Estell Manor School District

REGISTRATION FORM

128 Cape May Ave. Estell Manor, NJ 08319
(609) 476-2267

STUDENT INFORMATION

Student's Last Name:	First:	Middle:	Grade:	School:

Primary Language English: ❑ Yes ❑ No	Birth City:	Birth State:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	County:	Home Phone No.: ( )

P.O. Box:	City:	State:	ZIP Code:

Ethnicity:

❑ Hispanic ❑ White ❑ African American ❑ American Indian/ Alaskan ❑ Asian ❑ Hawaiian native/ other Pacific Islander

ADDITIONAL INFORMATION

Siblings that attend Estell Manor School District:	Name:	Grade:

Has your child been found eligible for special education services? ❑ Yes ❑ No

Does your child receive any services and/or therapy from a speech therapist? ❑ Yes ❑ No

Is your child eligible for any school accommodations based upon Section 504 eligibility? ❑ Yes ❑ No

Does this child have health insurance? (Health insurance including NJ Family Care/Medicaid, Medicare, private or other.)

❑ Yes, my child has health insurance. Name of insurance company: ____________________________________

❑ No, my child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance.
*By law, your child must have health insurance. NJ Family Care provides free or low cost health insurance for uninsured children and certain low-income parents. For more information visit www.njfamilycare.org to apply online, or call 1-800-701-0710.

Is the student a dependent of a full-time, active duty member of the Armed Forces? ❑ Yes ❑ No
(Members include: Army, Navy, Air Force, Marine Corps, Coast Guard & National Guard)

TRANSPORTATION

Nearest intersection to home:	Medical Conditions:	Notes (i.e. wheelchair, etc.):

*If the student is going to be with a babysitter, please provide the following information. The student must be transported to and from that specific location 5 days per week,and must be located within the Estell Manor School District.

Name: _________________________ Address: ____ Phone: ___________________

I give permission for the above medical condition(s) to be shared with the bus driver: ❑ Yes ❑ No

The above information completed for Estell Manor School Distrcit registration form is true to the best of my knowledge.

_______________________________________ _______________________

Patient/Guardian signature *Date*

ESTELL MANOR SCHOOL DISTRICT

128 Cape May Avenue, Estell Manor, New Jersey 08319
Phone: (609) 476-2267 Fax: (609) 476-4205
www.estellmanorschool.com

Enrollment Residency Questionnaire

Student's Name____

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

Please indicate if the student resides in any of the following facilities:

____Hotel/Motel

____Shelter

____Transitional Housing Facility

____Domestic Violence Shelter

____Runaway Youth Shelter

____Home for Adolescent school-age mothers

____Migrant Family Housing

____Family/Friend's home out of necessity (fire, flood, eviction, etc.)

____None of these situations apply.

Parent/Guardian Signature: ___________________________________Date______________________

PARENT/ GUARDIAN CONTACT INFORMATION

***Custody Papers are required if the child lives with one parent/guardian.**

Mother's Name:	
Address (if different than student's):	
City, State, ZIP:	
Email:	
Home Phone:	
Cell Phone:	Work Phone:

Father's Name:	
Address (if different than student's):	
City, State, ZIP:	
Email:	
Home Phone:	
Cell Phone:	Work Phone:

Alternative Emergency Contacts

Emergency Contact Name 1:	
Relationship:	
Cell Phone:	Home Phone:

Emergency Contact Name 2:	
Relationship:	
Cell Phone:	Home Phone:

Emergency Contact Name 3:	
Relationship:	
Cell Phone:	Home Phone:

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Home Language Survey Form

Introduction

This survey is to identify whether or not a student is eligible to be an English Language Learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the instructions.

Student Information

Student name: Student birth date:

Street Address:

City: State: Zip Code:

Phone number:

Survey Questions

Question 1

What was the first language used by the student?

____ A language other than English. Proceed to question 2a.

____ English. Proceed to question 2b.

Question 2a

At home, does the student hear or use a language other than English more than half of the time?

____ Yes. Proceed to question 3.

____ No. Proceed to question 3.

Question 2b

At home, does the student hear or use a language other than English more than half of the time?

____ Yes. Proceed to question 3.

____ No. Proceed to question 3.

Question 3

Does the student understand a language other than English?

____ Yes. Proceed to question 4.

____ No. Proceed to question 4.

Question 4

When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

____ Yes. Proceed to question 5.

____ No. Proceed to question 5.

Question 5

When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

____ Yes. Proceed to question 6.

____ No. Proceed to question 6.

Question 6

Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

____ Yes. Proceed to question 7.

____ No. Proceed to question 7.

Question 7

What are the home language(s) spoken?

____

____

____

Estell Manor SCHOOL DISTRICT
128 Cape May Ave. Estell Manor, NJ
08319
(609) 476-2267

PARENTAL PERMISSION FOR TRANSFER OF STUDENT RECORDS

This form is provided by the Estell Manor School District for the purpose of obtaining your child's school records.

I also understand that discipline records (if any) will also be transferred to my child's new school district as per NJSA 18A: 36-19A.

Name of Child____ Date of Birth______________

Address of Child____ Grade________

I HEREBY AUTHORIZE THE ESTELL MANOR SCHOOL DISTRICT to obtain all records (including psychological tests, medical, and sociological records if any) of my above named child from:

____
School or Agency

____
Street Address

____
City State Zip

_____________________ _____________________
Phone Number Fax Number

Please send records to the school designated below:

Estell Manor School District

128 Cape May Ave.

Estell Manor, NJ 08319

AS DEFINED BY THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 (PUBLIC LAW 93-380), I UNDERSTAND THAT I MAY REVIEW AND/OR RECEIVE A COPY OF THE RECORDS, IF DESIRED, AND HAVE AN OPPORTUNITY FOR A HEARING TO CHALLENGE THE CONTENT OF THE RECORDS.

___________________________ ____
Date Parent or Guardian Signature

____
Relationship

For Office Use Only
Record Request Mailed______________
Records Received__________________

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 <u>that is being used to complete the form</u>. 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 <u>www.nj.gov/health/forms/ch-15.dot</u> 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 <u>should</u> 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.