Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

Dear Parents,

Welcome to Mendham Township Elementary School. We are now accepting registrations for the 2026-2027 school year. Spaces are limited, and enrollment is on a first-come first serve basis. Prospective Pre-Kindergarten students must be 3 or 4 years old by September 2026. **All students entering the Pre-School program must be toilet trained in order to enroll.**

All of our registration forms can be accessed on our website www.mendhamtwp.org . These forms include:

- **Child's original birth certificate**
- ****Child's immunization records (Record from Doctor).**
- **Proof of residency – current utility bill**
- **Notarized homeowner/renter certificate of residency**
- **Registration/Transportation Form**

By N.J. Law, we will admit no child on the first day of school without all immunization requirements.

*****ALL PRE-SCHOOL STUDENTS MUST HAVE A RECENT AND UP TO DATE PHYSICAL***

In order for children to enter school in August 2025, they must have had the following immunizations (Chapter 14, NJ Sanitary Code):

- Pre-K children 6 months through 59 months are required to receive about one dose of influenza vaccine between September 1st and December 31st of each year.
- Diphtheria, pertussis, tetanus immunization: a minimum of four doses, one dose must be **after** the fourth birthday (DPT).
- Poliovirus vaccine: a minimum of three dose of live, trivalent, or oral Poliovirus vaccine, one dose must be **after** the fourth birthday,
- Rubella (regular measles): First vaccine must be given **after** the first birthday, or have a medical documentation of the history of the disease.
  Proof of a second measles vaccine is required (this is most often given as an MMR) no less than 30 days after the first dose.
- Rubella (German measles) vaccine, one required (usually an MMR).
- Mumps: one required (usually an MMR).
- Hepatitis B vaccine. Series of three required.
- Varicella (chicken pox). Required as of September 2004 or documentation of disease.
- A record of any other immunization or TB test that your child may have had.

Sincerely,

Every Student, Every Day
http://www.mendhamtwp.org

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Dr. Julianne Kotcho, Principal

FULL DAY PRESCHOOL 2026-2027 REGISTRATION FORM

TUITION COST PER MONTH is $1,475.00 (due the 1st of each month)

The tuition registration fee pays the final tuition payment (June)

Checks Payable to: Mendham Twp. Board of Education

Please include a copy of your child's birth certificate for our records

STUDENT'S NAME_____
LAST FIRST MI

GRADE ENTERING_____DATE OF BIRTH_____SEX_____

DOMINANT LANGUAGE SPOKEN IN THE HOME_____

FULL NAME OF MOTHER OR GUARDIAN_____

FULL NAME OF FATHER OR GUARDIAN _____

STREET ADDRESS_____

TOWN_____STATE_____ZIP_____

MAILING ADDRESS_____

TOWN_____STATE_____ZIP_____

NEAREST INTERSECTION_____

HOME PHONE #_____

MOTHER'S CELL/WORK #_____

FATHER'S CELL/WORK#_____

MOM'S EMAIL _____ DAD'S EMAIL _____

IF PARENT OR GUARDIAN LIVES IN A SEPARATE DWELLING/Request for separate important document copies/and or mailing YES_NO ____ **NAME__**

ADDRESS AND PHONE: _____

_____

_____

MENDHAM TOWNSHIP ELEMENTARY OFFICE USE ONLY;

LOCAL ID. #_____ **NJ SMART ID #** _____

DEPOSIT RECEIVED*:* _____**DATE:** _____**CK#** _____

Copy of Check & Registration form to BOE Office: _____ ***Date:*** _____***ES Staff Member Initials:*** _____

BOARD OF EDUCATION OFFICE USE ONLY;

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CHECK RECEIVED BY: _____ DATE: _____

Date of Check Deposit: _____

PRESCHOOL CHECKLIST/PRESCHOOL READINESS

Please indicate whether your child can demonstrate these skills by writing a **"Y"** for YES or **"N"** for NO

CHILD'S NAME: _____

Emotional Development

__Recognizes own emotions
__Recognizes other people's emotions
__Takes turns and is able to share toys
__Can separate himself from you for a 4-8 hours
__Accepts correction from an adult other than caregiver
__Can adjust to new situations and environments
__Takes naps/capable of independent quiet time for 1 hour

Attention

__Listens to and understands simple instructions
__Sit still during a story for 5-10 minutes
__Remains on task for 5-10 minutes
__Listens when spoken to by an adult

Independence/Self-Help

__Cleans up toys after play
__Keeps hands away from nose and mouth
__Uses a tissue
__Can dress independently: puts on socks, shoes, coat, fastens pants
__Enjoys doing things by him/herself independently
__Takes care of toileting needs (potty trained): vocalizes need to use the toilet, wipes self
__Can feed him/herself using utensils: spoon ____ fork____

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__Can drink from a water bottle
__Uses a dominant hand when feeding (left/right)

Language/Literacy

__Expresses thoughts and needs verbally
__Recites the alphabet and recognizes some letters
__Recites and can recognize full name
__Greets appropriately: eye contact, words, gestures

Math

__Recognizes some shapes
__Recognizes some colors
__Knows age
__Can count up to their age

Fine/Gross Motor Skills

__Interested in coloring/writing
__Can manipulate small objects using thumb and pointer finger (pincer grasp)
__Can walk in a line
__Looks forward when walking

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PRESCHOOL TOILET TRAINING POLICY

Children enrolled in preschool must be toilet trained before attending preschool. Children must be wearing underwear. A child having accidents daily would not be considered toilet trained. Please note that wearing pull ups is NOT considered toilet trained.

Why do children have to be toilet trained before they begin preschool?

- There are strict standards for changing and disposing of wet or soiled diapers/pull ups and our classrooms are not equipped for this.
- When an adult is busy changing a child's soiled clothing, it is taking away from learning time for all students and it removes one adult from the direct supervision of and interaction with the rest of the class.

We do understand that even toilet trained children will occasionally have accidents. By definition, "accidents" are unusual incidents and should happen infrequently. In these instances, the teachers will help children to change their clothes, encouraging independence as much as possible.

A toilet trained child is a child who can do the following:

- Communicate to the teachers that he/she needs to go to the restroom before they need to go
- Alert him/herself to stop what he/she is doing, to go and use the bathroom
- Pull down his/her clothes and get them back up without assistance
- Wipe him/herself after using the toilet (with minimal assistance for 3 year olds)
- Get on/off the toilet by him/herself
- Wash and dry hands
- Postpone going if they must wait for someone who is in the bathroom or if we are away from the classroom
- Wake up during nap time should they need to use the bathroom

We certainly will ask your child many times throughout the day and before nap time if they need to use the bathroom. A teacher will assist children as needed, but children should be able to complete toileting activities independently. This is an issue which protects all concerned.

It is not uncommon for a child who is fully toilet trained to have a setback when he/she is in a new environment. Preschool staff are aware of this and will assist the children when necessary. Please have your child dressed in clothing that he/she can easily manage independently. Please send a complete change of clothes appropriate for the season. These will be left at school in case of accidents, and returned at the end of the school year. Parents will be notified if a child has a toileting accident.

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We understand that each child arrives at this milestone differently, therefore we will allow 4 weeks from the first day of school for your child to demonstrate accomplishment of this goal. However, if the situation is not manageable within the classroom environment, we will discuss the issue with the parents and reserve the right to suspend attendance of the child at such time.

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A child will not be considered toilet trained for our preschool program if the child continues to consistently have toileting accidents after the first 4 weeks of school.

After the first 4 weeks of school, the following policies will be in place for children who have accidents:

- If one or two accidents occur in one week, the parents will be notified with the understanding that the issue needs to be addressed and corrected.
- If three or more accidents occur in one week, the parent will be notified with the understanding that if the issue is not corrected by the end of the second week the child will have to stay home at least one week or longer until he/she is completely toilet trained.
- If multiple accidents occur in one day, the parent will be notified on that day; and if not corrected by day three, the child will have to stay home at least one week or longer until he/she is completely toilet trained.

Please note that this policy is not in place to shame or punish a child or inconvenience primary caregivers. Rather, cleaning accidents in the preschool setting is time consuming, and this time that teachers spend attending to and cleaning accidents is time that they are not spending interacting with children and facilitating the curriculum in a safe manner. This policy is intended to ensure the safety and happiness of children and staff at the Mendham Township Preschool.

Thank you for your cooperation and understanding.

PLEASE SIGN AND DATE BELOW INDICATING THAT YOU HAVE RECEIVED & REVIEWED THE MENDHAM TOWNSHIP PRE-SCHOOL TOILET TRAINING POLICY:

PLEASE RETURN THE BOTTOM PORTION OF THIS TOILET TRAINING POLICY

I HAVE RECEIVED AND REVIEWED THE MENDHAM TOWNSHIP PRE-SCHOOL TOILET TRAINING POLICY:

CHILD'S NAME: _____

PARENT'S SIGNATURE: _____ **DATE:** _____

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HOMEOWNER/RENTER CERTIFICATE OF RESIDENCY

PLEASE ANSWER ALL QUESTIONS

I CERTIFY THAT THE INFORMATION PROVIDED BELOW IS CORRECT.

Parent/Guardian
Name_____
Last First
Address _____
Telephone _____

Student Name(s) and Grade(s) _____

_____

1. Do you reside at the above address? YES / NO
2. Do you own or rent a home in Mendham Township? OWN / RENT
3. Date moved in _____
4. Former Address _____

5. Appropriate Documents – Please submit two (2) of the following:

Mortgage Statement	Tax Bill	Gas/Electric Bill
Certificate of Occupancy	Lease	Telephone Bill
Homeowner's Insurance	Deed	Contract

_____
Parent/Guardian

Sworn and subscribed before me This day of _____202__

_____
NOTARY PUBLIC OF NEW JERSEY

_____ _____
Signature of staff member reviewing proof of residency Date

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CHILD HEALTH HISTORY

(To be filled out by parent)

Student's Name:_____

Allergies (Describe reaction)
_____

Prenatal and Birth History
Any problems during pregnancy?_____ Full term? _____
Length of labor: _____ Delivery: Vaginal Delivery ____ C-section ____ Use of forceps ___ Birth weight _____
Condition at birth: Normal ____ Jaundiced _____ Cyanotic _____

Developmental History (Please record any developmental problems, delays, i.e. speech delays or poor coordination)
_____
_____
_____

Medical History (Check all that apply and include dates or age if possible)
Chicken Pox ____ Scarlet fever ____ Measles ____ Mumps ____ Strep Infections _____ Tonsillitis ____
Lyme Disease ____ Frequent colds ____ Ear Infections ____ Other: _____
Surgical Procedures (include dates/age)
_____
Significant Injuries (fractures,concussion,etc) _____

Does your child have any problems with their: Hearing ____ Speech ____ Vision ____ Wears glasses/contacts ____
Does your child see an eye specialist? ____ If so, who: _____ Last eye exam: _____
Date of most recent dental check-up: _____ Dentist's Name: _____
Is your child up to date with vaccinations? ____ If not, please explain: _____

Health Habits (please check any that causes parental concern)
Elimination___ Bedwetting ___ Diet___ Appetite___ Fears___ Peer Relations___ Sleep ___ Temper tantrums ___
Please Specify:
_____

Medications
Does your child take daily medications? ____ If yes, please list: _____
_____

I give the school nurse permission to share pertinent health information with other essential staff members when necessary to assist in meeting the health and educational needs of my child.

Signature of parent/guardian: _____ Date: _____

MTES Form #1 B

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	

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MENDHAM TOWNSHIP SCHOOL DISTRICT EMERGENCY CARD

Student's Name_____ **Date of Birth**_____ **Grade/Homeroom** _____

Home/Mailing Address_____ **Home Phone** _____

With whom does the student reside? _____

Duplicate Document Copies Requested if a Parent/Guardian lives in separate dwelling YES _____ NO _____

Address: _____

Mother's Name		Father's Name	
Cell #		Cell #	
Work #		Work #	
Email Address		**Email Address**	

May we share the above information with the H.S.A. for publication in their directory? Yes No
Would you like to receive news from the Mendham Township Education Foundation? Yes No
Please list your three primary emergency contacts in the order you wish them to be called:

NAME	RELATION TO STUDENT	PHONE

HEALTH INFORMATION
List any health concerns or allergies your child has: _____
_____

As a parent/ guardian of the above named student, I hereby authorize the release of pertinent medical information (ie; conditions, allergies, and treatment regimes) to be exchanged among appropriate professional staff involved in the care of my child. This consent is intended to allow the staff to better serve my child.

Parent/Guardian Signature_____ Date_____
If unwilling to document, but have concerns to share with the school nurse, please call.

Is your child covered by Health Insurance? Yes, name of insurance company_____ **No** ____
NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Signature:_____ **Printed Name:**_____ **Date:**_____

Minimal Immunization Requirements for School Attendance in New Jersey

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VACCINE	AGE	DOSES REQUIRED	NOTES
DTaP	Pre-K	4 doses	
	K	4 doses	4 doses with 1 on or after 4th birthday OR any 5 doses
Polio (IPV)	Pre-K	3 doses	
	K	3 doses	3 doses with one dose on or after the 4th birthday OR any 4 doses
MMR	Pre-K	1 dose	
	K	2 doses	
Varicella	Pre-K and older	1 dose	
HIB (Haemophilus Influenzae B)	2-11 Months	2 doses	minimum of 2 age-appropriate doses
	12-59 Months	1 dose	minimum of 1 dose on or after 1st birthday
Hepatitis B	K-12th Grade	3 doses	
Pneumococcal	2-11 Months	2 doses	minimum of 2 age-appropriate doses
	12-59 Months	1 dose	minimum of 1 dose on or after 1st birthday
Influenza	6-59 Months	1 dose annually	given between Sept 1 and Dec 31st of each year

I have read the minimum vaccination requirements for my child to be able to attend school, as required by the New Jersey Department of Health (N.J.A.C. 8:57-4), and will provide my child's most updated vaccination records signed by a physician, or any medical or religious exemptions, to the health office by the start of the school year.

Parent/Guardian Signature _____ Date: _____
Student's Name: _____ Age : _____ Grade: _____

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS (OTC) DURING SCHOOL HOURS

Student Name: _____ Date of birth: _____ Grade: _____
Parent/Guardian Name: _____
Home Address: _____
Parent/Guardian Phone: Home: _____ Cell: _____ Work: _____

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I request that my child be administered the following OTC medication(s) by the school nurse if needed throughout the current school year as directed by my child's medical provider below. Medical authorization forms are effective for the school year in which the order was written. New forms must be submitted each school year.

Parent/Guardian Signature: _____ Date: _____

This section for completion by Licensed Medical Provider:

The following OTC medications will be stocked in the school health office: Acetaminophen liquid (160mg/5ml), Acetaminophen tabs (325 mg/tab), Ibuprofen liquid (100mg/5ml), Ibuprofen tabs (200mg/tab), Diphenhydramine HCl/Benadryl liquid (12.5mg/5ml), Diphenhydramine HCl/Benadryl tabs (25mg/tab).

Medication: _____ Route: _____ Dosage: _____
Frequency: _____ Reason for use/signs & symptoms: _____
List side effects and/or contraindications: _____

Medication: _____ Route: _____ Dosage: _____
Frequency: _____ Reason for use/signs & symptoms: _____
List side effects and/or contraindications: _____

Medication: _____ Route: _____ Dosage: _____
Frequency: _____ Reason for use/signs & symptoms: _____
List side effects and/or contraindications: _____

Topical: (please check all that apply) Calamine anti-itch lotion ____ Medicaine ____ Neosporin _____

Hydrocortisone 1% cream ____

Provider's Signature: _____ Date: _____ **(STAMP)**

AUTHORIZATION FOR PRESCRIPTION MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

Student Name: _____ Date of birth: _____ Grade: _____
Parent/Guardian Name: _____
Home Address: _____
Parent/Guardian Phone: Home: _____ Cell: _____ Work: _____

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<u>This section for completion by Licensed Medical Provider</u>:

Diagnosis for which medication is prescribed: _____

Name of medication: _____ Route: _____ Dosage: _____

Frequency: _____ Time(s): _____ **May self-administer:** Y_____ N____

If PRN, for signs & symptoms: _____

Significant side effects and/or contraindications: _____

Start date: _____ Discontinue date: _____

<u>A pupil is only permitted to self-administer medication for asthma or other potentially life-threatening illnesses.</u> Every pupil that is authorized to use self-administered asthma medication MUST have their MDI accessible during the school day and have an Asthma Treatment Plan prepared by the pupil's LMP which shall identify, at a minimum, asthma triggers, the treatment plan and other such elements as required by the Department of Education (N.J.A.C. 6A:16-2.3(b). Students with medication orders for anaphylaxis must have an Allergy Action Plan completed by their LMP and epinephrine auto-injectors submitted to Health Office.

Provider's Signature: _____ Date: _____ **(STAMP)**

<u>This section for completion by Parent/Guardian:</u>

I request that the above medication be administered to my child. I understand and assume the responsibilities as required.

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

****Please Note**** This completed form, along with the medication, <u>must</u> be hand delivered to the school nurse by the parent/guardian. The medication <u>must</u> be in the original container appropriately labeled by the pharmacy or medical provider.

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

The Pediatric/Adult Asthma Coalition of New Jersey

Sponsored by AMERICAN LUNG ASSOCIATION.

NJ Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY (Green Zone)

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Ovar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Trig

Check all that trigg patient's

- ☐ Colds/fl
- ☐ Exercise
- ☐ Allergen
  - ○ Dust dust, anima
  - ○ Polle grass,
  - ○ Mold
  - ○ Pets - dande
  - ○ Pests cockr
- ☐ Odors (
  - ○ Cigar & sec smok
  - ○ Perfu clean prod scent prod
  - ○ Smok burni inside
- ☐ Weather
  - ○ Sudd temp chang
  - ○ Extre - hot
  - ○ Ozone
- ☐ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ☐ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma plan is mea not replace, decision-ma required to individual p

Disclaimer: [illegible]

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled [illegible] med above in accordance with NJ [illegible]

☐ This student is not ap[illegible] medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE___

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

REVISED AUGUST 2014

Permission to reproduce blank form • www.pacnj.org

Make a copy for parents and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number

2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check **"OTHER" and:**
     - ❖ **Write in asthma medications not listed on the form**
     - ❖ **Write in additional medications that will control your asthma**
     - ❖ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be prov in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchang information between the school nurse and my child's health care provider concerning my child's health and medications. In additi understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administr in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treat Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration o medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its emplo shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication presc on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administr or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
Pathway approved Plan available at www.pacnj.org

Disclaimer: [illegible]

Liability: [illegible]

Copyright: [illegible]

The Pediatric/Adult Asthma Coalition of New Jersey, [illegible] provided by the U.S. Centers for Disease Control and Prev[illegible] New Jersey Department of Health and Senior Services in the US [illegible] 2010 the American Lung Association in New Jersey. It has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your doctor or your healthcare professional.

Sponsored

AMERICA LUNG ASSOCIAT
IN NEW JERSEY

ES FORM #4

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

DESIGNATION OF ADMINISTRATION OF EPINEPHRINE

The certified school nurse may designate, in consultation with the building administrator, another employee of the district to administer a pre-filled single auto-injector mechanism containing epinephrine when the school nurse is not physically present at the scene, including sponsored after-school activities.

The employee(s) will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.

STUDENT NAME: _____ GRADE: _____

A list of employee(s) designated to administer epinephrine for your child in the event the school nurse is not physically present at the scene may be obtained from your building school nurse.

I give consent for the district's designated delegate to administer epinephrine in the event the school nurse is not present at the scene. I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine and that I indemnify and hold harmless the District and its employees or agents against claims arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine.

_____	_____	_____
Parent/Guardian Signature	Date	School Year

Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

NJ SMART DATA

STUDENT NAME: _____DATE _____

All information should correspond to child's birth certificate or other legal documentation

DATA ELEMENT	EXPLANATION
Last Name	
First Name	
Middle Name	
Generation Suffix – if any	
Gender	
Date of Birth	
City of Birth	
State of Birth	
Country of Birth	
City of Residence	
Ethnicity * Please circle either Yes or No "Yes" = Hispanic or Latino "No" = Not Hispanic or Latino	"Yes" "No"
Race * Please circle either Yes or No Note: More than one race category may be reported	
American Indian or Alaskan Native	"Yes" "No"
Asian	"Yes" "No"
Black	"Yes" "No"
Pacific	"Yes" "No"
White	"Yes" "No"
Health Insurance	"Yes" "No"
Health Insurance Provider – name	
Date of last medical exam	
Date of last lead test	
Lead level (Range of values: 2 – 100.00)	
Date of first polio immunization	

Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

*The categories reflect the revised Standards for the Classification of Federal Data on Race and Ethnicity by the US Office of management and Budget – Statistical Policy Directive No. 15 (1997)

CONSENT FOR PUBLICITY FORM
PRESCHOOL

SCHOOL YEAR: 2026-2027

Dear Parent/Guardian:

Each school year, with the permission of parents and guardians, the school district celebrates the accomplishments of students and staff by publishing the names, photographs, videos and schoolwork of students. This is done using the district and individual school websites and by permitting students to be interviewed and photographed (by both still and video photographers) by representatives of various media, including newspapers, magazines and other written publications, websites, blogs, local and national TV stations, and motion picture productions.

Concerning website postings, the State of New Jersey requires us to provide you with the following information:

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child. Pursuant to law, the district will not release any personally identifiable information without prior written consent from you as parent or guardian.

The purpose of this form is for you to grant or deny the district permission to use your child's name, image (whether in a photograph or video) or school work for the above purposes. If a child is on a team or in a club, it is very likely that his/her photo or name will be in the media since school events are often covered by the press.

Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

Please fill out the form below and return it to your child's homeroom teacher.

CONSENT FOR PUBLICITY 2025-2026

□ **I WILL PERMIT** my child to be interviewed, to have his/her name, photo and/or school work, in print, on video, on TV, in motion pictures, or on district and/or school websites for publicity purposes.

□ **I WILL NOT PERMIT** my child to be interviewed, to have his/her name, photo and/or school work, in print, on video, on TV, in motion pictures, or on district and/or school websites for publicity purposes.

Student Name: _____

Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Student: _____

School: _____

Grade: _____

Homeroom Teacher: _____

Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

Mendham Township Elementary School
PRESCHOOL

Acceptable Use Policy- 2026-2027 School Year

Mendham Township Elementary School would like to utilize our computer lab, our networked environment and Internet capabilities as effective learning tools in order to achieve our academic goals in a safe and controlled environment. This policy has been reviewed in your child's computer class. We are asking all parents to discuss the following rules with their children. Please return this signed agreement to your child's classroom teacher.

I will get permission from an adult...
before I start to use any computer equipment
before I print anything
before I view or conduct any google or other internet search
I will tell an adult immediately if...
I see someone using a computer incorrectly
I have a problem with a computer
I see something on the computer that I think is wrong or makes me feel uncomfortable.

I will only use the computer to print or copy something if I have permission from the person who wrote it. I will never give out my last name, address or phone number to anyone on the Internet. I promise to follow these computer rules. I understand that if I break the computer rules, I will lose computer privileges for a period of time. I have discussed these rules with my parents.

Family name (please print clearly) _____

Teacher: _____

Student's Name: _____

Parent's Signature: _____

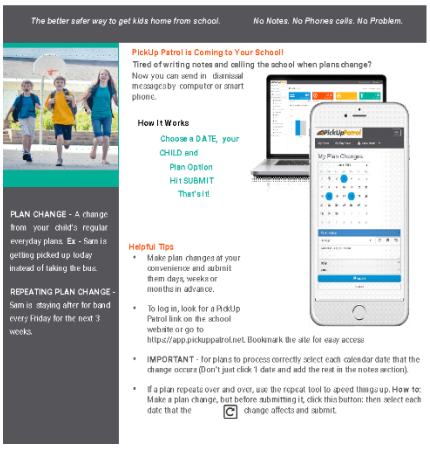
Mendham Township Elementary School

8 West Main Street, Brookside, NJ 07926
973-543-7107

Date:_____ **School Year AND grade level**_____

We utilize the Pick Up Patrol Program for all student after school pick-ups and after school programs

PickUpPatrol



****PLEASE CHECK OUT THE PICK UP PATROL WEB-SITE FOR FURTHER INFORMATION:**

https://www.pickuppatrol.net/Default

PICK UP/DROP OFF PROCEDURE

As we begin a new school year, I would like to notify those of you who are new to the district and remind our 'veteran' parents of the arriving and departing procedure in order to ensure the safety of our children. To make this process safe, orderly and efficient, I respectfully request that you carefully follow the established procedure detailed below. It is imperative that the traffic flow in each instance of morning arrival and afternoon departure is precisely adhered to.

All morning arrivals and afternoon departures by car will take place at the rear of the building. You should be aware ***that supervision is unavailable prior to 8:45 a.m.*** Therefore, it is essential that you drop off your child at or after this time. Once on the property, please proceed along the drive and bear to the right, both as you approach the circle and upon reaching the side parking lot. The line will proceed around the perimeter of the side lot, along the soccer field, and approach the entrance to the new gym.

In order to ensure that the car line moves along smoothly we kindly request, upon arriving and departing, that you remain in your vehicle throughout the process. The staff member on duty will assist your child with

entering your vehicle. To support us with expediting this procedure we would greatly appreciate you placing a placard clearly identifying your last name on the passenger side window when picking up so that your child (ren) can be called quickly from the gymnasium.

With your assistance, I'm sure we will make this procedure as safe and efficient as possible. I thank you in advance for your anticipated cooperation and look forward to working with you as the year progresses.

Attendance Procedures & Potentially Missing Children (5113)

The Mendham Township Elementary School remains committed to ensuring the safety of each and every one of our students. The following outline represents the procedures that parents, students, teachers, and office staff should utilize in order to expediently detect and report "potentially missing children":

1. Parents: If for any reason a student is going to be absent from school, it is critical to contact the Elementary School office at any time of day or night before 9:15 AM on the day of the absence.
2. Office / School Staff: Flag Salute/daily announcements commence at 9:00 AM.
3. Teachers: Prior to daily announcements, homeroom teachers utilize a "structured roll call procedure" to take attendance. Enter an 'X' (absent) next to every absentee student. Once a student's status is officially entered onto the attendance sheet during roll call, it should not be changed – the office staff will rectify discrepancies via the student tardy sign-in sheet.
4. Teachers: Tardy students must have a pass signed by the office staff. If the student does not have a pass the office should be contacted to confirm the late arrival.
5. Teachers / Office Staff: OnCourse Attendance needs to be taken ASAP but no later than 9:15 AM.
6. Office Staff: Account for all absences. If a student is absent and the parent or guardian has not notified the office, all emergency contact numbers must be utilized to locate the student. If the student cannot be located by 9:30 AM, contact the Mendham Township Police Department and request a "locator check" (no later than 10 AM).
7. Teachers / Office Staff: Office will provide Daily Attendance Report to all instructional staff no later than 9:45 AM.
8. Teachers: Take attendance at beginning of every period – notify office of discrepancies.
9. Office Staff: Immediately upon securing update from MTPD, inform Superintendent via email copied to principal. Detail event in Administrators Plus and include "welfare check report" in Superintendent's monthly report.