



Pennsauken Public Schools

1695 Hylton Road, Pennsauken, New Jersey 08110 | 856-662-8505 | www.pennsauken.net

Acknowledgement of Residency Policies and Procedures

STUDENT NAME: _____

Please PRINT

(First Name)

(Last Name)

Date of Birth: _____

____ / ____ / ____

School Year: _____

____ / ____

Grade: _____

Dear Parent/Guardian

The Pennsauken Board of Education has policies and procedures related to **"Proof of Domicile"** (residence) for students who attend our schools. The District shall only provide a Free public education to those students who are domiciled within the District or who otherwise qualify for a free public education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 and N.J.A.C. 6A:22-1.1 et seq. A student shall be domiciled in the District "when he or she is the child of a parent or guardian whose domicile is located within the school district" –N.J.A.C. 6A:22-3.1(A)(1). A person's domicile is where his permanent home is located, and "a home is permanent when the parent or guardian intends to return to it when absent and has no present intent of moving from it..."

If the District discovers that a student is attending school whose parents are NOT domiciled within the District and who is NOT otherwise eligible for a free public education, the District may apply for the student's removal and seek tuition reimbursement for a period of ineligible attendance in accordance with provision of N.J.S.A. 18A:38-1(b)-(2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense. N.J.S.A. 18A:38-1 (c). if imprisoned for up to 6 months-N.J.S.A. 2C:43-3; N.J.S.A. 2C:43-8.

Any false statements, answers, or declarations contained in the Affidavit or in applications for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C: 28-2. If convicted for such a crime, the applicant may be punished by a fine of \$10,000.00 and/or be imprisoned for up to 18 months – N.J.S.A. 2C: 43-3; N.J.A.C. 2C:43-6.

Please Check which one applies:

____ Homeowner

____ Renter w/ Lease

____ Living w/ Homeowner

____ Living w/ Renter

I, the undersigned, hereby acknowledge that I have read and understand the contents of these Residency policies and procedures.

Printed Name of Parent/Guardian

EMAIL

Signature of Parent/Guardian

Date

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services ([U.S. ED EL Toolkit](#), Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: _____ Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

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

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

_____ **No** _____ **Yes**

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

_____ **No** _____ **Yes**

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

_____ **No** _____ **Yes**

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

_____ **No** _____ **Yes**



Pennsauken Public Schools - Registration

1695 Hylton Road, Pennsauken, NJ 08110

(856) 662-8505 | FAX (856) 662-5210

www.pennsauken.net

STUDENT REGISTRATION FORM

IMPORTANT: This registration application can only be processed if the parent/legal guardian has met with the Registrar to validate **ORIGINAL** documents. To avoid delay, all forms must be **FILLED-OUT** and **DOCUMENTS MUST BE COMPLETE** at the time of the scheduled appointment.

DATE: _____

School Year _____

STUDENT INFORMATION

Student Gender: _____ Male _____ Female Grade: _____

LAST NAME: _____

FIRST NAME: _____ Middle Name: _____

Date of Birth: _____ CITY of Birth: _____
Month Day Year

STATE of Birth: _____ COUNTRY of Birth: _____

HOME ADDRESS: _____

Apt #: _____ City: _____ State: _____ Zip Code: _____

Home Language: _____ Child's Primary Language: _____

REQUIRED: Please complete a **Home Language Survey** at the time of your appointment.

Registrar's initials when completed _____ Parent's initial when completed _____ Date: _____

ETHNICITY & RACE OF STUDENT: (Check all that apply)

☐	Hispanic or Latino: a person having origins in any of the original people of Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race.
☐	Non-Hispanic or Latino
☐	American Indian/Alaskan Native: a person having origins in any of the original peoples of North and South America including Central America and who maintains cultural identification through Tribal affiliation or Community attachment.
☐	Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
☐	Black or African American: a person having origins in any of the original peoples of Africa.
☐	Native Hawaiian or other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
☐	White: a person having origins of the original peoples of Europe, the Middle East, or North Africa

Date Entered U.S.: _____ Date Entered U.S. Schools: _____

PRIOR SCHOOL DISTRICT & HOME ADDRESS INFORMATION: *(if applicable)*

Prior Home Address: _____
City: _____ State: _____ Zip Code: _____ Telephone: _____
Prior SCHOOL Name: _____ Prior School Grade: _____
Prior School District: _____ Prior School County: _____
Prior School Address: _____
City: _____ State: _____ Zip Code: _____ Telephone: _____
Was the Student Retained? _____ Yes _____ No If yes, what grade? _____

PARENT(S) / GUARDIAN(S) INFORMATION:

Is there a **CUSTODY** agreement in place for this student? _____ Yes _____ No
(If, YES, a copy MUST be provided)

Guardian #1 Information: *(Information provided is used as PRIMARY contact)*

FULL Name: _____ Relation to Student: _____
Home Address: _____
Apt#: _____ City: _____ State: _____ ZIP Code: _____
****EMAIL:** _____
Primary Phone #1: _____ Cell Home Work
Secondary Phone #2: _____ Cell Home Work
Name of Employer: _____ Telephone #: _____
Are you a current **teaching** staff member of Pennsauken Public Schools? _____ Yes _____ No
Are you a current **non-teaching** staff member of Pennsauken Public Schools? _____ Yes _____ No

Guardian #2 Information:

FULL Name: _____ Relation to Student: _____
Home Address: _____
Apt#: _____ City: _____ State: _____ ZIP Code: _____
****EMAIL:** _____
Primary Phone #1: _____ Cell Home Work
Secondary Phone #2: _____ Cell Home Work
Name of Employer: _____ Telephone #: _____
Are you a current **teaching** staff member of Pennsauken Public Schools? _____ Yes _____ No
Are you a current **non-teaching** staff member of Pennsauken Public Schools? _____ Yes _____ No

Do you have health insurance coverage for your child? _____ Yes _____ No
If not, would you like an application for NJ Family Care Insurance? _____ Yes _____ No

EMERGENCY CONTACT (S)	
Full Name: _____	Relation to student:
Telephone #: _____ Email: _____	Permission to pick up from school? ____ Yes ____ No
Full Name: _____	Relation to student:
Telephone: _____ Email: _____	Permission to pick up from school? ____ Yes ____ No
Full Name: _____	Relation to student:
Telephone: _____ Email: _____	Permission to pick up from school? ____ Yes ____ No

Are there sibling(s) currently attending Pennsauken Public Schools?
Yes
No

SIBLING NAME	DATE OF BIRTH	SCHOOL	GRADE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SPECIAL EDUCATION / 504 PLAN / RELATED AIDS OR SERVICES
(CHECK All Services your child receives)

Basic Skills Instructions (BSI)
504 Plan (Please provide a copy)
English Language Learner (ELL) / Multi-Lingual (ML)
Special Education / I.E.P. (please provide a copy)

****REQUIRED:** Please complete a SCHOOL MEAL application at the time of your appointment.
Parent's initials: _____

I /We CERTIFY all the information is true and correct and understand school officials may verify the information.

PRINT Parent/Guardian Name	SIGNATURE Parent/Guardian	Date
PRINT Parent/Guardian Name	SIGNATURE Parent/Guardian	Date

PLEASE DO NOT FILL BELOW THIS LINE

OFFICE USE ONLY
REGISTRAR MUST CHECK DOCUMENTS SUBMITTED
OFFICE USE ONLY

Property/Homeowner	Renters	Living w/ Homeowner	Living w/ Renter	CUSTODY / Other	STUDENT RECORDS	OTHER
☐ ID Parent/Guardian ☐ Tax Bill ☐ Tax Assessment ☐ Property DEED ☐ Mortgage Statement ☐ _____	☐ ID Parent/Guardian ☐ Form A-1 Parent/Guardian ☐ 2 Proofs of Address ☐ Signed Lease ☐ Form C – Sworn statement of Owner/Landlord	☐ ID Parent/Guardian ☐ Form A-1 (Parent/guardian) ☐ 2 Proofs of Address ☐ Form A (Homeowner) ☐ Proof of ownership ☐ Homeowner's ID	☐ ID Parent/Guardian ☐ Form A-1 Parent/Guardian ☐ 2 proofs of address ☐ Lease ☐ Form A – Renter ☐ Renters ID ☐ Form C – Sworn Statement of Owner/Landlord	(if applicable) ☐ Custody Order ☐ State Agency Placement ☐ Foster ☐ DCF/DCPP ☐ Guardianship ☐ Other Legal documents	☐ Original Birth Certificate ☐ Transfer Card ☐ Report Card ☐ Test Scores ☐ High School Records ☐ Health Record ☐ Immunizations ☐ Physical If applicable: BSI ____ 504 ____ IEP ____ ELL/ML ____	Grade Level: _____ School: _____ Family Code:(if applicable) _____ STATE ID: _____ ☐ School Meal Application Completed & Sent to Food Dept ☐ Home Language Survey ☐ Child of BOE employee Teaching ____ Non-Teaching ____

Enrolled in:
☐ Charter
☐ Choice
☐ Vocational
☐ Pennsauken District

Entered by: _____
Date: _____

**PENNSAUKEN PUBLIC SCHOOL
ADMINISTRATION OFFICES**

1695 Hylton Road
Pennsauken NJ 08110
(856)-662-8505

REQUEST FOR OFFICIAL RECORDS

DATE OF REQUEST: _____ Sent via ☐ Mail ☐ Fax ☐ E-mail ☐

PREVIOUS SCHOOL: _____

NAME OF SCHOOL DISTRICT: _____

PREVIOUS SCHOOL ADDRESS: _____

STREET

CITY

STATE

ZIP

PHONE: _____ FAX: _____

Student: _____	Grade: _____
Has enrolled in: _____	

PLEASE SEND US THE FOLLOWING RECORDS:

1. TRANSCRIPT (or cumulative record) of academic work including an explanation of your grading system
2. GRADES from classes presently in progress
3. STANDARDIZED TEST RESULTS (including the NJASK, 3, 4, 5, 6, 7: GEPA, or HSPA)
4. ATTENDANCE and other administrative information
5. HEALTH RECORDS (Medical and Immunizations)
6. DISCIPLINE RECORDS
7. **SPECIAL EDUCATION RECORDS (Request will be sent under separate cover from Student Support Services. Do not forward with above request records)**

PLEASE FORWARD THE ABOVE RECORDS TO:

School: _____

Address: _____

Attn: _____

Phone: _____ Fax: _____

We appreciate your immediate attention to this request. The records are needed to make an accurate educational placement. If more than one department is involved, please forward this request to that department.

Signature of Parent or Guardian

Relationship to Student

Date

PENNSAUKEN PUBLIC SCHOOL

Student Support Services

(856) 662-8500 ext. 5247

(856) 910-2623 (fax)

REQUEST FOR SPECIAL EDUCATION OFFICIAL RECORDS

DATE OF REQUEST _____ sent via: mail ☐ fax ☐ email ☐

PREVIOUS SCHOOL _____

NAME OF PREVIOUS SCHOOL DISTRICT _____

PREVIOUS SCHOOL ADDRESS _____

(City) _____ (State) _____ (Zip Code) _____

PHONE _____ FAX _____

STUDENT:	GRADE:
HAS ENROLLED IN:	

PLEASE SEND US THE FOLLOWING SPECIAL EDUCATION RECORDS

- | | |
|-----------------------------|---|
| 1. Psychological Evaluation | 6. Psychiatric Evaluation |
| 2. Social Evaluation | 7. Speech Evaluation |
| 3. Learning Evaluation | 8. Individualized Education Program (IEP) |
| 4. Eligibility Conference | 9. Health Records |
| 5. Neurological Evaluation | 10. Other |

.....

PLEASE FORWARD THE ABOVE SPECIAL EDUCATION RECORDS TO:

Pennsauken High School
Student Support Services
800 Hylton Road
Pennsauken, NJ 08110

We appreciate your immediate attention to this request. The records are needed to make any accurate educational placement. If more than one department is involved, please forward this request to that department.

Signature of Parent/Guardian

Relationship to Student

Date

EMERGENCY INFORMATION VERIFICATION FORM

Current School:		School Year:	Grade:	Homeroom:	
Student's Full Name: _____ Current Address: _____ _____			Date of Birth:	Gender:	
			Court Order / Legal Restrictions: ☐ Yes (Please, provide a copy) ☐ No		
Please include the company name for Work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used if we cannot reach the other numbers listed. The "Primary" will be used for ATTENDANCE auto-dialer.					
PARENT/GUARDIAN #1 Name: (PRIMARY)		Primary Telephone #:		Email:	
Relation to student:		Work/Company Name		Work/Company Telephone:	
Parent/Guardian #2 Name:		Telephone #:		Email:	
Relation to Student:		Work/Company Name:		Work Telephone:	
EMERGENCY #1 Name:		Telephone #:		Email:	
Relation to Student: ☐ Permitted to pick up from school?		Work/Company Name:		Work/Company Telephone:	
Emergency #2 Name::		Telephone #		Email:	
Relation to Student: ☐ Permitted to pick up from school?		Work/Company Name:		Work/Company Telephone:	
Emergency #3 Name:		Telephone:		Email:	
Relation to Student: ☐ Permitted to pick up from school?		Work/Company Name		Work/Company Telephone	

HEALTH INFORMATION: Please list any Medical alerts/allergies: Receives daily medication during school hours: YES NO Wears glasses and/or contact lenses: YES NO		This student's health information may be shared with pertinent school staff if necessary to maintain well-being and safety. ATTENDANCE: Parent/Guardian MUST call the school if the student will be absent or late. _____ initials _____ Signature Date	
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Health care provider information (for emergency treatment when we are unable to contact you):		
Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

Does your child have health insurance coverage? Yes No If yes, what is the name of the Insurance Company?		PERMISSION: Please SIGN to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency. _____ Signature Date	
--	--	---	--

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. ☐ Yes, you may release my name and address to NJ FamilyCare Program to contact me about health insurance.			
Parent/Guardian Signature		Printed Name	Date

For School Use Only:	Genesis ID#:	STATE ID#
	Date updated in Database:	Initials:

HEALTH FORMS

www.pennsauken.net > Registration > HEALTH SERVICES > Required Enrollment Health & Physical Forms

Student REQUIRED health documents:

- ☐ Immunization/Vaccination Record
- ☐ Physical examination record

Please fill out all Health Forms:

- ☐ Emergency Information Verification Form
- ☐ Health History Questionnaire (2 pages)
- ☐ Physical Exam Notification (Acknowledgement of Required Physical)
- ☐ Medication Administration Policy
- ☐ Permission Form for School Health Services
- ☐ Universal Child Health Record - Physical
- ☐ Required Immunization Acknowledgement Form
- ☐ Tylenol/Advil Permission Form (*ONLY for Middle & High School Students Grades 6 - 12*)

www.pennsauken.net > Registration > HEALTH SERVICES > Required Enrollment Health & Physical Forms

**PENNSAUKEN PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES**

HEALTH HISTORY QUESTIONNAIRE

Child's Name _____ Birth Date _____ Gender: male ☐
female ☐

Parent/Guardian Name _____

PERINATAL / BIRTH HISTORY (PreK-6 Only)

Did mother have any problems/illnesses during the pregnancy or birth? Yes ☐ No ☐

If yes, explain briefly _____

Was child born full term _____ early ☐ late ☐ ?

What was child's birth weight? _____

Did your child have any illnesses or problems as a newborn?

Yes ☐ No ☐ If yes, explain briefly _____

HEALTH CONDITIONS HISTORY

	YES	NO	YEAR
Allergies			
Asthma			
Cardiac (heart) condition/problem			
Chicken Pox			
Diabetes			
Frequent colds			
Frequent Ear Infections			
Frequent headaches			
Frequent nosebleeds			
Frequent stomachaches			
Frequent throat infections			
Hearing Problems			
Hemophilia			
High fever (>104 degrees for 2 days or longer)			
Meningitis			
Seizures			
Sickle Cell Disease			
Toothaches/Dental Problems			
Tubes placed in ears			
Vision Problems			

If yes to any of the above, please describe _____

over

How often is your child sick? often ☐ occasionally ☐ not often ☐

Is your child currently taking any medication? Yes ☐ No ☐

If yes, please list the name of the medications and how often medication is taken:

Name of Medication	How Often is Medication Taken
none	

Will your child need to take this medication(s) in school? Yes ☐ No ☐

Has your child ever been hospitalized? Yes ☐ No ☐

If yes, please explain _____

Are there any additional health concerns that you would like the nurse and/or school staff to be aware of?

Primary Physician:

Name: _____ Phone: _____

Do you have health insurance for your child? Yes ☐ No ☐

If yes, child's health insurance coverage plan: _____

If no, you may release my name and address to NJ Family Care Program to contact me about health insurance. Yes ☐ No ☐ Apply online at www.njfamilycare.org or call 800-701-0710

I GIVE PERMISSION TO THE SCHOOL NURSE TO SHARE ANY OF THE ABOVE INFORMATION WITH THE APPROPRIATE SCHOOL PERSONNEL:

Parent/Guardian Signature: _____ Date: _____

**PENNSAUKEN PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES**

PHYSICAL EXAM NOTIFICATION

Dear Parent/Guardian,

All students in Pennsauken are required to have documentation of a physical examination upon entry into school. According to New Jersey Department of Education regulations and school district policy, **this physical exam must be done by your family doctor.** Please have your doctor complete the attached Universal Child Health physical form and return it to school.

If you do not have a family doctor or you do not have health insurance for your child, please contact me at school for assistance.

Please sign the letter below for our files. Thank you.

School Nurse
Pennsauken Public Schools

Name of Student

Parent/Guardian Signature

Date

PENNSAUKEN PUBLIC SCHOOLS MEDICATION POLICY

The following are policy requirements for students requiring medication during school hours:

1. Written orders from the student's doctor for dispensing the medication.
2. Written permission from the parent/guardian.
3. Medication must be in the original container for both prescription and non-prescription medications.
4. No student under age 18 is permitted to carry medication to school. All medication must be transported to and from school by the parent/guardian or a designated adult.

Medications cannot be dispensed unless all of the above requirements are met.

The medication requirements are also outlined in your student/parent handbook for reference.

Please sign, detach and return

MEDICATION POLICY

AGREEMENT

We have read the above requirements and agree to comply with them.

Parent/Guardian Signature

Date

Student Name

Grade

**PENNSAUKEN PUBLIC SCHOOLS
SPECIAL SERVICES DEPARTMENT**

PERMISSION FOR SCHOOL HEALTH SERVICES

I hereby give permission for my child, _____,
to receive the following medical attention as part of the school health services program in
Pennsauken Public Schools:

1. A Mantoux intradermal test for tuberculosis for specified students as mandated by New Jersey Department of Health and Senior Services.
2. Vision, hearing, height and weight screenings according to New Jersey School Health Services Guidelines.
3. Scoliosis screening by the school nurse or certified trained professionals. All students ages 10 through 18 years of age are required to have this exam in New Jersey every other year.

I understand that I will be notified by the school nurse if any problems are found as a result of these screenings.

I give permission for my child to be taken to _____ Hospital
for treatment, in case of emergency, if I cannot be reached.

Parent Signature: _____ Date: _____

Address: _____

Telephone: (HOME) _____

(WORK) _____

(EMERGENCY CONTACT) _____

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 health 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.



Pennsauken Public Schools

Required Immunization Acknowledgement – Health Forms

Dear Parent/Guardian:

By State law, in order to be enrolled in any school in New Jersey, a complete immunization record must be presented at the time of enrollment. **NO** child can be admitted into school without a complete immunization record.

http://nj.gov/health/cd/imm_requirements

Students entering **Pre-K** **must** have the following immunizations:

DTaP:	4 doses
POLIO:	3 doses
MMR:	at least 1 dose after the age of 1 (12 months)
Varicella:	at least 1 dose after the age of 1 (12 months) unless your child had chicken pox – need to provide school with either: 1. Documented laboratory evidence showing immunity 2. A physician written statement that the child previously had the chicken pox or 3. A parent's written statement that the child previously had the chicken pox
HIB:	at least 1 dose given on or after 1 st birthday
PCV:	at least 1 dose given on or after 1 st birthday

Students entering **Kindergarten** **must** have the following immunizations:

DTaP:	4 doses with 1 dose given on or after the 4 th birthday, or any 5 doses
POLIO:	3 doses with 1 dose given on or after the 4 th birthday, or any 4 doses
MMR:	2 doses on or after the 1 st birthday
Varicella:	1 dose on or after the 1 st birthday
Hepatitis B:	3 doses

Students entering **6th grade** **must** have the following immunizations:

Meningococcal:	1 dose given no earlier than 10 years of age
Tdap:	1 dose given on or after 11 th birthday

Seasonal Influenza: required for those children 6 months through 59 months of age each year. Students must have the vaccine by December 31st.

It is the responsibility of the parent or guardian to provide proof of all required immunizations before the start of the school year. Over the summer months, proof of immunizations may be dropped off at the student's assigned school for the nurse or main office. If you have a doctor's appointment for your child in September or October, please provide a written note from the doctor stating the date of the appointment and the immunization(s) to be administered. Parents who register their children over the summer or after the school year begins are subject to the same requirements. If you are unsure whether your child has received the required immunizations, please check with your child's pediatrician or the school nurse. _____ parent/guardian initials

****IMPORTANT:**

Children who do not have the required immunizations will be excluded from attending school, even if registered.

I acknowledge that I have read the guidelines relating to the immunization of my child(ren) prior to entering Pennsauken Public Schools.

Parent/Guardian (printed)

Parent/Guardian (signature)

Date