*CHOICE PROGRAM*_____

Pittsgrove Township Preschool
Registration Checklist

In order that the requirements of various state and federal laws be met, the following information is necessary for the registration of students in the Pittsgrove Township School District.

Student's name:_____ Grade _____

I. Proof of identity or Parent/Guardian with photo – **One (1) must be provided**

_____ Driver's license/State Issued ID _____Passport

II. Proof of grade placement – **One (1) must be provided**

_____ transfer card _____report card _____transcript

III. Proof of immunizations – **Must be provided** _____

IV. Proof of Physical *(if applicable)*– **Must be provided within 30 days of school entry date** _____

V. Proof of residence – **Two (2) must be provided, One (1) from List A and One (1) from List B** (parent/guardian must be named on document)

List A (1 must be provided)

_____ Lease agreement (apartment or home)
_____ Tax bill
_____ Property deed
_____ Mortgage or settlement papers
_____ Acceptance letter from Park Manager at Harding Woods, Holly Tree Acres, Picnic Grove/Tullertown or The Villages I

List B (1 must be provided)

_____Utility bill
_____Change of Address Form from Post Office
_____Bank Statement
_____Auto Insurance or registration card
_____Medicaid or Welfare Card
_____Food Stamp ID

VI. Proof of Student's Date of Birth and Relationship to Parent/Guardian - **One (1) must be provided**

_____ Birth or baptismal certificate of student
_____Legal guardian (court documentation)
_____ Foster parent (state agency documentation)

VII. Proof of custody or restricted contact *(if student does not reside with both natural parents)*

VIII. Completed registration packet **(obtained from the Board of Education Office)**

Note: New Jersey State Law – 18A:38-A
Any person who fraudulently allows a child of another person to use his residence and is not the primary financial supporter of that child and any person who fraudulently claims to have given up custody of his child to a person in another district commits a disorderly person offense.

_____ _____

Parent/Guardian Signature *Date*

Pittsgrove Township Preschool Program
(856) 358-3094

*CHOICE PROGRAM*_____

Student Registration Form

Name _____

Sex_____Grade _____

Street Address _____

Mailing Address ***(if different than street address)***_____

Home Phone Number_____Email Address: _____

Date of Birth_____City and State of Birth _____

Previously School Attended _____

Pittsgrove Township School District uses an automated telephone calling system in the event of snow closings, student absences, emergencies, and occasional school announcements. Please indicate the phone number you would like utilized for student absences. _____

Is there a second number (in addition to the primary/attendance phone numbers) which must be contacted for all automated calls from the school? _____

Children in family/household under 18 (include last name if different from this student) and age/date of birth

Name	Age	Date of Birth

Parent 1/Guardian Name_____Relationship_____

Address _____

Employer Name/Telephone Number _____

Parent 1/Guardian Home Phone _____

Parent 1/Guardian Cell Phone _____

Parent 2/Guardian Name_____Relationship_____

Address _____

Employer Name/Telephone Number _____

Parent 2/Guardian Home Phone _____

Parent 2/Guardian Cell Phone _____

(reg. cont'd)

Is student currently receiving services for:

_____Child Study Team _____Basic Skills _____504 _____Speech Services

Language spoken in home, if other than English _____

Are there any medical or physical problems that the school system should be aware of (_____) Yes (_____) No

If yes, please explain _____

Doctor's Name_____Doctor's Phone _____

If student is in high school, has the student ever participated in high school sports? (_____) Yes (_____) No

Child Resides with? _____
(Must provide documentation, if applicable)

Please provide a brief explanation of parental visitation or restricted contact if any:

_____

_____

_____

_____

_____

Second mailing needed for Non-custodial Parent? ( ) Yes ( ) No

Name_____Relationship_____

Address _____

Phone Number _____

Ethnicity ***(may check more than one)***

_____ White _____American Indian/Alaskan Native

_____ Black _____Asian

_____ Hispanic _____Pacific Islander

This information will be shared only with appropriate school personnel in accordance with Federal FERPA regulations.

_____ _____

Parent/Guardian Signature Date

Pittsgrove Township Preschool Program
(856) 358-3094

☐ ***Norma Elementary***
873 Gershal Ave
Pittsgrove, NJ 08318
856-358-6904
Fax 856-691-2885

☐ ***Building Blocks Learning Center LLC***
219 Harding Highway
Pittsgrove, NJ 08318
856-358-2044

☐ ***Firm Foundations***
431 Front Street
Elmer, NJ 08318
856-521-0195
Fax 856-358-0231

☐ ***Child Study Team***
856-358-7080
Fax 856-358-7320

Records Release Form

I hereby grant permission for _____
(Previous School)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone Number)

to release all records pursuant to NJSA 18A:36-19a including:

- ☐ Academic
- ☐ Attendance
- ☐ Discipline/School violence report
- ☐ Immunization/Health
- ☐ SAC / I&RS / 504 plans
- ☐ CST Records

_____ to Pittsgrove Township Schools at the above checked address.
(Student Name)

_____
(Parent Signature)

_____
(Student Signature, over 18 yrs.)

_____
(Date)

_____
(Witness)

Pittsgrove Township Preschool Program
(856) 358-3094

Child's Name: _____ Birthdate: _____

Parent's Name: _____

Address: _____

Phone Number: _____

The following providers are available for both three and four-year old preschool students. Please select which you would prefer your child to attend.

☐ Norma School — School Hours: 8:00 A.M.–2:00 P.M.
873 Gershal Avenue
Pittsgrove, NJ 08318

☐ Building Blocks Learning Center, LLC — School Hours: 8:00 A.M.–2:00 P.M.
219 Harding Hwy
Pittsgrove, NJ 08318

☐ Firm Foundations — School Hours: 8:00 A.M.–2:00 P.M.
431 Front Street
Elmer, NJ 08318

No child will be assigned to their choice provider until all registration requirements are met (birth certificate, proof of residency, and health records).

FIRST CHOICE: _____

SECOND CHOICE: _____

Health History Form

CHILD'S NAME_____ **DOB**_____

Has your child had any of the following:

	YES	NO	YEAR		YES	NO	YEAR
ASTHMA				RHEUMATIC FEVER			
DIABETES				MONONUCLEOSIS (MONO)			
HEPATITIS				STREP INFECTION			
CHICKEN POX				NEUROMUSCULAR DISEASE			
PNEUMONIA				OTITIS MEDIA (EAR INFECTION)			
HEART DISEASE				SEIZURES / CONVULSIONS			
LYME'S DISEASE				OTHER -			

Past & Current History:

	YES	NO		YES	NO
BRONCHITIS OR CHRONIC COUGH			ORTHOPEDIC PROBLEMS		
FREQUENT: COLDS/SORE THROAT			BEHAVIORAL/EMOTIONAL PROBLEMS		
SPEECH DIFFICULTIES			NOSE BLEEDS		
EAR PROBLEMS/HEARING AID/TUBES			TONSILS REMOVED		
VISION PROBLEMS/GLASSES/CONTACTS			HEAD INJURY		
DENTAL PROBLEMS			LEARNING DIFFICULTIES		

PRENATAL HISTORY:
Birth weight _____ Birth length_____ **Check one:**_____Full term Pregnancy _____Premature
Delivery: _____vaginal _____c-section
Problems during delivery? _____
Congenital defects? _____

OTHER MEDICAL INFORMATION:

Allergies to foods, medicines, hayfever: Please list _____
Allergy to bee sting _____
Medication or treatment for allergies _____

Has your child ever had a serious illness? If yes, please explain_____

Has your child been hospitalized for any reason? If yes, please explain_____

Has your child ever had any type of surgery? If yes, please explain_____

Has your child had any broken bones? If yes, which bones? (i.e. right forearm)_____

Does your child take any medication on a regular basis? (i.e. allergy, inhalers, Ritalin, etc.)
Name of medication _____

Is there a family history of any medical problems? If yes, please explain _____
_____

Is there any other health information that we have not asked for, but that would be helpful to us? _____
_____

This information shall be disseminated to appropriate school personnel.

DATE:_____PARENT SIGNATURE_____

Norma Elementary School
873 Gershal Avenue
Pittsgrove, NJ 08318

Building Blocks Learning Center LLC
219 Harding Highway
Pittsgrove, NJ 08318
856-358-2044

Firm Foundations
431 Front Street
Elmer, NJ 08318
856-521-0195
Fax 856-358-0231

CODE OF TECHNOLOGY ETHICS
ACCEPTABLE USE AGREEMENT

As a user of Pittsgrove Township School's computing facilities, I agree to the following rules and provisions:

1. A student will be expected to use Norma's computer technology equipment in a safe and proper manner.
2. A student will be asked to follow directions and only use the computers and software as instructed by school personnel.
3. A student will not be allowed to bring software or CD's from home to use on the school's computers. Students will not copy or remove any software from the school's computers.
4. A student will be expected to behave properly in the computer lab.

_____ _____
Student Signature/Date Parent Signature/Date

_____
Print Student Name/Grade

*CHOICE PROGRAM*_____

Student Transportation Form

PowerSchool ID#_____ Grade:_____ Date of Birth: _____

NJ SID # _____

Last Name_____ First Name_____M.I. _____

School Code_____ Female / Male (circle one)

Home telephone_____ Other telephone _____

Street Address _____

Mailing Address (if different from street address) _____

Parent/Guardian Name _____

Alternate pick up/babysitting arrangements (please explain): _____

_____

_____

_____

Pittsgrove Township Preschool Program
(856) 358-3094

Residency Questionnaire

Student Name:_____DOB:_____Grade: _____

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

Please select one of the following:

☐ The student is my legal responsibility and resides with me at the address listed at bottom of the page.

As appropriate, please indicate if the student resides in any of the following:

☐ Residing with family or friend. (Parent/Guardian not listed on lease, deed or mortgage documents)
Residing out of necessity? Yes _____ No _____
(If yes you will need to complete the Families in Transition Form and have it notarized)

,

☐ Hotel/motel

☐ Shelter

☐ Transitional housing facility

☐ Domestic violence shelter

☐ Runaway youth shelter

☐ Home for adolescent school-age mothers

☐ Migrant family dwelling

☐ None of the above situations apply – please explain: _____

_____

Parent/Guardian signature:_____Date: _____

Please print name: _____

Address:_____

Telephone:_____

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	

CH-14 OCT 17 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.

Norma Elementary School
873 Gershal Avenue, Pittsgrove, NJ 08318
Phone: (856) 358-6904 Fax: (856) 691-2885

Dr. Priscilla Ocasio-Jiménez, Principal (Ext. 4732)

Dear Parent/Guardian,

In accordance with the New Jersey Immunization of Pupils in School regulations (N.J.A.C 8:57), all students entering a preschool program **must** have the following immunizations:

DTap: 4 doses

Polio: 3 doses

Hib: At least 1 dose on or after first birthday

MMR: 1 dose on or after first birthday

Varicella: 1 dose on or after first birthday

Pneumococcal Conjugate Vaccine: At least 1 dose given on or after first birthday

Flu Vaccine: Children six months through 59 months of age attending preschool shall annually receive at least one dose of influenza vaccine **between September 1 and December 31 each year.** Students who have not received the flu vaccine by December 31 must be excluded for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in preschool after December 31 must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective.

If you have any questions, please do not hesitate to contact me at (856) 358-6904 (Ext. 4707).

Sincerely,

Lori Patch, RN, BSN, CSN
School Nurse

Pittsgrove Township Preschool Program
(856) 358-3094

Name:_____ Grade:_____ Date of Birth:_____

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

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 and address to the NJ FamilyCare Program to contact me about health insurance.

Signature_____ **Printed Name**_____ **Date** _____
Written consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b)

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

Dental Exam _____ _____
Date Braces

Eye Exam _____ _____
Date Contacts Glasses

Allergy _____ _____
Kind Medications

Allergic Reaction _____ _____
Date Medications

Immunizations/Tetanus _____ _____
Date Type

Restrictions _____
Type

Doctor_____ Telephone _____

Dentist_____ Telephone _____

Hospital_____ Address_____ Telephone _____

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 even 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 for said child.

_____

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

Pittsgrove Township School District
Home Language Survey
Parent/Guardian Language Questionnaire

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

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. What language did the child learn when he/she first began to talk?

   English_____Other [specify]_____

2. What language does the family speak at home most of the time?

   English_____Other [specify]_____

3. What language does the parent [guardian] speak to the child most of the time?

   English_____Other [specify]_____

4. What language does the child speak to his/her parent [guardian] most of the time?

   English_____Other [specify]_____

5. What language does the child speak to her/her brothers and sisters most of the time?

   English_____Other [specify]_____

6. What language does the child speak to his/her friends most of the time?

   English_____Other [specify]_____

7. In which language do you wish to receive school communication?

   English_____Other [specify]_____

Signature:_____ Date
_____[person completing the survey]

Pittsgrove Township School District

Encuesta del Idioma usado en el Hogar
Idioma de Padres/Guardianes

Nombre: _____ Edad: _____
[Nombre] [Inicial] [Apellido]

Fecha de la entrada a la escuela: _____

Persona que completa la Encuesta: [ ] Madre [ ] Padre [ ] Abuelo(a)
[ ] Guardián [ ] Otro: _____

Direcciones: Seleccione o escriba la respuesta correcta para cada una de las siguientes preguntas acerca de su hijo.

1. ¿Que idioma aprendió su hijo(a) cuando empezó a hablar por primera vez?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

2. ¿Que idioma se habla en su hogar la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

3. ¿Que idioma le habla ustedes al niño(a) la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

4. ¿Que idioma habla el niño(a) con ustedes la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

5. ¿Que idioma le habla el niño(a) a sus hermanos(as) la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

6. ¿Que idioma habla el niño(a) a sus amigos la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

7. ¿En que idioma desea recibir comunicados de la escuela?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

Firma: _____ Fecha: _____

[Persona que lleno la encuesta]