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

HADDON TOWNSHIP BOARD OF EDUCATION

500 RHOADS AVENUE • WESTMONT, NEW JERSEY 08108
PHONE: 856-869-7750 ext. 1100 • FAX: 856-854-7792
WEBSITE: www.haddontwpschools.com

Dear Parent/Guardian:

As we prepare to welcome your child to the Haddon Township School District, please know that we need the following items in regard to your child's medical history:

- **Physical exam/health history** - The history must include date of exam, physician/nurse practitioner's signature, height, weight, blood pressure, medications, vision and hearing screening, allergies and pertinent medical history.

- **Immunization history** – This must be a complete record of all immunizations received to date.

Per NJAC 6A: 16-2.2, **each student entering the school district must have a physical examination no more than 365 days prior to entry.** Please have your child's physician or nurse practitioner complete the enclosed physical examination form and return it along with their current immunization record to your child's school as soon as possible.

Sincerely,

Alexis A. Gray

Alexis Gray
Secretary to the Assistant Superintendent

/ag

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
  Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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

PLEASE COMPLETE THIS FORM IF STUDENT IS TRANSFERRING SCHOOLS

HADDON TOWNSHIP PUBLIC SCHOOLS
HADDON TOWNSHIP, NEW JERSEY

Parent Authorization for Release of School Records

_____
Name of School or District Transferring From

_____
Street Address

_____ FAX: _____
City *State* *Zip Code*

In accordance with the Family Education Rights Privacy Act, Governing Board Policy and NJ State Law, the above-named school is hereby authorized to release to the school named below all school records including: grade transcripts, discipline records, pupil progress reports, standardized test scores, special education records, psychological evaluations, social, educational or developmental information and school health records including immunizations and the **A-45 State of NJ Health History and Appraisal** regarding:

Name of Student	*Grade*	*Date of Birth*	*School Assignment*

Date: _____ _____
Signature of Parent / Guardian

Request for Transcript of School Records:

Please send all school records for the above-names child(ren) who is/are enrolled in the Haddon Township School District to the Haddon Township School in which they are assigned. Thank you.

Haddon Township School District enrollment date: _____

Edison Elementary School
205 Melrose Avenue
Westmont, NJ 08108

Jennings Elementary School
100 East Cedar Avenue
Oaklyn, NJ 08107

Stoy Elementary School
206 Briarwood Avenue
Haddonfield, NJ 08033

Strawbridge Elementary School
307 Strawbridge Avenue
Westmont, NJ 08108

Van Sciver Elementary School
625 Rhoads Avenue
Haddonfield, NJ 08033

Rohrer Middle School
101 MacArthur Boulevard
Westmont, NJ 08108

Haddon Township High School
406 Memorial Avenue
Westmont, NJ 08108

HADDON TOWNSHIP BOARD OF EDUCATION
500 RHOADS AVENUE • WESTMONT, NEW JERSEY 08108
PHONE: 856-869-7750 ext. 1100 • FAX: 856-854-7792
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:_____