Weymouth Township School District
1202 Eleventh Avenue - Dorothy, NJ 08317
P: (609) 476-2412 F: (609) 476-3966
Weymouthtownshipschool.org

Dear Parent/Guardian:

The Weymouth Township School District runs three (3) 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
- Enrollment Residency Questionnaire
- Language survey
- Health Assessment Record (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)
- Screening Inventory – Parent Questionnaire (completed by parent)
- Permission to Use Student Images and Media

The following documents are also required at the time of registration: Please bring ***originals*** and we will make copies for our files.

1. Proof of Residency - two (2) documents required:
   - *Current Deed* **OR** *Current Tax Bill* **OR** *Current Lease* ***AND***
   - One (1) Utility Bills/two documents with name and address on it.
   - ***Notarized*** affidavit/letter from resident with whom you are living and their 2 documents of proof of residence.
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.

Warmly,

Michelle Mesghali

Michelle Mesghali
Supervisor of Curriculum & Instruction

:lkq

Weymouth Township
School District

Student Registration Form

Grade: _____
Date: _____

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	Home Language Spoken: English Spanish Other:	

Is this student a dependent of a full or part time, active duty member of the Armed Forces? (Army, Navy, Air Force, Marines, Coast Guard, National Guard) ☐ No ☐ Yes, Full-time ☐ Yes, Part-time

Does this child have health insurance? (including NJ Family Care/Medicaid/Medicare, private or other) ☐ Yes ☐ No
Please list Insurance Carrier:

PARENT OR GUARDIAN EMERGENCY CONTACT INFORMATION – In preferred order of contact:

1 **Name:** _____

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

Lives in home with student: ☐ Yes ☐ No ***(If 'No',***

select one: ☐ Sole Custody ☐ Shared/Joint Custody
(please supply custody papers)

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 ***(If 'No',***

select one: ☐ Sole Custody ☐ Shared/Joint Custody
(please supply custody papers)

Email Address: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____ ext. _____
Address (if different from student):
_____
Custody/Guardianship papers provided: __ Yes __ No

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: _____

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WEYOUTH TOWNSHIP SCHOOL DISTRICT NEW STUDENT ENROLLMENT FORMS

ENROLLMENT RESIDENCY QUESTIONNAIRE

Student Name_____School_____

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. Please indicate which situation applies and provide supporting documentation.

Please indicate if the student resides in any of the following:

- ☐ Own my residence in Weymouth Township
- ☐ Rent my residence in Weymouth Township
- ☐ Share housing and expenses in Weymouth Township with family member/friend by choice
- ☐ Hotel/Motel
- ☐ Shelter or Transitional Housing Facility
- ☐ Domestic Violence Shelter
- ☐ Runaway Youth Shelter
- ☐ Home for Adolescent School-Age Mothers
- ☐ Family Member's Home out of Necessity (grandparent, aunt, uncle, brother, sister, cousin, etc.)
- ☐ Friend's Home out of Necessity
- ☐ Homeless without Residence
- ☐ None of the Above Situations Apply

Parent/Guardian Signature: _____Date: _____

Phone #: _____

COMMENTS:

_____

_____

_____

_____

Al Lewis, Ed.D.
Superintendent/Principal
alewis@weymouthtsd.org

Dawn L. Leary, RSBA
Business Administrator/Bd. Sec.
dleary@weymouthtsd.org

Michelle Mesghali
Supervisor of Curriculum & Instruction
mmesghali@weymouthtsd.org

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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	
		Yes / No	

:lkq

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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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To the Parent(s) of Incoming Students:

We would like to welcome to Weymouth Township School District! In order for your child to begin school you will need the following health documents listed below:

The following immunizations:

- DTaP, DT, Td, or TDaP, four (4) doses are required
- Polio, three doses.
- MMR, one dose.
- HIB, two doses, minimum of 1 dose of Hib-containing vaccine in needed after the first birthday
- Pneumococcal, minimum of 2 doses, with one dose after the first birthday.
- Influenza, one dose, given between September 1 and December 31 of each year.
  (Note, students entering between December 31 and March 31 must also receive one dose.)

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

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

In addition, every student must have a physical filled out on the Universal Child Health Record, which can be found located at www.state.nj/us/health/forms/ch-14.pdf
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.

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

Sincerely,

Lauryn Hooven, RN. BSN

Al Lewis, Ed.D.
Superintendent/Principal
alewis@weymouthtsd.org

Dawn L. Leary, RSBA
Business Administrator/Bd. Sec.
dleary@weymouthtsd.org

Michelle Mesghali
Supervisor of Curriculum & Instruction
mmesghali@weymouthtsd.org

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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:	

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.)?		

	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.

_____

_____

_____

_____

_____

_____

Universal Child Health Record (attached)- pages 3 & 4

Section I – To be completed by parent – Important: Complete Section 1 before your child is examined.
Section II –- To be completed by Physician

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

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.

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Weymouth Township School
Permission to Use Student Images and Media

Please read over the following as to Weymouth School's use of student photographs and media in print and digital form. The use as described on this form implies consent to the examples listed below.

Examples of how your child's image/photograph or student work may be used:

- Appear in a printed publication such as a class picture, bulletin board, or yearbook
- Utilized as a demonstration or presentation in class or for the student body
- Utilized on the school's website, weymouthtownshipschool.org, to highlight student activities and achievements
- Appear on video/electronic image made during a student presentation of a project, or in broadcasts or video/electronic images within the building (i.e. weekly announcements, the lobby display, end of the school year video)
- Appear in district, NJDOE, ACDOE, social media accounts
- Other educational activity as WTS deems necessary

Your child's name or other identifying information **WILL NOT** be included with your child's image/photograph when published on the Web.

RELEASE AUTHORIZATION

The notice above grants WTS approval to publicize without prior notification and remains in effect until WTS receives written notice that you would like this revoked, such as the opt-out below.

Photo and Media Release Permission or Opt-Out to Deny Consent

Please select an option:

☐ I/We give permission for _____'s image/photograph or work to be used as described above.

☐ I/We ***DO NOT*** give permission for _____'s image/ photograph or work to be used as described above.

_____
Parent Printed Name

_____ _____
Parent Signature Date Signed

:lkq

Al Lewis, Ed.D.
Superintendent/Principal
alewis@weymouthtsd.org

Dawn L. Leary, RSBA
Business Administrator/Bd. Sec.
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