Genesis Parent / Guardian Access Form

PLEASE PRINT

Parent/Guardian

Last Name: _____

First Name: _____

Relationship: _____

Address: _____

Cell / Home Number: _____

E-Mail: _____

Parent/Guardian

Last Name: _____

First Name: _____

Relationship: _____

Address: _____

Cell / Home Number: _____

E-Mail: _____

Please note:

1. Your password for access will be e-mailed to each registrant.
2. Students will have their own access to Genesis through the Student Portal. Students are not to have access to parent accounts.

Users will be able to change contact information and electronically sign documents through the "Genesis Parent Access" portal. I understand that students *MAY NOT* have access to the parent's Genesis account. I will log out of the account when it is not in use and keep my password secure. Any actions or changes made through my account will be considered to be authorized and made by me.

Signed: _____ Date:

Students to be linked to my account:

Student 1: Last Name: _____ First Name: _____ Grade: _____ School ID # _____

Student 2: Last Name: _____ First Name: _____ Grade: _____ School ID # _____

Student 3: Last Name: _____ First Name: _____ Grade: _____ School ID # _____

Student 4: Last Name: _____ First Name: _____ Grade: _____ School ID # _____

OFFICE USE

Verified by: _____ Date: _____ Entered by: _____ Date: _____

Audubon Public Schools

350 Edgewood Avenue, Audubon, New Jersey 08106-2299
Phone (856) 547-7695 • Fax (856) 546-8550
www.audubonschools.org

RELEASE FOR STUDENT RECORDS/VERBAL INFORMATION

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

D.O.B.: _____

School Last Attended: _____ **Grade Last Attended** _____

Address _____
Bldg.# *Street* *City* *State* *Zip Code*

Tel. No. ( ) _____ **Fax No. ( )** _____

This child has registered in our school for the current year. Please forward the following information:

- ☐ Official Transcript
- ☐ Standardized Test Records
- ☐ Health Records
- ☐ Others _____
- ☐ State Issued ID (**SID #**)
- ☐ Disciplinary Records
- ☐ **Special Education & Related Services Records**

To the school / office checked below:

☐ **HAVILAND AVENUE ELEM. SCHOOL**
240 South Haviland Avenue
Audubon, NJ 08106
Phone: 856-546-4922
Fax: 856-547-1248

☐ **MANSION AVENUE ELEM. SCHOOL**
300 Mansion Avenue
Audubon, NJ 08106
Phone: 856-546-4926
Fax: 856-547-1483

☐ **JR/SR HIGH SCHOOL**
350 Edgewood Ave.
Audubon, NJ 08106
Phone: 856-547-7695
Fax: 856-547-1901

To Whom It May Concern:

This will serve as authorization to send the records requested above to the Audubon Public Schools.

_____ _____
Parent / Guardian Printed Name **Parent / Guardian Printed Name**

_____ _____
Parent / Guardian Signature **Parent / Guardian Signature**

_____ _____
Date **Date**

Audubon Public Schools
350 Edgewood Avenue, Audubon, New Jersey 08106-2299
Phone (856) 547-7695 • Fax (856) 546-8550
www.audubonschools.org

HEALTH HISTORY

Student Name _____ **Grade** _____

Date of Birth _____ **Age**_____ **Sex:** **Male** **Female**

Does your child have any of the following:

	No	Yes	
Allergy: • Bee Sting • Food • Medication **Epinephrine Ordered by Doctor**			bee sting reaction: _____ food & reaction: _____ medication & reaction:_____ AllergyEmergencyTreatmentPacket
Allergies: Hayfever/Seasonal			season & symptoms:
ADD/ADHD			
Anemia			
Asthma			mild___ severe___ AsthmaActionTreatmentPlan.pdf - required by N.J. law
Behavioral Issues			
Broken Bone History			
Cardiac Condition			
Chronic Constipation			
Developmental Delay			
Dental Problems			
Diabetes			
Eczema			
Fainting Spells			
Frequent Ear Infections • Earaches • Hearing Loss • Tubes in Ears			
Headaches			
Muscle Problems			
Nosebleeds			
Physical Handicap			
Premature or Low Birth Weight			
Seizures/Epilepsy/Tics			
Speech Difficulty or Delay			
Stomachaches			
Vision problem • Color Deficiency • Corrective Lenses • Patch			type of corrective lens?_____ right_____ left_____

Has your child had any of the following:

Illness	No	Yes	Date(s) of Illness
Chickenpox			
Measles			
Mumps			
German Measles			
Lyme Disease			
Strep. Infection			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Hepatitis (type)			
Mononucleosis			

Student Name _____ Date of Birth_____

Is your child currently receiving daily medication? **NO**☐ **YES**☐

- If YES, please give name of medication, amount and reason: _____
- Will your child require the medication during school hours? **NO**☐ **YES**☐

Prescription/NonPrescriptionMedicationForm must be completed by parent and doctor for any medication, including over the counter medication, which needs to be given during school hours.

Was a health problem and/or handicap present at birth? **NO**☐ **YES**☐

- At what age was diagnosis made? _____
  Diagnosis:_____

List any operations, injuries or hospitalizations and dates:

Operations/Injuries/Hospitalizations	*Date*
_____	_____
_____	_____
_____	_____

- Do any of the conditions still affect your child? **NO**☐ **YES**☐
- If YES, please list_____
- Physical Ed Activity: Does condition restrict his/her activities? **NO**☐ **YES**☐

Do you have any concerns about your child's health? If so, please describe_____
_____

I give permission for health concerns to be shared with appropriate staff having contact with my child.
YES☐ **NO**☐

Routine screenings are performed, in the Audubon Public schools, by certified school nurses as part of a comprehensive health program required by New Jersey law. Pupils can be exempted from screenings with a written request from the parent/guardian.

Authorization for Medical Treatment

*I/We, the undersigned, do hereby authorize officials of the Audubon School District to contact directly the persons named on the "**EMERGENCY CONTACT INFORMATION**" and do authorize the appropriate school personnel to render first aid as may be deemed necessary in an emergency, for the health of the said child. Pertinent medical information may be shared with school personnel as needed.*

*In the event that parents or other persons named on the "**EMERGENCY CONTACT INFORMATION**" cannot be contacted, the school officials are hereby authorized to take whatever action necessary in their judgment, for the health of aforesaid child, including transportation to the nearest medical emergency facility.*

I will not hold the Audubon School District financially responsible for the emergency care and/or transportation for said child.

Name of Child's Doctor:_____**Telephone #**_____
Date of Last Medical Exam: _____

Name of Child's Dentist:_____**Telephone #**_____
Date of Last Dental Exam: _____

Health Insurance Information: Does your child have health insurance?

YES____ Name of Insurance:_____
Name of Subscriber: _____
I.D. Number:_____
Group Number:_____

NO____ Do you want Medicaid/NJ Family Care to contact you about free or low-cost health insurance? No____Yes____

Parent/Guardian Printed Name_____**Signature** _____Date_____

Parent/Guardian Printed Name_____**Signature** _____Date_____

Information Regarding
SEMI Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program does not impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one)_____Mailed to parent(s)_____Emailed to parent(s)_____IEP meeting_____Hand Delivered

AUDUBON PUBLIC SCHOOLS CHILD STUDY TEAM

350 Edgewood Avenue, Audubon, New Jersey 08106
Phone: (856) 547-7695, ext. 4152 Fax: (856) 547-2303

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Audubon School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in your child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

Please complete the information on the form, sign and return it at your earliest convenience to the address above. Elementary students may return the form in a sealed envelope labeled CST to their teacher who will forward it to the Child Study Team office. High school students may return the form in a sealed envelope to the Child Study Team office. Thank you.

As parent/guardian of the child named below, I give permission to disclose information as described above and II understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Date: _____ / _____ / _____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting the administrator at your child's school, in writing.

Audubon Public Schools

350 Edgewood Avenue, Audubon, New Jersey 08106-1545
Phone (856) 547-7695 • Fax (856) 546-8550
www.audubonschools.org

STUDENT RESIDENCY VERIFICATION

STUDENT NAME_____ **GRADE**_____

School: ☐ Haviland Avenue Elementary School ☐ Mansion Avenue Elementary School ☐ Jr/Sr High School

In accordance with New Jersey state law (NJSA 18A:38-1 and 18A-7B-12), it is necessary to determine the residency of students entering the school district.

Please indicate the applicable student resident facility:

1 . ☐ Own my own residence within Audubon Borough

2. ☐ I have a contract with the Audubon Park Mutual Housing Authority

3 . ☐ Rent my residence within Audubon Borough

4 . ☐ Share housing and expenses in Audubon Borough with family member/friend *by choice* (Affidavid needed)

5 . ☐ Reside with family member/friend in Audubon Borough due to *economic hardship*

6 . ☐ Reside in domestic violence shelter/runaway youth shelter / other shelter, or any other transitional living program

7 . ☐ Reside in motel, hotel, park, or campground due to lack of adequate housing

8 . ☐ Reside in car or RV or in a public place (such as a bus station)

9 . ☐ Reside in sub-standard housing, such as an abandoned building

10 . ☐ Student(s) awaiting foster care placement

11. ☐ Parents are migrant workers

12. ☐ Reside in home for adolescent school-age mothers

13. ☐ My student is School Choice Program and we reside in_____

13. ☐ Other: Please explain - _____

☐ **NONE OF THE ABOVE SITUATIONS APPLY**

_____	_____	_____
Parent / Guardian Printed Name	**Parent / Guardian Printed Name**	**Date**
_____	_____	_____
Parent / Guardian Signature	**Parent / Guardian Signature**	**Date**

-OR-

_____	_____	_____
Unaccompanied Youth – Print Name	**Unaccompanied Youth-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.