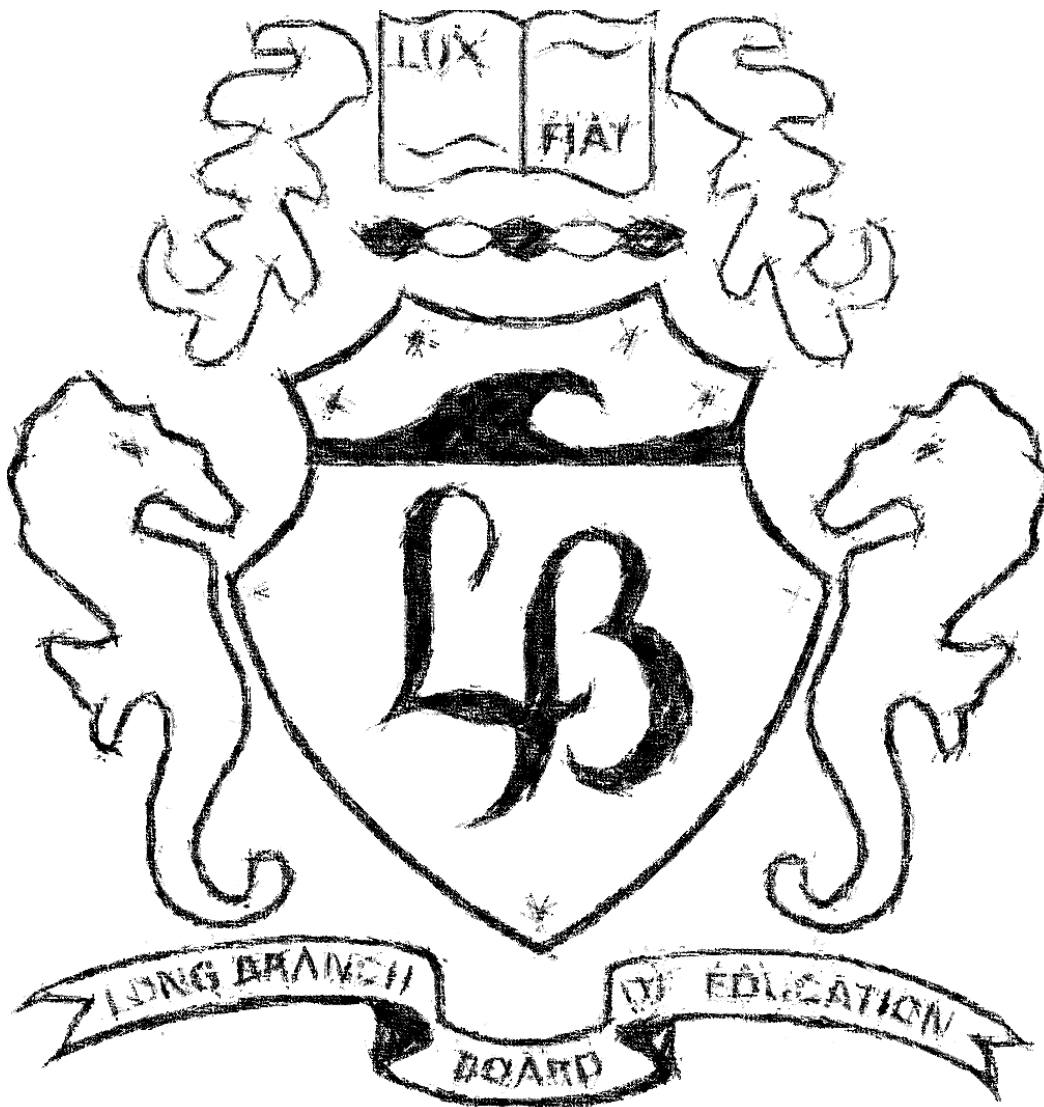


LONG BRANCH PUBLIC SCHOOLS

"Where Children Matter Most"

540 BROADWAY
LONG BRANCH, NJ 07740



REGISTRATION PACKET GRADES K-12

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 NECESÁRIOS 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 aplicable)
- 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 (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

<input type="checkbox"/>	English / Inglés
<input type="checkbox"/>	Spanish / Español
<input type="checkbox"/>	Portuguese / Portugués
<input type="checkbox"/>	Italian / Italiano
<input type="checkbox"/>	Creole / Creole (Haitiano)
<input type="checkbox"/>	Korean / Coreano
<input type="checkbox"/>	Russian / Ruso
<input type="checkbox"/>	Chinese / Chino
<input type="checkbox"/>	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?

<input type="checkbox"/>	Always / Siempre
<input type="checkbox"/>	Sometimes / A veces
<input type="checkbox"/>	Never / Nunca

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

<input type="checkbox"/>	Yes (Provide additional information on Section A) / Sí (proporcione información adicional sobre la Sección A)
<input type="checkbox"/>	No

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

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”

Idioma hablado en el hogar

Los reglamentos del Departamento de Educación de New Jersey exigen que *todas* las escuelas determinen los idiomas que se hablan en los hogares de los estudiantes para así identificar sus necesidades específicas relacionadas con el idioma. Esta información es esencial para que las escuelas puedan proveer instrucción que todos los estudiantes puedan aprovechar. **Si en su hogar se habla otro idioma que no sea inglés, se requiere que el Distrito evalúe a su hijo más a fondo.** Ayúdenos a cumplir con este importante requisito respondiendo a las siguientes preguntas. Gracias por su ayuda.

Información del estudiante	
Nombre _____	Segundo nombre _____
País de nacimiento _____	Fecha de nacimiento (mm/dd/aaaa) _____
	Fecha de matriculación inicial en CUALQUIER escuela de EE.UU. (mm/dd/aaaa) _____
	Apellido _____
	Sexo F <input type="checkbox"/> M <input type="checkbox"/>
Información de la escuela	
_____ / _____ /20 _____	_____
Fecha de comienzo en la escuela nueva (mm/dd/aaaa)	Nombre de la escuela y ciudad anterior
	Grado actual
Preguntas para los padres/encargados	
¿Cuál es el idioma natal del padre/la madre/los encargados? (encierre en un círculo) _____ (madre / padre / encargado) _____ (madre / padre / encargado)	¿Qué idioma(s) se habla(n) con su hijo? (incluya parientes -abuelos, tíos, tías, etc. - y encargados del cuidado) _____ infrecuentemente / algunas veces / frecuentemente / siempre _____ infrecuentemente / algunas veces / frecuentemente / siempre
¿Cuál fue el primer idioma que entendió y habló su hijo?	¿Qué idioma usa usted principalmente con su hijo?
¿Qué otros idiomas sabe su hijo? (encierre en un círculo todo lo que corresponda) _____ habla / lee / escribe _____ habla / lee / escribe	¿Qué idiomas usa su hijo? (encierre uno en un círculo) _____ infrecuentemente / algunas veces / frecuentemente / siempre _____ infrecuentemente / algunas veces / frecuentemente / siempre
¿Requerirá usted la información impresa de la escuela en su idioma natal? Sí <input type="checkbox"/> No <input type="checkbox"/>	¿Requerirá usted un intérprete/traductor en reuniones de padres y maestros? Sí <input type="checkbox"/> No <input type="checkbox"/>
Firma del padre/la madre/encargado: X	_____ / _____ /20 Fecha de hoy: (mm/dd/aaaa)



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

MICHAEL SALVATORE
Superintendent of Schools
(732) 571-2868, Ext 40010
Fax: (732) 229-0797

"Where Children Matter Most"

Estimado Padre / Tutor:

Las Escuelas Públicas de Long Branch presenta el Sistema de Información Estudiantil; Génesis. Esta poderosa herramienta permitirá a los padres ver a los grados de su hijo(a), la asistencia y horario, todo a través de la Internet. Con el fin de crear una cuenta para este servicio, por favor proporcione la información solicitada a continuación. Una vez que el sistema está listo para su uso general, usted recibirá un correo electrónico con su información de entrada y será capaz de ver la información de su hijo(a). Una cuenta de correo electrónico es necesaria para crear su cuenta en Génesis.

Dirección de correo electrónico:	
Apellido del Padre:	
Primer nombre del Padre:	
Segundo Nombre del Padre:	
Dirección:	
Número de Teléfono:	
Número de Teléfono Alternativo:	
Nombre del Estudiante:	
Escuela	

Nombres de hermano/a (os/as)

Nombre Completo	Escuela

Firma del Padre/Tutor

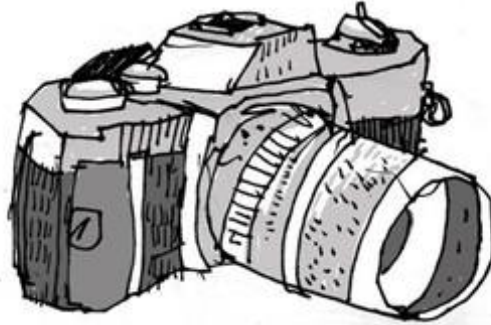
Fecha



**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 | ➤ <i>JC Penney</i> |
| ➤ Walmart | ➤ <i>Old Navy</i> |
| ➤ Kohls | ➤ <i>GAP</i> |
| ➤ K-Mart | |

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

LONG BRANCH PUBLIC SCHOOLS
Long Branch, New Jersey
Transportation Request

____ New Entrant ____ Moved
____ Change in Transportation
SCHOOL _____
GRADE _____

***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
(Check sitter info below, if needed) PM

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
Sitter's Name: _____
Sitter's Phone: _____
Sitter's Address: _____

PM
Sitter's Name: _____
Sitter's Phone: _____
Sitter's Address: _____

4 My child will go to wrap-around care. AM
 PM
(transportation is not provided to/from home for wrap around care)

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

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”

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

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

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> 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 health 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.