English/Spanish

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

REQUIRED DOCUMENTS FOR STUDENT REGISTRATION

The following documents are required to register a new student:

1. **Birth Certificate**
2. **Social Security Number** (if applicable)
3. **Immunization Records**
4. **Proof of Residence** (A copy of one of the following documents must be provided)
   - Utility bill (gas, water, electric)
   - Telephone or cell phone bill
   - Cable bill
   - Credit card bill
   - Medical bill
   - Bank statement
   - Insurance bill
   - Correspondence from the Monmouth County Social Services

NOTE: Bills must have a current date.

The parent or guardian's full name listed on the Birth Certificate must be on the Proof of Residency. No bills are accepted under someone else's name.

Affidavit of Residence: Must be completed at our Administrative Offices located at 540 Broadway by appointment only (732) 571-2868 Ext. 40082.

DOCUMENTOS NECESSÁRIOS PARA REGISTRAR UN NUEVO ESTUDIANTE

Los siguientes documentos son necesarios para registrar un nuevo estudiante:

1. **Certificado de Nacimiento**
2. **Número de Seguro Social** (Si es applicable)
3. **Registros de Vacunaciones**
4. **Prueba de Residencia** (una copia de uno de los documentos listados abajo)
   - Copia de una factura de servicios públicos (gas, agua, electricidad)
   - Copia de una factura de teléfono/celular
   - Copia de una factura de servicios de televisión
   - Copia de una factura de tarjeta de crédito
   - Copia de una factura médica
   - Estados de cuentas bancarias
   - Facturas de seguros
   - Correspondencia de los Servicios Sociales de Monmouth County

NOTA: Las facturas deben tener una fecha actual.

El nombre del padre que aparece en el certificado de nacimiento debe estar en la prueba de residencia. No se aceptan billetes bajo cualquier otro nombre.

I. STUDENT INFORMATION / INFORMACIÓN DEL ESTUDIANTE

First Name / Nombre

Middle Name (If applicable) / Segundo Nombre (Si es aplicable)

Last Name / Apellido

Generation Code or Suffix / i.e.: Jr.,Sr., III. (If applicable)
Código de clasificación de generación o sufijo (Si es aplicable)

Date of Birth / Fecha de Nacimiento
[MM-DD-YYYY]

Social Security Number (If applicable) / Número de Seguro Social (Si es aplicable)

☑ **Ethnicity** / Raza

	White / Blanco
	Black or African American / Negro o Afroamericano
	Hispanic / Hispano
	American Indian or Alaska Native / Indio Nativo de América o Nativo de Alaska
	Asian or Pacific Islander / Nativo de la Isla de Asia o del Pacífico
	Other race (print below) / Otra raza (indique abajo)

Grade Level / Grado del Estudiante

Is this a High School Entry? ☐Yes ☐No
Es ésta una entrada de la secundaria?

If yes, enter entry date below.
Si sí, indique la fecha de inscripción más abajo.
[MM-DD-YYYY]

☑ **Gender** / Género

	Female / Femenino
	Male / Masculino

City of Birth / Ciudad de Nacimiento

State of Birth / Estado de Nacimiento

I. STUDENT INFORMATION (Continued) / INFORMACIÓN DEL ESTUDIANTE (Continuado)

Country of Birth / País de Nacimiento

Student's Birth Certificate # (If applicable) / # de Certificado de Nacimiento (Si es aplicable)

☑ **Primary Language Spoken at Home** / Idioma hablado en su casa

	English / Inglés
	Spanish / Español
	Portuguese / Portugués
	Italian / Italiano
	Creole / Creole (Haitiano)
	Korean / Coreano
	Russian / Ruso
	Chinese / Chino
	Other (print below) / Otro (indique abajo)

Student's Date of Entry into the United Stated (If applicable)
Fecha de entrada a los Estados Unidos (Si es aplicable)

		-			-				

[MM-DD-YYYY]

First entry into U.S. Schools (If applicable)
Entrada inicial en las escuela de los EE.UU. (Si es aplicable)

		-			-				

[MM-DD-YYYY]

II. STUDENT SUPPORT SERVICES / SERVICIOS DE APOYO AL ESTUDIANTE

1. **Does your child speak English? / ¿Su niño habla Ingles?**

☑

	Always / Siempre
	Sometimes / A veces
	Never / Nunca

2. **Does your child have an Individualized Education Program (IEP)?** / ¿Su hijo tiene un Programa de Educación Individualizado (IEP)?

☑

	Yes (Provide additional information on Section A) / Sí (proporcione información adicional sobre la Sección A)
	No

A. If applicable, what immediate services are required (i.e.: medical, counseling, instructional support…)?
¿Si es applicable, qué servicios inmediatos se requieren (médico, consejo, instrucción académica…)?

III. STUDENT CONTACT INFORMATION / INFORMACIÓN DE CONTACTO DEL ESTUDIANTE

A. Primary Residence / Residencia Primaria

Phone Number / Número de teléfono

			–				–				

Street Name / Nombre de la calle

City / Ciudad

State / Estado

Who Does the Child Live With? / ¿Con Quién Vive el estudiante?

☐ **Mother** / Madre ☐**Father** / Padre ☐**Both Parents** / Ambos Padres ☐**Grandparent/s** / Abuelo(s)
☐ **Guardian** / Tutor ☐**Other** / Otro _____

B. Primary Parent/Guardian Information / Información sobre el pariente/guardián primario

Name of Primary Parent / Guardian / Nombre del pariente/guardián primario

Relationship to student / Relación parentesca al estudiante

Primary Parent / Guardian home phone number / Número de teléfono

			–				–				

Primary Parent / Guardian work phone number / Número de teléfono de trabajo

			–				–				

Primary Parent / Guardian cell phone number / Número de teléfono celular

			–				–				

C. Secondary Parent/Guardian Information

Name of Secondary Parent / Guardian / Nombre del pariente/guardián secundario

Relationship to student / Relación parentesca al estudiante

III. STUDENT CONTACT INFORMATION (Continued) / INFORMACIÓN DE CONTACTO DEL ESTUDIANTE (Continuado)

Secondary Parent / Guardian home phone number / Número de teléfono

			–				–				

Secondary Parent /Guardian work phone number / Número de teléfono de trabajo

			–				–				

Secondary Parent / Guardian cell phone number / Número de teléfono celular

			–				–				

D. Emergency Contact Information / Contacto de Emergencia

Primary emergency contact name / Nombre del contacto primario en caso de emergencia

Relationship to student / Relación parentesca al estudiante

Primary phone number / Número de teléfono Primario

			–				–				

Additional phone number / Número de teléfono adicional

			–				–				

Secondary emergency contact name / Nombre del contacto secundario en caso de emergencia

Relationship to student / Relación parentesca al estudiante

Primary phone number / Número de teléfono

			–				–				

Secondary emergency contact additional phone number / Número de teléfono adicional

			–				–				

IV. ACKNOWLEDGMENT / RECONOCIMIENTO

By completing and signing this form, I _____,
[Print Full Name]

as Legal Guardian to the child named above, attest that to my knowledge the information provided is correct:

_____ _____
Signature Date

Al llenar y firmar este formulario, yo _____,
[Imprima su nombre completo]

como tutor legal del menor mencionado anteriormente, aseguro que la información proporcionada es correcta:

_____ _____
Firma Fecha

The Long Branch Public Schools provide a free breakfast program to every student prior the start of the school day.

Las escuelas de Long Branch públicas proporcionan un programa de desayuno gratis a cada estudiante antes del inicio de la jornada escolar.

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

Home Language Survey

New Jersey Department of Education regulations require that all schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. **If a language other than English is spoken in the home, the District is required to do further assessment of your child.** Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

_____ First Name

_____ Middle Name

_____ Last Name

F ☐ M ☐ Gender

_____ Country of Birth

_____/_____/_____ Date of Birth (mm/dd/yyyy)

_____/_____/_____ Date first enrolled in ANY U.S. school (mm/dd/yyyy)

School Information

_____/_____/_____ Start Date in New School (mm/dd/yyyy)

_____ Name of Former School and Town

_____ Current Grade

Questions for Parents/Guardians

What is the native language(s) of each parent/guardian? (circle one) _____ Mother _____ Father _____ Guardian	Which language(s) are spoken with your child? (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____sometimes / often / always _____sometimes / often / always
What language did your child <u>first</u> understand and speak?	Which language do you use most to communicate with your child?
Which other languages does your child know? (circle all that apply) _____speak / read / write _____speak / read / write	Which languages does your child use to communicate? (circle one) _____sometimes / often / always _____sometimes / often / always
Will you require written information from school in your native language? ☐ Yes ☐ No X	Will you require an interpreter/translator at Parent-Teacher meetings? ☐ Yes ☐ No
Parent/Guardian Signature:	_____/_____/20_____ Today's Date: (mm/dd/yyyy)

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

Dear Parent/Guardian:

The Long Branch Public Schools is excited to present the Genesis Student Information System Parent Portal. This powerful tool will allow parents to view their child's grades, attendance, and schedule via the internet. In order to create an account for this service, please provide the information requested below. Once the system is ready for general use, you will receive an e-mail with your login information and you will be able to view your child's information only. An active e-mail account is necessary for the setup of users in Genesis.

Please fill out this form completely and either e-mail it to genesislb@longbranch.k12.nj.us, or send it to back to your child's homeroom teacher.

☐ No Email	If you do not have an active email at this time, please check this box and a paper copy of the above information will be sent to you via mail.
Email address:	
Parent Last Name:	
Parent First Name:	
Parent Middle Name:	
Address:	
Home Phone:	
Alt. Phone:	
Student's Full Name:	
Student ID:	
School:	

Sibling(s) Full Name	**Full Name**	**School**

_____ _____

Signature of Parent/Guardian **Date**

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

REQUEST FOR STUDENT RECORDS

Student: _____

Grade: _____ **Date of birth:** _____ **State ID#:** _____

Last School Attended

School Address

City **State**

Date Last Attended [DD-MM-YYY]

School Phone Number

The above student has been registered in the Long Branch Public School District, please forward all academic/health (original A45 form), IEP and Special Placement Information records concerning this student to the school specified below.

***FOR OFFICE USE ONLY:**

School Name: _____ **Address:** _____

Phone Number: _____ **Fax:** _____ **Attention**:_____

As a legal guardian to the student named above, by completing this form, I give permission for the release of any and all information requested.

_____ _____
Signature of Parent/Guardian **Date**

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

PARENTAL CONSENT TO PUBLISH STUDENT PROGRAMS AND ACTIVITIES

Dear Long Branch Families,

During the school year, the children participate in various programs and activities, which celebrate innovation, character and learning. At times, we broadcast these events to the public via social media, television, local newspapers and/or our webpage.

We realize some families would like to preserve the anonymity of their child/children and would prefer NOT to be included in broadcasts; therefore, we kindly request you complete the information below and return to your child's teacher.

✂ -

PARENTAL CONSENT TO PUBLISH STUDENT PROGRAMS AND ACTIVITIES

Student: _______________________________ Grade: _______ Homeroom:________

Signature of Parent: ___________________________________ Date:_____________

☐ **I DO NOT give permission for my child's photo to be used.**

☐ **I GIVE permission for my child's photo to be used.**

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

Dear Long Branch Families,

The Long Branch Public Schools has refined the dress and grooming policy, which reflects "Uniformity of Dress" for all Preschool – Grade 12 students. Students are required to wear any combination of the following, which will be strictly enforced:

* Pants, shorts, jumpers and/or skorts in khaki color (grades 9-12 can wear black pants)
* Collared Golf/Polo shirts, short or long-sleeved, in dark green, white or gray
* Collared Shirt Exceptions: Turtlenecks and blouses in dark green, white or gray
* All shirts must have the Long Branch Public Schools Emblem

Purchases for clothing can be made at the store of your choice. The district does not have a private provider for clothing. Local stores and vendors that stock the items mentioned above are as follows:

- Target
- Walmart
- Kohls
- K-Mart
- *JC Penney*
- *Old Navy*
- *GAP*

The District's extension of "Uniformity of Dress" for the current school year will be extremely successful with your cooperation. We look forward to a wonderful school year with many safe and exciting learning opportunities ahead.

Sincerely,

Michael Salvatore
Superintendent of Schools




Sample Clothing

_____ New Entrant ____Moved
____Change in Transportation
SCHOOL _____
GRADE_____

LONG BRANCH PUBLIC SCHOOLS
Long Branch, New Jersey
Transportation Request

English/Spanish

***Please mark only one (X) for an AM box and one (X) for PM box.**
You can choose from Walker, Bus, Babysitter or the Wrap-Around Program

Child's Name/Nombre de Nino _____ Date/Fecha _____

Check all boxes that apply:

1 ☐ **I will drive my child.** ☐ AM
I will drive my child. ☐ PM

Parent will drive child to /from school

2 ☐ **My child needs bus transportation.** ☐ AM ☐ PM
(Check sitter info below, if needed)

Dirección del Niño/Niña
Address of Child _____
Nombre de padre/madre
Parent's Name _____
Telefono
Phone # _____
Celular
Cell # _____
Firma
Parent's Signature _____

3 ☐ **My child will go to a babysitter (within Long Branch School District)** ☐ AM ☐ PM

(Fill in additional sitter information) →

AM		**PM**	
Sitter's Name:		**Sitter's Name:**	
Sitter's Phone:		**Sitter's Phone:**	
Sitter's Address:		**Sitter's Address:**	

4 ☐ My child will go to **wrap-around** care. ☐ AM ☐ PM

CHILD MUST BE REGISTERED WITH THE WRAP-AROUND PROGRAM BEFORE THEY CAN ATTEND.

(transportation is not provided to/from home for wrap around care)

ANY CHANGES **to transportation must be made in person at your child's school.**

LONG BRANCH PUBLIC SCHOOLS

"Where Children Matter Most"

540 BROADWAY
LONG BRANCH, NJ 07740

DISTRICT MEDICAL FORMS

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. Your child will continue to receive services at no cost to you under this new system. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

Please fill in the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Child's Name: _____
(First) (Mid. Initial) (Last)

Child's Date of Birth: _____ /_____/ _____
(Month) (Date) (Year)

As parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature:_____ **Date:** _____
(Parent or person in parental relationship) (Month/Day/Year)

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

PHYSICAL EXAM FORM

FORM MUST BE COMPLETED BY DOCTOR & RETURNED TO NURSE

District policy requires students to have periodic physical exams as follows:

- **ALL NEW STUDENTS Pre K -12**
- **STUDENTS IN GRADES 4,10**
- **Pupil Personnel Service Referrals**
- **Working Papers**

Please have your child's Health Care Provider complete this form and return it to the School Nurse. Examinations completed within the past 6 months do not have to be repeated, but documentation of the examination is required.

El Proveedor de atención médica de su hijo debe completar este formulario y devolverlo a la enfermera de la escuela. Exámenes efectuado dentro de los últimos 6 meses no necessitan ser repetidos, pero se requiere la documentación del examen.

Student: _____ Grade: _____ School:_____

Date of birth: _____ Teacher:_____ Exam Date:_____

DPT #1_____ #2_____#3_____#4_____#5_____

Tdap #1_____

OPV/IPV #1_____#2_____ #3_____#4_____

HIB #1_____#2_____#3_____#4_____

MMR #1_____#2_____#3_____

HEP B #1_____#2_____#3_____

HEP A #1_____#2_____

Varivax #1_____#2_____

Gardasil #1_____#2_____#3_____

Menactra #1_____

MMR Titer date_____Pos./Neg. Varicella Titer date_____Pos./Neg.

Seasonal Flu Vaccine #1_____#2_____

H1N1 (Swine) Flu Vaccine #1_____#2_____

Medical or ReligiousExemption/explain_____

PHYSICAL EXAM FORM (Continued)

Past Medical History_____

Current Medications _____

_____

Ht._____ **Wt.**_____**BMI**_____**B/P**_____**Pulse**_____

Eyes_____ **Vision R 20/**_____**L 20/**_____**Glasses/Contacts**_____

Hearing: Right_____**Left**_____

Ears(otoscopic)_____**Myringotomy Tubes Right**_____ **Left**_____

Nose, throat, mouth_____

Cardiovascular_____

Respiratory_____

Genito-urinary_____

Hernia_____

Liver_____

Lymph glands_____

Musculoskeletal_____

Neurological_____

Nutrition_____

Posture/Scoliosis_____

Skin_____

Speech_____

Spleen_____

Laboratory Tests_____

1. **Is student subject to any condition which limits:**
   - **Physical education?**_____
   - **Competitive sports?**_____
   - **Classroom activities?**_____
2. **Is there any emotional, mental or physical condition for which the student should remain under periodic medical supervision?**_____

***MEDICAL OFFICE STAMP:** **TODAY'S DATE:** _____

_____

SIGNATURE OF PHYSICIAN

OFFICE OF THE SUPERINTENDENT
LONG BRANCH PUBLIC SCHOOLS
540 Broadway, Long Branch, New Jersey 07740

"Where Children Matter Most"

Your child's learning depends upon good health. To assist in providing health services at school, please complete and return this form. / *Por favor rellene el formulario.*

STUDENT'S NAME / *Nombre del Estudiante:*	**DATE OF BIRTH** / *Fecha de Nacimiento:*	**SEX** / *Sexo:* **M F**

1. **Does your child have any of the following conditions/illnesses?**
Su niño/niña tiene algunas de estas condiciones?

√CHECK ANY THAT APPLY √ (*MARCA LA QUE APLICA)*

	ADHD		**Heart condition** *(enfermedad del corazón)*
	Allergy (*Alergias)*		**Hepatitis** (*hepatitis)*
	Bee sting allergy (*Alergia a picadura de abejas)*		**Hernia**
	Food allergy (*alergia de comidas*)		**Hospitalization /emergency room visits**
	Medication allergy (*alergia de medicinas*)		**Lead poisoning (***envenenamiento por plombo)*
	Peanut allergy (*alergia nueces/cacahuete)*		**Lyme Disease**
	Asthma (*Asma)*		**Menstrual Problems** (*problemas de menstruación)*
	Bladder problems (*problemas de las vejiga*)		**Mononucleosis**
	Broken bones (*fracturas)*		**Nosebleeds** *(sangra mucho de la nariz)*
	Bone or joint problems (*problemas musculares)*		**Operations** (*Operaciónes*)
	Cancer (*cáncer)*		**Rheumatic Fever** (*Fiebre Reumática)*
	Chicken pox (*viruelas)*		**Scoliosis** (*Escoliosis)*
	Chest pains (*dolor de pecho*)		**Seizures** (*Convulsiones)*
	Contagious disease (*Enfirmedades contagiosa*)		**Serious Illness/Injury** (*enfermidaded/accidente serio)*
	Concussion *(conmoción cerebra)*		**Sickle Cell Anemia** *(Anemia de células falciformes)*
	Dental problems (*problemas dental*)		**Skin Rashes** (*problemas de la piel)*
	Diabetes (*diabetis*)		**Sleeping Problems** (*problemas de dormir)*
	Dietary restrictions (*restriciones de dieta)*		**Strep Infections** (*Infección de la garganta*)
	Ear infections/tubes (*infección del oído/tubos en los oídos)*		**Substance Abuse** (*toxicomanía/alcohólico)*
			Stitches (*puntos)*
	Fainting (*desmayo*)		**Tuberculosis**
	Head injury – serious (*golpe a la cabeza*)		**Weight - over/under** (*sobrepeso/desnutrido)*

2. Please explain any checked answers / *Haga el favor de comentar sobre los problemas medicos:*

_____

_____

_____

3. School transferring from */ Escuela de Transferencia:*

_____

4. Did student ever attend Long Branch Public Schools*?* ☐ Yes ☐ No
El estudiante ha asistir a las Escuelas Públicas de Long Branch?

Important Questions */ Preguntas Importantes*

1. Was the child born premature? / *El niño nació prematuro?* ☐ Yes ☐ No
2. Did the child have any difficulty before, during or after delivery? ☐ Yes ☐ No
El *niño/niña tuvo problemas durante el parto?*
3. Did the child have any delays in sitting or walking? ☐ Yes ☐ No
El niño/niña se detuvo en aprender a sentarce o caminar?
4. Did the child have any delays in starting to speak? ☐ Yes ☐ No
El niño/niña se detuvo en aprender a hablar?
5. Does the child have any speech problems? ☐ Yes ☐ No
El niño/niña tiene problemas al hablar?
6. Does the child wear eyeglasses or contact lenses? ☐ Yes ☐ No
El niño/niña usa los anteojoss o lentes de contacto?
7. Does the child have any hearing difficulty? ☐ Yes ☐ No
El niño/niña tiene problemas de oir?
8. Does the child take any medication besides vitamins daily? ☐ Yes ☐ No
El niño/niña necesita medicamentos?
9. Has the child ever had a serious illness or injury? ☐ Yes ☐ No
El niño/niña tuvo un golpe serio?
10. Has the child ever had an operation? ☐ Yes ☐ No
El niño/niña tuvo una operación?
11. Does your child have depression or emotional difficulties? ☐ Yes ☐ No
El niño/niña tiene depresión o dificultades emocionales?

12. Mother's age at birth of this child: _____
Edad de la madre en el nacimiento de este niño:

13. Date of last physical exam: / *Fecha del último examen físico:* _____

13A. Please explain any "YES" answers or medical problems in this area.
Haga el favor de comentar sobre los problemas médicos del niño/niña.

_____

_____

14. Do you have health insurance? / *Tiene segura de salud?* ☐ Yes ☐ No

15. Name of Health Care Provider / *Nombre del eguro medico:*

_____

Signature / *Firma*: _____ **Date** / *Fecha*: _____

UPDATED IMMUNIZATION RECORD MUST BE ATTACHED TO FORM.
REGISTRO DE VACUNAS ACTUALIZADOS DEBE ESTAR JUNTO CON ESTE FORMULARIO.

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 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.