Haddon Township Schools Registration Form

Office Use Only: Student Number: _____
Student Registration Form 11/1/2016

School: _____

Student Information

Last Name _____ **Phone** _____

First Name _____ MI ____ **Grade** _____ Male [ ] Female [ ]

Street Address _____ *First Date of Entry* _____
Haddonfield 08033 [ ] Westmont 08108 [ ] Oaklyn 08107 [ ] W. Collingswood Ext. 08107 [ ] W. Colls Hgts 08059 [ ] W. Colls 08104 [ ]

Date of Birth _____ **Place of Birth** (City and State)_____

Proof of Residency: Tax Bill [ ] Deed/Lease Agreement [ ] Utility Bill [ ] Other (specify) _____
Driver's License [ ] Affidavit of Temp Residency [ ] _____

Ethnicity: Is the student Hispanic or Latino? Yes____ No____
Race Category (check all that apply):
White [ ] Black/African American [ ] Asian [ ] American Indian/Alaskan Native [ ] Native Hawaiian/Other Pacific Islander [ ]

Previous School and District Attended: _____

- Has the student ever been referred to the Child Study Team for evaluation? Yes [ ] No [ ]
- Is the student eligible to receive Special Education services? Yes [ ] No [ ] If Yes, what kind?_____
- Is the student eligible for 504 services? Yes [ ] No [ ] If yes, what kind? _____
- Will the student be eligible for Free or Reduced Lunch? Yes [ ] No [ ] N/A [ ] Unknown [ ]
- Is the student receiving any related services? Yes [ ] No [ ] Which? _____(OT, PT, Speech, Counseling)
- Has the student attended Haddon Township Schools before? Yes [ ] No [ ] If Yes, which school(s)? _____ Dates: _____
- Is another language besides English spoken in the home? Yes [ ] No [ ] If yes, what language(s)? _____Which dialect? _____
- Did the student receive ESL (English as a Second Language) services at their former school? Yes [ ] No [ ]

Head(s) of Household Information

Student Lives with: Both Parents [ ] Father [ ] Mother [ ] Foster Parent [ ] Guardian [ ]Relationship _____

Name _____ Employer _____
Last First MI
Email (if checked regularly): _____ Work Phone:_____ Cell Phone: _____

Name _____ Employer _____
Last First MI
Email (if checked regularly): _____ Work Phone:_____ Cell Phone: _____

Non - Resident Parent

Name _____ Address _____
Last First MI
Home Phone: _____ **Email (if checked regularly):** _____
Employer _____ Work Phone:_____ Cell Phone:_____

Emergency Contact (other than parent)

Name of Contact _____ Phone Number _____ Relationship to Student _____

Medical Conditions/Allergy ALERTS

_____

Physician: _____ Phone #: _____ Hospital Preference: _____

LEGAL ALERTS:

_____

Signature of Person Completing Form: _____ Date _____

Siblings and Others in Household

Last Name	First Name	Gender	Date of Birth	Name of School Currently Attending (if applicable)	Grade	Relationship to Student

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)

Signature/Date

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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.

Haddon Township Public Schools
Annual Health History Update

Dear Parent/Guardian:

This form lists medical conditions that your son/daughter may have experienced in the past or currently experiences. The updated information enables the Health Office to respond in case of an emergency. Please complete and return this form to the School Nurse as soon as possible.

Thank you.

1. Has the student been advised not to participate in any activity or sports? Yes No
   If yes, please explain: _____

   _____

2. Has the student had any major illness since his/her last medical exam? Yes No
   If yes, please explain: _____

   _____

3. Has the student been hospitalized since his/her last medical exam? Yes No
   If yes, please explain: _____

   _____

4. Has the student had any injury or surgery since his/her last medical exam? Yes No
   If yes, please explain: _____

   _____

5. Has the student had any special test such as x-rays, bone scan, EKG, CT, MRI, etc? Yes No
   If yes, please explain: _____

   _____

6. Has the student been under the care of a physician for any other medical conditions? Yes No
   If yes, please explain: _____

   _____

7. Is the student currently taking any medications on a regular basis? Yes No
   If yes, please explain: _____

   _____

8. History of asthma and/or allergies (including medications, food, bee stings, etc.): Yes No
   If yes, please explain: (Use of inhaler, Epi-pen, Benadryl, etc.) _____

   _____

____ Yes, you have my permission to share this information with appropriate faculty/staff members.

____ No, please do not share this information.

Student Name: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Does child have Health Insurance?

Yes ____ If 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 & address to NJ FamilyCare Program to contact me about health insurance.

_____ _____ _____

Signature Printed Name Date

Written consent required pursuant to 20 U.S.C.§1232 g (b)(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child has received during the past year:

Dental Exam _____ (date) _____ (braces)

Eye Exam _____ (date) _____ (contacts) (glasses)

Allergy _____ (kind) _____ (medications)

Allergic Reactions _____ (date) _____ (medications)

Immunizations/Tetanus _____ (date) _____ (type)

Restrictions _____ (type)

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Hospital _____ Telephone _____

Address _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

_____ _____

Signature of Parent(s) / Guardian(s) Date

RELEASE FORM FOR PRESCHOOL DISMISSAL

My child may be released to the following persons:

_____

_____

_____

_____

_____

_____

_____

Child's Name_____

- I give my permission to release my telephone number and address to other parents in my child's class.
- ___YES ___No

_____ _____

Parent/Guardian Signature Date

Important
INFORMATION

Child's Name: _____

Home School: _____

Mark #1 and #2 preference for Preschool Program...

- **Session Preference**: A.M. [ ]
  P.M. [ ]

  Reason:

  _____

  _____

  _____

- **School Preference***: Edison [ ]
  Van Sciver [ ]
  Stoy [ ]

  **These are the current locations of the programs, but we cannot guarantee classes will be held at these schools next year.*

  Reason:

  _____

  _____

  _____

HADDON TOWNSHIP BOARD OF EDUCATION

500 RHOADS AVENUE • WESTMONT, NEW JERSEY 08108
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ALL APPLICANTS MUST CHECK ONE BOX WHEN REGISTERING FOR HADDON TOWNSHIP SCHOOL DISTRICT PRESCHOOL:

☐ I am NOT applying for Tuition Free Preschool Program

☐ I am applying for Tuition Free Preschool Program *(Temporary Eligibility)*
(Please complete attached application form)

Please note: Proof of income must be resubmitted for final approval. You will be contacted by the Board of Education prior to the start of the school year.

Parent Name:	
Child's Name:	
Street Address:	
City, State, Zip:	
Phone:	

1/6/16

HADDON TOWNSHIP BOARD OF EDUCATION
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WESTMONT, NEW JERSEY 08108
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WEBSITE: www.haddontwpschools.com

2424. PRESCHOOL PROGRAM

The Board of Education supports a Preschool Program for all children who have attained the minimum age of three years on or before October 1st of the year in which entrance is sought and have not yet attained the age at which admission to Kindergarten is permitted. In February, the district will schedule a Preschool Round-up in order to register students who will meet the admission criteria the following school year. Based on the number of pupils enrolled at the Preschool Round-up, the Superintendent will recommend the number of classes for the following school year to be included in the District's budget.

The Board of Education will annually set a tuition rate for students to attend the district's Preschool Program. Tuition paying resident families with more than one child in preschool living in the same household will pay one-half of the established tuition rate for the second child. Additional children in the same household will attend at no cost. Separate rates will be established for resident and non-resident students.

Preschool class size should not exceed 20 pupils, pursuant to Policy 5120, Assignment of Pupils.

To ensure enrollment preschool parents or guardians must complete all registration requirements prior to March 1st. A schedule of tuition payments will be disseminated to parents and guardians prior to July 30th. The first of ten equal tuition payments must be submitted upon application to the program to ensure a place in the program. Withdrawal from the program that is initiated by the family or the BOE, prior to June 1st will result in total reimbursement to the family. Subsequent tuition payments are due the 1st of each month from September through May. Enrollments received on or after March 1st will be accepted based on the availability of space. Should enrollment exceed the number of classes included in the budget, a wait list will be established in order of registration date and time.

Preschool age children of nonresident District employees will pay the established in-district tuition rate.

Upon recommendation of the Superintendent, the Board will admit nonresident pupils on a tuition basis in accordance with Policy 6150, Tuition Income, to fill available seats after July 15th.

Township residents who meet the established standard for free or reduced lunch may enroll their children tuition free. This entitlement will not be extended to non-resident pupils.

Pupils of Township residents unable to meet district academic or behavioral standards may, upon recommendation of the building principal, repeat preschool. In the event of such a recommendation, parents will not be liable for a second year's tuition.

N.J.S.A.	18A:38-3; 18A:38-19; 18A:46-21
N.J.A.C.	6A:23-3.1 et seq. through 3.4 et seq.
N.J.A.C.	6A:14-7.8
Policy 6150	Tuition Income
Policy 5120	Assignment of Pupils

Adopted: May 21, 2009
Revised: March 17, 2011
Revised: August 21, 2014
Revised: February 18, 2016

HADDON TOWNSHIP BOARD OF EDUCATION

500 RHOADS AVENUE • WESTMONT, NEW JERSEY 08108
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WEBSITE: www.haddontwpschools.com

Home Language Survey
Parent/Guardian Language Questionnaire

Name:_____ DOB: _____
[first] [middle] [last]

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Date of School Entrance_____

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent
[ ] Guardian [ ] Other _____

Directions: Check or write in the correct response for each of the following questions about your child.

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

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

   -Yes

   -No

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

   -Yes

   - No

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*?

   -Yes

   - No

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*?

   -Yes

   - No

Signature:_____ Date:_____