PATERSON PUBLIC SCHOOLS
Division of Academic Services & Special Programs
Department of Bilingual/ESL/World Languages
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Home Language Survey

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). 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 (MMDDYYYY): _____

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**

ENTERING SCHOOL _____

FROM SCHOOL _____

PATERSON PUBLIC SCHOOLS
HEALTH HISTORY APPRAISAL
(El Formulario de la Historia de la Salud)

GRADE _____

ACADEMIC YEAR _____ - _____

Name of Student (Nombre de Estudiante)	**Date of Birth** (Fecha de Nacimiento)	**Gender:** ☐ **M** / ☐ **F** / ☐ **X**

Yes (Si)	No (No)	Please indicate whether the student suffers from any of the conditions listed below (Por favor indique si el estudiante sufre de cualquier condicion de la lista abajo)			
☐	☐	**Allergies** (Alergias)	**Type** (tipo)	**Medication** (medicamento)	**Need to be taken in school** (necesita tomar en escuela) ☐ **Yes/Si** ☐ **No** (elije uno)
☐	☐	**Asthma** (Asma)	**Triggers** (los disparadores)	**Medication** (medicamento)	**Need to be taken in school** (necesita tomar en escuela) ☐ **Yes/Si** ☐ **No** (elije uno)
☐	☐	**Other Medications** (Otras medicinas)	**Type/Dose** (tipo/ dosis)	**Purpose** (el proposito)	**Need to be taken in school** (necesita tomar en escuela) ☐ **Yes/Si** ☐ **No** (elije uno)
☐	☐	**Accidents/Injuries** (Accidents/heridas)	**Date** (fecha)	**Type of Injury** (tipo de herida)	**Complications** (complicaciones)
☐	☐	**Hospitalization** (Hospitalizacion)	**Date** (fecha)	**Reason** (razon)	**Complications** (complicaciones)
☐	☐	**Congenital Abnormalities** (Defectos congitos)	**Date** (fecha)	**Type** (tipo)	**Limitations** (limitaciones)

Please indicate whether your child has any of the conditions below:
(Por favor indique si su hijo tienes cualquier conidcion de la lista abajo)

	Yes (Si)	No (No)		Yes (Si)	No (No)		Yes (Si)	No (No)
ADD/ADHD (trastorno de atención)	☐	☐	**Fainting** (desmallos)	☐	☐	**Lupus** (lupus)	☐	☐
Autistic Spectrum (autismo)	☐	☐	**Gastric Disorder** (desorden astrointestinal)	☐	☐	**Migraines** (migranas)	☐	☐
Behavior Problems (comportamiento)	☐	☐	**Glasses/Vision** (problemas de vision)	☐	☐	**Nose Bleeds** (sangrado de la nariz)	☐	☐
Blood Disorder (problema de sangre)	☐	☐	**Hearing Loss** (perdida de sonida)	☐	☐	**Orthopedic Disorder** (trastornos ortopedicos)	☐	☐
Concussion (concusion)	☐	☐	**Heart Disease** (enfermedad del corazon)	☐	☐	**Psychiatric Disorder** (dificultades mentales/emocionales)	☐	☐
Convulsive Disorder (trastorno convulsivo)	☐	☐	**Heart Murmur** (soplo en el corazon)	☐	☐	**Scoliosis** (escoliosis)	☐	☐
Dental Problem (desorden de dientes)	☐	☐	**Hepatitis** (hepatitis)	☐	☐	**Sickle-Cell Disease** (anemia de celulas falciformes)	☐	☐
Developmental Delay (retrasos en el desarrollo)	☐	☐	**Immune Disorder** (desorden inmune)	☐	☐	**Speech Defect** (defecto del discurso)	☐	☐
Diabetes (diabetes)	☐	☐	**Kidney Disease** (enfermedad de los rinones)	☐	☐	**Toileting Problem** (problema para ir al baño solo)	☐	☐
Eczema (eczema)	☐	☐	**Lead Poisoning** (envenenamiento de plomo)	☐	☐	**Other** (otro enfermedad)	☐	☐

Explanation of any "YES" answers above (explicación de cualquier respuesta de "sí" como se indicó anteriormente):

Parent/Legal Guardian Signature (Firma de Padres/Guardianes): _____ **Date:** _____

Nurse Signature: _____ **Date:** _____

OFFICE OF THE SUPERINTENDENT OF SCHOOLS
PATERSON PUBLIC SCHOOLS
PATERSON, NEW JERSEY

PHYSICAL EXAMINATION

N.J.A.C. 6A:16-2.2 & N.J.S.A. 18A:40-4 requires that each student, upon entry into the school district, shall have a medical examination conducted at the medical home of the student, and a report sent to the school nurse. The complete physical examination shall be documented on the approved school district form and shall include the immunizations, medical history including allergies, past serious illnesses, injuries and operations, medications and current health problems, health screenings including height, weight, hearing, blood pressure and vision. This examination must be completed no more than 365 days prior to school entry and must state what, if any, modifications are required for full participation in the school program.

Recommended subsequent medical examinations shall be conducted at the medical home and a report sent to the school at least one time during each developmental stage at early childhood, pre-adolescence, and adolescence. (Recommended grades: Kindergarten, 4th grade, 8th grade, 10th grade.)

A student shall be examined pursuant to a comprehensive child study team evaluation and when applying for working papers.

A physical examination of each candidate for a school athletic squad or team shall be conducted within 365 days prior to the first practice session. This examination must be documented on the approved New Jersey Department of Education Athletic Pre-Participation Physical Examination form.

In-school health screenings, including height, weight, vision, hearing, blood pressure, strip to the waist biennial scoliosis screening and referral will be conducted by the school nurse and the school physician.

A copy to this signed consent/notification form will be kept with your child's health records.

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

Signature of Parent/Legal Guardian: _____ **Date:** _____

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EXAMENES FISICOS

N.J.A.C. 6A:16-2.2 & N.J.S.A. 18A: 40-4. Todos los estudiantes que entran a un distrito escolar deben tener un examen medico, hecho por el medico de la familia del estudeante, y deben enviar un reporte a la enfermera de la escuela. Este examen fisico completo debe ser documentado en un formulario del distrito y debe incluir las vacunas, historia medica incluyendo alergias, enfermedades serias del pasado, heridas y operaciones, ademas de medicinas y actuales problemas de salud, examnes de salud como altura, peso, audicion, presion sanguinea y vision. Este examen debe haber sido completado no mas de 365 dias antes del la matricula y debe indicar si se requieren modificaciones para participar plenamente en el programa escolar regular.

Un estudiante debe ser examinado tambien de acuerdo a lo que indique un equipo de estudio escolar, o cuando solicite documentos para trabajar.

Un examen de cada candidato para un equipo atletico escolar deber ser conducido dentro de los 365 dias antes de la primera practica de entrenamiento. Este examen debe ser documentado en el Formulario de Examen Fisico de Preparticipacion Atletica del Departmento de Educacion de New Jersey.

Todos los subsecuentes examenes medicos deben ser hechos por el medico de la familia y enviar un reporte a la escuela por lo menos una ves en cada estapa de desarrollo en la Ninez, Pre-adolescencia, y Adolescencia (Grado recomendados: Kindergarten, Grado 4, Grado 8 y Grado 10).

Los examenes de salud en la escuela tales como el de altura, peso, vision, audicion, presion sanguinea, examen bienal de escoliosis y referencias seran conducido por la enfermera de la escuela y/o el medico de la escuela.

Una copia de este Permiso firmado sera guardado junto a los records de salud de su hijo o hija.

Estudiante: _____ **Fecha de nacimiento:** _____ **Grado:** _____

Firma de Padres/Guardianes: _____ **Fecha:** _____

PATERSON PUBLIC SCHOOL PHYSICAL EXAMINATION FORM

DATE OF EXAM_____

PATERSON PUBLIC SCHOOL # _____ **SCHOOL NURSE: 973-321-**_____

DATE GIVEN_____ **DUE BACK**_____ **TIME**_____ **DATE RETURNED**_____

STUDENT NAME:_____ **DOB:**_____ **AGE:**_____ **SEX: M F GRADE:**_____

ADDRESS:_____ **PATERSON, N.J.**_____

HISTORY OF ILLNESS OR ABNORMALITIES:_____

Vision (R) 20/_____ (L) 20/_____ **Corrected** Y / N **Glasses:** Y / N **Contacts** Y / N **Hearing** (R)_____ (L)_____

Height_____ % **Weight**_____ % **B/P**_____ / _____ **Pulse**_____ bpm

Allergies _____

Asthma _____

Ears_____ **Eyes**_____

Lymph Glands_____ **Thyroid**_____

Nose_____ **Throat**_____

Teeth _____ **Mouth**_____

Heart_____ **Murmur** ☐ Yes ☐ No

Lungs _____

Abdomen_____ **Hernia**_____

Genito-Urinary_____

Orthopedic: Structural_____ **Posture**_____ **Feet**_____ **Scoliosis** _____

Skin_____ **Nutrition**_____

Nervous System _____

Speech _____

General Appearance_____ **Other**_____

What if any modifications are required for full participation in the school program?_____

_____

What medical factors may effect his/her growth, development and/or academic progress?_____

_____

Is the child receiving medication ? _____ **Other therapy?**_____

If so, what are the side effects with regard to his/her academic progress in school?_____

Referrals made as a result of this examination:_____

_____

PHYSICIAN'S SIGNATURE_____ **TELEPHONE**_____

ADDRESS_____ **FAX**_____

PRINT PHYSICIAN'S NAME_____

IMMUNIZATIONS:

DTP/ DTaP /Td	POLIO	MMR	HEP B	HIB	BCG
1._____	1._____	1._____	1._____	1._____	1._____
2._____	2._____	2._____	2._____	2._____	OTHER
3._____	3._____	3._____	3._____	3_____	_____
4._____	4._____	4._____	4._____	4._____	_____
5._____	5._____	VZV	Varicella Disease Statement or Laboratory Evidence Attached ☐		
Tdap	MENINGOCOCCAL	1._____	OTHER:_____		
1_____	1._____	2._____	_____		

PPD Mantoux Test: Planted_____ Read_____ Result_____ mm

CXR: Y / N Date:_____ Result:_____ **INH:** Y / N _____ mg. X _____ mos. Date started: _____ Date Completed _____

Blood Lead Level_____ mcg/dL Date Tested_____ Not Available_____ REFERRED TO FOR TESTING_____

R-7
3/12ec

☐ YES ☐ NO **ASTHMA TREATMENT PLAN SENT** ☐ YES ☐ NO **ASTHMA TREATMENT PLAN RETURNED**

PATERSON PUBLIC SCHOOLS
REGISTRATION FORM

Student Information

Student's Name: _____
First Name *Middle Name* *Last Name*

Home Address: _____ Phone#: _____
House # *Street* *City* *Zip Code*

Date of Birth: _____ Gender: ☐ M ☐ F Place of Birth: _____
Month/Day/Year *City, State & Country, if not USA*

Race/Ethnicity (*Please select all that apply*):

☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian
☐ Hawaiian Native/Pacific Islander ☐ Hispanic ☐ White/Caucasian

Date entered the Country _____ Date entered US School _____
Has the student ever attended a Paterson Public School? ☐ Yes ☐ No
Transferred from *(School, City, State)*: _____
Does your child have an: ☐ IEP (Individualized Education Plan) ☐ 504 Accommodation Plan
Does your child receive services for: ☐ Bilingual/ESL
☐ None of the Above

Parent/Legal Guardian Information

Mother/Legal Guardian: _____ DOB _____
First Name *Last Name*

Home Address: _____ ☐
House # *Street* *City* *Zip Code* *Resides with child?*

Mobile #: _____ Email: _____

Father/Legal Guardian: _____ DOB _____
First Name *Last Name*

Home Address: _____ ☐
House # *Street* *City* *Zip Code* *Resides with child?*

Mobile #: _____ Email: _____

Name of Person registering child: _____ Relationship to child: _____
Language preferred for receiving communications ☐ English ☐ Spanish ☐ Other *(specify)* _____

List the name, date of birth, school and grade of siblings attending a Paterson Public School or Charter:

Sibling(s) Name	DOB	School Attending	Grade

Emergency Contacts

Name/Relationship	DOB	Home Address	Phone #

Residence Information

Per the McKinney-Vento Act 42U.S.. 17435, the following questions will help us to determine if your child is eligible for additional services.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No
   (a month to month lease is not considered temporary)
2. If yes, is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

If you answered No to both questions above, please sign and date below and **DO NOT** fill out the remainder of this form.

Signature of Parent/Guardian: _____ Date: _____

If you answered Yes to both questions above, please sign and date above **AND** complete the remainder of this form.

Where is the student presently living? (check one)

☐ In a hotel/motel ☐ With more than one family in a house or apartment ☐ In a shelter
☐ In a place not designated for ordinary sleeping accommodations (such as a car, park or campsite)

Declaration of Residency

This is to inform Paterson Public Schools that my child(ren) _____

_____and I (parent/guardian)_____

is/are temporarily residing at the following address: _____.

We are living with (name & relationship) _____.

My last address that I rented, leased or owned was _____.

The school district which my child(ren) attended while living at the address above was _____

_____. My child(ren) attended _____ school. The causes of

my becoming displaced/homeless are _____.

Please select an option below:

☐ I request to register my child(ren) in the Paterson Public School District.
☐ I prefer for my child(ren) to attend school in the former school district _____.
(name of former district)

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

Parent/Legal Guardian (please print): _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

McKinney-Vento Liaison Signature: _____ Date: _____

Updated 9/30/2021