Hepatitis: 3 doses of the Hepatitis vaccine are required.

4) Your child's registration is not considered fully complete until the required documents have been uploaded, reviewed and approved by the registrar's office. As this is a high volume time for registrations, we ask that you allow time for review and processing. 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) All questions regarding registration should be emailed to registrar@motsd.org

Checklist of required documents:

- ☐ **Proof A Residency**: Current Lease/Deed/Property 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**
- ☐ **Student Medical History Update** - completed by parent
- ☐ **Immunization Records** - from physician's office with stamp
- ☐ **Universal Health Form** - part 1 completed by parent/part 2 completed by physician
- ☐ **Dental Form** - completed by dentist with stamp
- ☐ **Vision Form** - completed by physician with stamp
- ☐ **Transportation Form** - completed by parent

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 that is being used to complete the form. 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 should 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.

Mt. Olive Township Public Schools
Student Medical History Update (parent to complete)

Student Name: _____ DOB:_____

School:_____ Grade/Teacher:_____ School Year:_____

Concerns	Yes	No	Complete- If Yes
Allergic to: Bee Stings			Epi-Pen Yes No
Allergic to: Medications			List:
Allergic to: Foods			List Food and reaction: Epi-Pen Yes No
Any medications taken at home (dose, times)?			
Asthma			Medications:
Seasonal Allergies			Medications:
Attention Deficit			Medications: Hyperactivity: Yes No
COVID-19			Date:
Headaches			Medications:
Migraines			Medications: Symptoms:
Stomach Problems			
Hearing Problems			Hearing Aids: Yes No
Visual conditions			Glasses: Yes No Last Eye Exam:_____
Diabetes			Pump: Yes No
Cardiac/Heart conditions			Medications:
Seizures:			Medications: Date of last seizure
Behavior/emotional concerns			
Other General health/ medical concerns (eating/ sleep habits, posture, teeth, skin, menstruation, weight, COVID-19 history)			

Please return to the Health Office School Year 2024-2025

Mt. Olive Township Public Schools
Student Medical History Update (parent to complete)

SCHOOL HEALTH ROUTINES AND SCREENINGS

- **Cough drops, Tylenol, Motrin, and all medications (this includes over the counter and prescription medications except those listed below) require a physician's order to be administered in school. Please see the Health Office website, and download forms if you wish your child to have any medication in school.**
- Height, weight and blood pressure, and hearing screenings are conducted on all student's preschool through 5th grade **as mandated by NJ State Law.**
- Vision screening is conducted on all kindergarten, 2nd and 4th grade students **as mandated by NJ State Law** for those students who have not submitted a private examination.
- If your child is in the 5th grade, scoliosis is required by NJ State law. If you would like your child to be excluded from this screening, please sign here: _. Copies of private physician examinations for scoliosis are due by June, 2025.
- **Please note that additional immunizations of Tdap and Meningococcal vaccine will be required for entrance to 6th grade.**

PERMISSIONS:

Do you give permission to share the aforementioned information with appropriate faculty and staff who work directly with your child? This information will be handled confidentially. **YES NO (circle)**

Health Care Practitioners/Specialists Information:

Practitioner Name	Practitioner Phone Number

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named as emergency contacts, and do authorize the named physicians to render such treatment as may be deemed in an emergency, for the health of said child. In the event that physicians, emergency contacts, 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.

Student Name: _____

Parent/Guardian Signature: Date: _____

MOUNT OLIVE TOWNSHIP SCHOOL DISTRICT NURSES' OFFICES

Mount Olive High School
18 Corey Rd. | Flanders, NJ
P: 973-927-2208 x7480
F: 973-927-2210

Mount Olive Middle School
160 Wolfe Rd. | Budd Lake, NJ
P: 973-691-4006 x5481
F: 973-691-4026

Chester M. Stephens
99 Sunset Dr. | Budd Lake, NJ
P: 973-691-4002 x6480
F: 973-691-6103

Mountain View School
118 Clover Dr. | Flanders, NJ
P: 973-927-2201 x1485
F: 973-927-2216

Sandshore School
498 Sandshore Rd. | Budd Lake, NJ
P: 973-691-4003 x3485
F: 973-691-4017

Tinc Road School
24 Tinc Rd. | Flanders, NJ
P: 973-927-2203 x2485
F: 973-927-2200

Proof of Dental Examination

Student Name: _____

Student Date of Birth: _____

School Attending: _____

Date of Dental Exam: _____

Conclusions / Recommendations

1. Normal dental examination YES NO

2. Follow up dental services advised YES NO

3. Re-examination recommendation: _____
(Date of return visit)

4. Other: _____

_____
Signature of Dentist

_____
Print/Stamp Dentist Name

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F: 973-691-4017

Tinc Road School
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P: 973-927-2203 x2485
F: 973-927-2200

Proof of Vision Examination

Student Name:_____

Student Date of Birth: _____

School Attending:_____

Date of Vision Exam: _____

The Mount Olive Township Board of Education recommends that all students have a complete eye examination before entering school. Optimal vision is essential for school success.

Conclusions / Recommendations:

		Distance	Near		Distance	Near
Vision w/o correction	O.D. Right			O.S. Left		
Vision with correction	O.D. Right			O.S. Left		

Muscle Balance _____ Stereopsis _____

Eye Defects _____ Color Test _____

1. Normal vision examination YES NO
2. Follow up services advised YES NO
3. Corrective lenses prescribed YES NO

4. Re-examination recommendation: _____
(Date of return visit)

5. Other:

_____

_____
Signature of Provider

_____
Print/Stamp Provider Name

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

Transportation Request Form - SY 2024/25

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