LAWNSIDE SCHOOL DISTRICT
BOARD OF EDUCATION
426 Charleston Avenue
Lawnside, New Jersey 08045

RONN H. JOHNSON, ED. D.
SUPERINTENDENT
856-546-4850
FAX: 856-310-0901
ronnjohnson@lawnside.k12.nj.us

Karen Willis
BUSINESS ADMINISTRATOR
856-547-2585
FAX: 856-547-3865
kwillis@lawnside.k12.nj.us

STUDENT REGISTRATION PACKET

Dear Parents/Guardians:

The following documents much be submitted by the Parent/Guardian to Lawnside School District 426 East Charleston Avenue. Lawnside, New Jersey.

1. ***Proof of Residency:***
   - Property Tax Bill, Mortgage Bill, Deed or Lease
     and
   - Utility Bill (less than 60 days)

2. ***Credentials for families who reside with another family:***
   - Proof of Residency of **homeowner** listed above
   - A Notarized Letter stating that you and your child/children resides with a family member/friend.
   - A McKinney-Vento Questionnaire which is included in the Registration Packet.
   - A Bill with a Lawnside address

3. ***Documentation of Relationship to Student:***
   - Original Birth Certificate of the student with the raised seal
   - State-issued ID/Driver's License, U.S. Passport of the parent or legal guardian
   - Legal custody, Court Order or Guardianship Document issued by the Court or by the State (if applicable.)

4. ***Student Records:***
   - Immunization Record from Previous School District
   - Physical Examination Record (PK and K)
   - Transfer Card
   - Report Card
   - 504 Plan or IEP

5. ***Other:***
   - Home Language Survey
   - Emergency Form
   - Free and Reduced Application

2024

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STUDENT REGISTRATION PACKET

Date: ____________________

Child's Name: ______________________ Age: ______ Grade: _____ Sex: M____ F____

Date of Birth: ________ Place of Birth: ______________________________ (City, State)

Home Address: ____

____

Race: ___Am. Indian/Alaskan ___Asian ___Black ___Hawaiian Native/Pacific Islander
___Hispanic ___White ___Other____________________ (***choose all that apply***)

Active Military Connected □ Yes or □ No What Branch ______________________________

Legal Mother/Guardian: ____________________ Legal Father: ________________________
Address: ______________________________ Address: ____________________________

______________________________________ ____________________________________

Cell Number: ______________________ Cell Number: ______________________
Home Number: ______________________ Home Number: ______________________
Work Number: ______________________ Work Number: ______________________

Email Address (Mother): ____
Email Address (Father): ____

Other children who attends Lawnside School if (applicable): __________________________________

Name and Address of previous school District:

____

____

____

Was your child receiving any of the services listed below? □ Yes □ No

If yes, please check the box below

□ IEP
□ Speech
□ 504
□ Other __________________________

For office use only

Assigned to grade: ______________ Student Number: ______________________________

Starting date: __________________ Teacher: ____________________________________

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This questionnaire is intended to address the McKinney-Vento Act 11435.

In accordance with New Jersey State Law (N.J.S.A. 18A:38-1 and 18A: 7B-12), it is necessary to determine the residence of students entering the school district by answering the following question:

1. Does the student reside in any of the following facilities (Please check where applicable)

___ A home the parent/guardian owns or is renting

___ Family* or friend's home by choice (*grandparent, aunt, uncle, etc.)

___ Family or friend's home ***out of necessity***

___ home for adolescent school-age mothers

___ motel

___ migrant family dwelling

___ shelter

___ transitional housing facility

___ other (identify)

Student's Name: ______________________________ DOB: ___________ Grade: ____

Parent's Name: __________________ Signature: ____________________ Date: __________

Presenting a false record or falsifying records is an offense under section 37.10 of the Penal Code, and enrollment of the child under false documents is subject to liability for tuition or other costs. TEC Sec. 25.002(3) (d)

1st Request ________________
2nd Request ________________
3rd Request ________________

PERMISSION TO OBTAIN/RELEASE RECORDS

To Whom It May Concern:

I hereby give my permission for the Lawnside School District, 426 East Charleston Avenue Lawnside, NJ 08045 to OBTAIN/RELEASE the permanent file, health record, and Child Study Team records for my child.

Name of Child: ____________________________ Date of Birth: _________ Grade: _______

Address: ____

Parent's/Guardian's Name (Print): ____

Records are to be OBTAINED from:

Name of previous school: ____

Address of previous school: ____

City, State and Zip Code: ____

Fax: ____

I understand that my child's records are confidential and therefore will not be shared by Lawnside School District staff without my permission.

Signature of Parent/Guardian: __________________________________ *Date:* ___________

AFFIDAVITS

If any information does not pertain to you or your situation, please place N/A for Not Applicable and return the entire packet to the school.

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AFFIDAVIT OF RESIDENCY for STUDENT AND PARENT

Please have this form legalized by a notary.

Name of Student ______________________________ Date of Birth ___________

Your Name (s) _____________________________ Relationship to student ____________

Previous School Name/Address ____

Your Previous Address ____

I, ______________________________, will be residing at ______________________________
Parent/Guardian Address

on a permanent basis with the above mentioned student, for whom (I/We) (am/are) the legal parent/guardian.

In order to document the validity of this living arrangement, I am providing the Lawnside Board of Education with the following proofs of my residency.
NO OTHER PROOF OF RESIDENCY WILL BE ACCEPTED

- ❑ Signed and notarized Lease or Mortgage/Settlement Papers with a Lawnside Address
- ❑ Tax bill with a Lawnside Address
- ❑ Utility Bill with a Lawnside Address (PSEG, sewer, CCMUA)
- ❑ NJ Driver's License, NJ Photo I.D., U.S. Passport

I have initialed here _____ to acknowledge receiving a copy of N.J.S.A. 18A:38-1.

I have read, or had read to me, this affidavit of residency that I have completed, and it's true and correct to the best of my knowledge. I understand that I can be held legally responsible4 for mu involvement in any violations of N.J.S.A. 18A:38-1 for fraudulently completing this legal/notarized statement which I have signed below.

______________________________ ______________________________
Print Your Name Your Signature

Sworn to and subscribed before me
this _____ day of __________ 20__

____
Signature of Notary

Seal

Lawnside School District
Residency Affidavit 2

If you're a parent/guardian residing with a family member/friend's home, please have ***homeowner/lessee*** *complete this form and have it notarized.*

Date: ____________________

I, the home owner/lessee _____________________________________currently reside at the following

Address: ___________________________________City:___________________State:______Zip_______

Email Address: ____

Please list the following person(s) who will be residing at the above address:

1. Parent/Guardian: _______________________Parent/Guardian: ______________________________

2. Student: _________________________________Student:____________________________________

Please return the following documents to the school provided by the homeowner:

- ☐ Notarized Residency Affidavit 2
- ☐ Lease, Mortgage Deed/Statement, or Tax Bill from Lawnside Boro Hall
- ☐ 2 Proof of Residency ~ water bill, gas bill, pseg bill, bank statement, etc.

Please have the Residency Affidavit signed by both parties in front of a notary.

Property Owner's Signature: _________________________________Date:____________________

Parent Signature: ____Date:____________________

The above individuals appeared before me on the _______day of _____________, 20_____

Notary Public Name _____________________________Notary Public Signature __________________

Seal:

Submission of false statements or false participation in this process violates the law and offenders may be prosecuted and/or charged tuition for illegal days of attendance. Lawnside's District Investigator reserves the right to verify the residency of any pupil and the validity of any affidavit concerning residency.

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DECLARATION OF RESIDENCY FORM For Homeless Students

This is to inform the Lawnside Board of Education that my child:

Name of Student: ______________________________ DOB: ____________ Grade: ____

and I, __________________________________ (parent/Guardian) are temporarily residing at

the following address: ____.
(street address, city, state & zip code)

We are living with ______________________________ telephone: ___________________
(Name & Relationship)

My last address that I rented/owned was: ____
(street address, city, state & zip code)

The school district that my child attended while living at that address was:

___________________________________ (City & State)

My child attended ____ School.

The causes of my becoming homeless are: ____

____

___ I request to register my child in the Lawnside School District.
___ I prefer for my child to attend school in the former school district

Parent/Guardian Name: ______________________________________

Parent/Guardian Signature: ___________________________________

Date: ___________________

Presenting a false record or falsifying records is an offense under section 37.10 of the Penal Code, and enrollment of the child under false documents is subject to liability for tuition or other costs. TEC Sec. 25.002(3) (d)

LAWNSIDE SCHOOL DISTRICT
BOARD OF EDUCATION
426 Charleston Avenue
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Dear Resident,

*It has come to my attention of the Lawnside Board of Education that residents are allowing children who do not live within the Borough to use their address to attend Lawnside Public School and Haddon Heights High School, or to collect reimbursement for private school transportation. The use of your address for this purpose is illegal, and could subject a person to be prosecuted as a disorderly person. Secondly, a resident who improperly allows an address to be used can be forced to reimburse the School board the cost of the non-resident child's education. For a child attending Lawnside School this could be up to **$9,744.00** and for Haddon Heights up to **$14,620.00.***

This policy of the taxpayers only paying for the education of bona fide Lawnside children will be strictly enforced. If you have any questions about this policy or know of a student who you think is improperly attending the elementary school or attending Haddon Heights, please call the Superintendent at 856-546-4850.

Sincerely,

Ronn H. Johnson, Ed. D.
Superintendent

ANY PERSON WHO FRAUDULENTLY ALLOWS A CHILD OR ANOTHER PERSON TO USE HIS/HER RESIDENCE AND IS NOT THE PRIMARY FINANCIAL SUPPORTER OF THAT CHILD, AND ANY PERSON WHO FRAUDULENTLY CLAIMS TO HAVE GIVEN UP CUSTODY OF HIS/HER CHILD TO A PERSON IN ANOTHER DISTRICT COMMITS A DISORDERLY PERSONS OFFENSE. New Jersey State Law – 18A-38-1

In order that the Board, Township, State and Federal laws requiring mandatory school attendance be met, the following information is necessary before a student can be registered in the Lawnside School system.

Parent/Guardian Signature ________________________________ Date ____________

New Jersey Department of Education

Household Information Survey 2024-2025

County: Camden District: Lawnside School District School: Lawnside

Please complete, sign, and return this form to your child's school.

Part A. Household Members

Fill in the information for every person living in your household (adults & children). For help determining who should be included in the household, see instructions on the second page.

List all who live in the household: Names (*Last Name, First Name*)	Date of Birth XX-XX-XXXX	Name of School the Student Attends (if applicable)	Grade Level	Student Information (mark as applicable)			
				Migrant	Homeless	Foster	In Head Start
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

*** If household size is greater than 8**, list additional household members on a separate paper, and **follow special instructions in Part C**.

Part B. Benefits Received (if applicable)

1) If anyone in the household receives FDPIR, TANF, or SNAP, check the appropriate box(es): ☐FDPIR ☐TANF ☐SNAP
2) If you checked a box, write the full name (Last, First) and 10-digit case number of any one person receiving the benefit and skip to Part D.

Name:______________________ Case #:______________________

Part C. Household Size and Gross Income (before deductions). For help determining your annual income, see page 2 of the survey.

- Households with 8 or fewer people: Check a box below for the Annual Income Range that reflects your total annual household income.
- If Household Size is greater than 8, DO NOT check an income range, but follow the special instructions below boxes 1 through 17.

Annual Household Income Ranges*

1. ☐ $0 - $16,744	5. ☐ $28,549 - $32,227	9. ☐ $40,627 - $46,254	13. ☐ $57,425 - $58,058
2. ☐ $16,745 - $22,646	6. ☐ $32,228 - $34,450	10. ☐ $46,255 - $49,025	14. ☐ $58,059 - $65,823
3. ☐ $22,647 - $23,828	7. ☐ $34,451 - $40,352	11. ☐ $49,026 - $52,156	15. ☐ $65,824 - $74,222
4. ☐ $23,829 - $28,548	8. ☐ $40,353 - $40,626	12. ☐ $52,157 - $57,424	16. ☐ $74,223 - $82,621
			17. ☐ $82,622+

*** Special Instructions for households with more than 8 people:** DO NOT check the boxes above. Instead, fill in items below:

Household size (# people):______________ Total annual Income: $______________

Part D: Certification - The head of household or adult designee who completed this form must complete this certification section.

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

Sign Here: X______________ Print Name:______________ Date______________

Last Four (4) Digits of Social Security Number (Optional): XXX-XX-__-__-__-__ (may be used to verify the accuracy of the information provided)

Address:______________ City:______________ Zip:______________

Home Phone:______________ Work Phone:______________ Email (optional):______________

Do **NOT** fill out this section. This is for school use only.

Status: F☐ R: ☐ N: ☐

Reason for ineligibility:

Determining Official's Signature:______________ Date:______________

Confirming Official's Signature:______________ Date:______________

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Home Language Survey

Purpose: The home language survey is used solely to offer appropriate educational services. This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: ________________________ Date of Birth (MM/DD/YYYY): _________

Current Address:

____

____

Survey Questions:

1.) List all languages used in the student's home.

____

____

____

2.) Was the first language used by the student a language other than English?

______ No ______ Yes

3.) Does the student speak or understand a language other than English?

______ No ______ Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time?**

______ No ______ Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

______ No ______ Yes

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Paso 1: Encuesta sobre el idioma que se habla en casa

Objetivo: la encuesta sobre el idioma que se habla en casa se utiliza únicamente con el fin de ofrecer servicios educativos adecuados (de acuerdo con el capítulo 1 de la Herramienta EL del Departamento de Educación de EE. UU.). Esta encuesta es el primero de los tres pasos para determinar si un estudiante es elegible para ser identificado como estudiante de inglés (ELL, por sus siglas en inglés). En este sentido, se entiende por "Casa" el lugar de residencia actual del estudiante.

Información del estudiante:

Nombre del estudiante: ______________________________

Fecha de nacimiento (AAAA/MM/DD): ______________

Dirección actual:

____

____

Preguntas de la encuesta:

1.) Liste todos los idiomas que se hablan en la casa del estudiante.

____

____

2.) ¿El primer idioma hablado por el estudiante fue un idioma distinto del inglés?

_____ No _____ Sí

3.) ¿El estudiante habla o entiende un idioma distinto del inglés?

_____ No _____ Sí

4.) Cuando se relaciona con otras personas en casa (por ejemplo: padres, encargados, hermanos), ¿el estudiante entiende o habla en un idioma distinto del inglés la mayor parte del tiempo?

_____ No _____ Sí

5.) Cuando se relaciona con otras personas fuera de casa (por ejemplo, amigos, cuidadores), ¿el estudiante entiende o habla en un idioma distinto del inglés la mayor parte del tiempo?

_____ No _____ Sí

Photograph Consent Form

The Lawnside School District is making strides to promote and bring forth academic excellence throughout the school year. One aspect of creating excellence is to promote the great achievements that your children are making on a daily basis. This year, teachers and district administrators will be photo-journalling your children's achievements. Lawnside will collect various pictures featuring students working independently and diligently, working with friends, having fun while learning, taking class trips, receiving rewards, and much more. Students may be showcased in the district's newsletters or website. These functions promote academic excellence and encourage our students to continuously persevere for academic success.

If you would **NOT** like us to showcase your child's academic excellence through the use of photography, please fill out the form at the bottom of this letter, attach a current (less than 6 months) photo of your child, and place it in an envelope. Please address envelope Attn: Technology Coordinator. Then drop it off in the main office.

DO NOT INCLUDE
Please print

First Name of Student____________________ Last Name of Student________________

Teachers Name________________________ Age of Student_________________

Grade________________________________

I do NOT wish for my child to be photographed.
Signature of Parent or Guardian

Please complete all Medical Forms

Universal Child health record to be completed by your Health Care Provider

Student Emergency Information Form

A. STUDENT INFORMATION

Child's Name ____ Grade__________________

Date of Birth _____________________ Birth Place _________________ Age: ____Male or Female: ___

Race: ☐Am. Indian/Alaskan ☐Asian ☐Black ☐Hawaiian ☐Hawaiian Native/Pacific Islander
☐White ☐Hispanic ☐Multi ☐Other____

Address ____

Legal Mother/Guardian _____________________Legal Father/Guardian _______________________

Cell Number _____________________________ Cell Number ______________________________

Home Number____________________________ Home Number _____________________________

E-mail Address ___________________________E-mail Address ____________________________

Work Number ____________________________Work Number _____________________________

Sibling Name(s) that attend LPS.____

Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child up from school. A non-custodial parent has the right to be listed as an emergency contact unless a court order or other legal document stating otherwise has been presented to the school. If a legal custodial agreement is in place, please attach.

B. HEALTH INFORMATION

Please check appropriate boxes: (If any box is checked, please explain below)

☐ **Health Problems** ☐ **Allergies** ☐ **Restrictions**

Explanation: ____

____

____

Physician's Name: ______________________________Telephone #: _________________________

C. EMERGENCY CONTACT INFORMATION OTHER THAN PARENT OR GUARDIAN.

Only the following adults may be notified and are authorized to accept responsibility for this child in case of illness/emergency or in the event the child is dismissed before the close of school.

Name:	Relationship:	Phone#:
Name:	Relationship:	Phone#:
Name:	Relationship:	Phone#:

I give permission for the school nurse to share medical information with the appropriate school personnel, to contact my child's physician, and for school personnel to have my child transported to the nearest hospital for treatment in the event of an emergency.

*Signature of Parent or Guardian*____*Date*_______________

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

Condition	Status	Comments
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.

MEDICAL HISTORY FORM

Student's Name: ____________________________ Date of Birth: _____________ Grade: ______

Instructions to Parent/Guardian:

Please provide the following information concerning your child and return this form to the health office. If you have specific health conditions, please call me to discuss your concerns at 856-546-1473.

1. Please check any of the following that your child has had.

- ❑ Seizures/convulsions
- ❑ Head Injury
- ❑ Orthopedic Problems/Injuries
- ❑ Sickle Cell
- ❑ allergies
- ❑ Diabetes
- ❑ Asthma
- ❑ Scarlet Fever
- ❑ Heart Problems
- ❑ chicken pox

2. Please check all of the following areas in which your child has problems

- ❑ Speech
- ❑ Hearing
- ❑ Vision
- ❑ Following verbal directions
- ❑ Playing with other children
- ❑ Attention
- ❑ Behavior
- ❑ Walking, running, balance, holding objects, other motor skill problems

3. Is your child frequently sick? ___ Yes ___ No If yes, what is the most common cause of the problem?

____

4. Is there anything about your child's health, habits, or behaviors that you would like to tell us?

____

5. Does your child take medication regularly? ___ Yes ___ No if yes, please list

____

*If your child needs to take medication during school hours, please see the nurse for the appropriate forms and/or questions.

6. Is your child under a physician's care for an ongoing condition, asthma, or allergies? ___ Yes ___ No

If yes, please see School Nurse

7. Does your child have any special dietary allergies or needs? ___ Yes ___ No If yes, please explain and send in documentation from your physician. ____

8. Does your child have any special toileting issues of which we should be aware? ___ Yes ___ No If yes, please explain

____

9. Health Insurance Provider ____

   Provider ID number ____

10. If you do not have health insurance check here ☐

Health Screening Permission Form

Student's Name: ___________________________ Date of Birth: ____________ Grade: ______

I hereby give my permission to Lawnside School for my child named above, to receive the following screening and services as part of the school health program. I understand that the school nurse will be present at all times. I also understand that I can refuse any of these health assessments by submitting a written refusal to the school nurse. I understand that the school nurse will contact me if any problems are detected during the health screenings.

1. Height, weight, and blood pressure screening
2. Vision and hearing screenings
3. A scoliosis screening examination by the school physician and/or nurse will be done bi-annually on all students between 10 and 11 years old. Scoliosis is a lateral curve of the spine, most commonly found during the adolescent growth period.
4. Medical screening on selected grades by the school physician, as needed, if time permits

This medical permission for allows your child to participate in the School Health Program. It will cover your child from Pre-Kindergarten through 8th grade. It will be incorporated into your child's health records.

______________________________ ____________________

*Signature of Parent/Guardian Date

*do you wish to be present for any of the above screenings? ___ Yes ___ No
If yes, please contact school nurse at 856-546-4850 x2205

Student's Name: ____________________________ Date of Birth: ___________ Grade: ______

Medication Allergies/sensitivities: ____

Long-term medications your child receives: ____

I give my permission for the School Nurse to give my child any of the medications I have checked below (which have been approved by the school's physician) as deemed necessary. I understand that the generic equivalent medication may be used. It will cover your child from Pre-Kindergarten through 8th grade.

_____ for abrasions, minor lacerations, brush burns
(Neosporin, polysporin, bactine, mediquick)

_____ for first- and second-degree burns (burn gel)

_____ for cold sore/fever blister (blistex, camphophenique/carmex)

_____ for eye irritation (eye wash, collyrium sol., saline eye wash, visine)

_____ for insect bites, itchy skin, minor skin irritations
(sting kill/itch X, caladryl, or hydrocortisone cream)

_____ for mouth ulcers/tooth pain (anbesol, oil of clove, glyoxide)

_____ for cough/sore throat (chloroseptic throat spray, cough drops/lozenges)

_____ for headache, pain, cramps (Tylenol)

____________________________________ ____________________

Parent/Guardian's Signature Date

Check List

- ☐ Tax Bill, Mortgage Bill or Lease
- ☐ Utility Bill
- ☐ Credentials for families who reside with a family member
- ☐ Notarized Documents
- ☐ Birth Certificate
- ☐ Divers License
- ☐ Immunization Record
- ☐ Physical Exam PK & K
- ☐ Report Card/Transfer Card
- ☐ Home Language Survey
- ☐ Emergency Form
- ☐ Free/Reduced Application

Please Note: Your child is not registered until all documents have been received. Thank you

If you have any questions, please call Ms. Williams at 856-546-4850 extension 2201