

Document Checklist – Grades 6th thru 8th

For registering children into the East Orange School District

In order to register your child into the East Orange School District you MUST bring the documents listed below to your appointment. Your child will NOT be registered without them.

1. Parent/Guardian/Foster Parent must show Photo ID
(GUARDIANSHIP PAPERS OR FOSTER PARENT PLACEMENT LETTER MUST BE SHOWN)
2. Child’s birth certificate
3. Any three (3) of the proof of residency requirements listed on the Proof of Residency List
4. Proof of immunization (shot) records
REGISTRATION CAN NOT TAKE PLACE WITHOUT A COPY OF THE SHOT RECORDS & A CURRENT PHYSICAL!
5. Child/Children must be present at the time of registration
6. Copy of most recent report card
7. Transfer from previous school
8. If your child has auditioned for a **Performing Arts school** or applied to **STEM Academy**, you must bring the **Acceptance Letter**
9. If your child has been accepted into a Charter School please return to the web-site and download the Charter School Registration Packet
10. If your child has an active/current IEP please call (862) 233-7300 ext. 28337 to make an appointment with the Special Education Department

For grades 6 thru 8 your child must have a current record of immunization (shot) records that are age appropriate. These shots are required and are without exception:

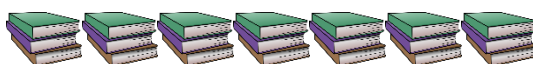
- DTap series (Diphtheria, Tetanus, and Pertussis): A minimum of four (4) doses is required provided one dose is given on or after the 4th birthday
- Polio series: A minimum of three (3) doses is required provided one dose is given on or after the 4th birthday
- MMR series (Measles, Mumps, Rubella): Two (2) doses of Measles, One (1) dose of Mumps and Rubella or two (2) MMR series
- 3 doses Hepatitis B series, appropriately spaced
- 1 dose Varicella (Chicken Pox)
- TB testing is required for foreign-born students from select countries
- Tdap Booster
- Meningococcal Vaccination

To schedule an appointment for registration please visit our web-site @

enrollment.eastorange.k12.nj.us

Confirmation Code: _____ - _____ - _____

An ink pen is necessary to fill out the Registration Packet.



Grades 6 thru 8

To register your child for school they must have a transfer and a current report card. **All children must be present at the time of registration, and the registration must be done by the parent or a legal guardian (guardianship papers must be presented at the time of registration).** Parent or legal guardian must have a valid photo ID present at the time of registration. **Birth certificates and immunization (shot) records are mandatory. A current physical.** All persons coming to register children must bring **three (3) proofs of residency.**

Proof of Residency List

. Verification of a child's residency in East Orange requires the presentation of:

Any three (3) of the following items listed:

- Homeowner — East Orange property tax bill, mortgage statement, or signed Contract of Purchase.
- Tenant — Active lease
- Child and Parent Living with an East Orange Resident — Signed, notarized Sworn Statement of Residency (Residency Check Form) completed by the East Orange resident and parent or guardian. **(MUST BE PICKED UP FROM THE ENROLLMENT CENTER – 74 HALSTED ST) (PLEASE BE ADVISED AN ATTENDANCE OFFICER WILL VISIT THE HOME TO VERIFY YOUR RESIDENCY)**
- Child Placed in East Orange by Court — Court order placing child in home of East Orange resident.
- Child Placed in East Orange by Child Welfare Agency — Document of child welfare agency ordering that child be placed in home of East Orange resident or Foster Parent Placement Letter.
- Driver's license
- Vehicle registration
- Auto insurance card
- Current utility bill
- Current cable television bill
- Current credit card bill
- Hospital/Medical bills
- Official mail (bank statement, government correspondence: Internal Revenue, Division of Taxation, Social Security Administration)
- Public assistance documents
- Income tax return (current year received thru the mail)
- Unemployment benefit verification
- Recent paycheck/stub

For grades 6 thru 8 your child must have a current record of immunization (shot) records that are age appropriate. These shots are required and are without exception:

- DTaP series (Diphtheria, Tetanus, and Pertussis): A minimum of four (4) doses is required provided one dose is given on or after the 4th birthday
- Polio series: A minimum of three (3) doses is required provided one dose is given on or after the 4th birthday
- MMR series (Measles, Mumps, Rubella): Two (2) doses of Measles, One (1) dose of Mumps and Rubella or two (2) MMR series 3 doses
- Hepatitis B series, appropriately spaced.
- 1 dose Varicella (Chicken Pox)
- TB testing is required for foreign-born students from select countries
- Tdap Booster
- Meningococcal Vaccination
- Current physical

Specialty Schools

If your child has auditioned for a Performing Arts school or applied to STEM Academy, you must bring the **Acceptance Letter**.

Charter Schools If your child has been accepted into a Charter School please return to the web-site and download the Charter School Registration Packet

Special Education

If your child has an active/current IEP you must contact the Special Education Department for registration requirements at (862) 233-7300 ext. 28337 or 28510.

Children must be present at time of registration.

An ink pen is necessary to fill out the Registration Packet.

Registration must be done by parent/legal guardian (must present guardianship papers)

EAST ORANGE SCHOOL DISTRICT

Sondaj Lang Matènèl Lang Paran/Gadyen an

Non elèv la _____ Laj li _____
Dat Antre nan Lekòl la _____ Nivo: _____

Moun ki ap konplete kesyonè a : [] Manman [] Papa [] Granparan
[] Gadyen [] Lèt: _____

Direksyon: Chwazi oswa ekri repons kòrek la pou chak kesyon sa yo konsènan pitit ou a.

1. Ki lang ou toujou pale lakay ou?
[] Anglè [] Yon lòt lang Ki lang sa a ? _____
2. Èke elèv ke'w ap enskri jodia pale yon lòt lang ke anglè? (Pa konte lang etranje ke li aprann nanlekòl.) [] Non [] Wi
Si'w reponn wi: Ki lang sa-a? _____
3. Nan ki lang ou [gadyen an] pale tout tan? [] Anglè [] Yon lòt lang
Ki lang sa a? _____
4. Nan ki lang pitit ou a pale ak ou [gadyen an] tout tan?
[] Anglè [] Yon lòt lang Ki lang li sa a ? _____
5. Nan ki lang èske pitit ou a pale ak frèl/sèl tout tan?
[] Anglè [] Yon lòt lang Ki lang sa a? _____
6. Nan ki lang ou pale pi souvan lè ou ap pale ak pitit ou a?
[] Anglè [] Yon lòt lang Ki lang sa a? _____
7. Nan ki lang ou [gadyen an] ta renmen resevwa kominikasyon de lekòl la? [] Anglè [] Yon lòt lang? Ki lang sa a? _____

Siyati Paran/Gadyen _____ Dat jodi a _____
Moun ki konplete kesyonè a

EAST ORANGE SCHOOL DISTRICT

Sondage de Langue Maternelle Langue des Parents/Gardiens

Nom de l'élève: _____ Age _____

Date d'Entrée à l'Ecole _____ Nivo _____

Personne qui remplit le Sondage : [] Mère [] Père [] Grandparent
[] Gardien [] Autre _____

Directions: Choisissez ou écrivez la réponse correcte pour chacune des questions suivantes concernant votre enfant.

1. Quelle langue parlez-vous couramment à la maison? [] anglais [] français
[] une autre langue Spécifiez _____
2. Est-ce que l'enfant que vous inscrivez parle autre langue que l'anglais?
(Exclues les langues étrangères étudiées à l'école.) ____ Non ____ Oui
Si oui: Quelle langue est-ce? _____
3. Quelle langue parle t-on à la maison la plupart du temps?
[] Anglais [] français [] Une autre langue Spécifiez _____
4. Quelle langue est ce que vous le parent [gardien] parle à votre enfant la plupart du temps?
[] anglais [] français [] Une autre langue Spécifiez _____
5. En quelle langue est-ce que votre enfant parle avec ses frères et soeurs?
[] anglais [] français [] Une autre langue Spécifiez _____
6. En quelle langue est ce que l'élève parle avec ses amis le plus souvent?
[] anglais [] français [] Une autre langue Spécifiez _____
7. Dans quelle langue est-ce que vous aimeriez recevoir les communications de l'école. [] anglais [] français [] Une autre langue Spécifiez _____

Signature du Parent/tuteur _____ Date du jour _____

EAST ORANGE SCHOOL DISTRICT
Division of Operation, Compliance &
Educational Support Services
Department of Special Education Services
 199 4th Avenue
 East Orange, New Jersey 07017-1026
 Phone (973) 266-5785 Fax (973) 266-5805

Tonya H. Santos, Director

t.hardin@eastorange.k12.nj.us

SCHOOL HEALTH SERVICES
HEALTH HISTORY QUESTIONNAIRE

Early Intervention

Today's Date: _____
 Student Name: _____ Date of Birth: _____
 Parent/Guardian Name: _____
 Prenatal Illness: (explain) _____
 Medications taken during Pregnancy/Delivery: _____
 Type of Delivery (complications): _____
 Length of Pregnancy: _____
 Newborn Health Problems: _____ Child's Birth Weight: _____ lbs _____ oz.
Child Hospitalizations/Operations: (List Below)
 Diagnosis: _____ Length of stay: _____ Age: _____
 Diagnosis: _____ Length of stay: _____ Age: _____
 Diagnosis: _____ Length of stay: _____ Age: _____
 Child's Current Medications: _____

Check if your **CHILD** has any of the following health Problems:

| <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> | |
|------------|-----------|---------------|------------|-----------|----------------|------------|-----------|---------------|------------|-----------|----------------------------|
| _____ | _____ | Asthma | _____ | _____ | Hepatitis | _____ | _____ | Measles | _____ | _____ | Seizures/Epilepsy |
| _____ | _____ | Diabetes | _____ | _____ | High Fevers | _____ | _____ | Mono | _____ | _____ | Sickle Cell Disease |
| _____ | _____ | Eye Problems | _____ | _____ | Kidney/Urinary | _____ | _____ | Mumps | _____ | _____ | Sickle Cell Trait |
| _____ | _____ | Fainting | _____ | _____ | Lead Poisoning | _____ | _____ | Nose Bleeds | _____ | _____ | TB or Exposure |
| _____ | _____ | Heart Disease | _____ | _____ | Lung Disease | _____ | _____ | Scarlet Fever | _____ | _____ | Chicken Pox _____ (Age) |

Other Health Problems: _____
 Fractures or Dislocations: _____
 Serious Injuries: _____
 Allergies (Medication & Food): _____
 Other Health Problems: _____

At what age did your child? Walk _____ Talk _____ Toilet Train _____

FAMILY HEALTH: Check if your **CHILD'S** Parents, Grandparents, and/or Siblings have any of the following:

| <u>YES</u> | <u>NO</u> | <u>RELATIONSHIP</u> | <u>YES</u> | <u>NO</u> | <u>RELATIONSHIP</u> |
|------------|-----------|---------------------|------------|-----------|---------------------|
| _____ | _____ | Asthma | _____ | _____ | High Blood Pressure |
| _____ | _____ | Cancer | _____ | _____ | Seizures/Epilepsy |
| _____ | _____ | Heart Disease | _____ | _____ | Other: _____ |

 Signature of Physician/School Nurse

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STUDENT MEDICAL EMERGENCY CARD/CONSENT

THIS FORM IS TO BE RETAINED BY THE SCHOOL NURSE OR THE STUDENT'S EMERGENCY MEDICAL FOLDER
(Top portion to be completed by School Nurse)

DATE: _____

GRADE: _____

SCHOOL: _____

BIRTHDATE: _____

TEACHER: _____

Student's Name: _____
(Last) (First) (Middle)

Address: _____ Apartment #: _____ Zip Code: _____

Parent or Guardian: To serve your child in case of an ACCIDENT OR EMERGENCY, it is necessary that you furnish the following information for EMERGENCY CARE/CALLS.

Mother: _____
(Name) (Home Address) (Business Phone #) (Cell Phone #)

Father: _____
(Name) (Home Address) (Business Phone #) (Cell Phone #)

List two people who can assume temporary care of your child IF you cannot be reached. Please note, we will ALWAYS try to reach you first!

Name: _____

Name: _____

Address: _____

Address: _____

Daytime Phone: _____

Daytime Phone: _____

Cell Phone: _____

Cell Phone: _____

Child's Physician: _____

Phone #: _____

Child's Dentist: _____

Phone #: _____

Child's Eye Doctor: _____

Phone #: _____

Child's Emergency Hospital: _____

Phone #: _____

Insurance Company: _____

Policy/Group # #: _____

HEALTH INFORMATION: List any health conditions, such as asthma, heart disease, diabetes, epilepsy, allergies, eye or ear problems, or any chronic health condition, etc. which your child may have. _____

MEDICATION TAKEN _____

SURGERY WITHIN THE PAST YEAR _____

IMMUNIZATIONS RECEIVED WITHIN THE PAST YEAR _____

In the event physician, other persons named above, or parent cannot be contacted, the school staff is hereby authorized to take whatever actions are deemed necessary, in their judgment, for the health and well being of my child. I, (We), agree to be responsible for the cost of any emergency care, treatment and/or transportation, and I, (We), hereby release the district from liability pertaining to any such emergency care, treatment and/or transportation.

Signature of Parent Print Name Date

Signature of Parent Print Name Date

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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i> | | | |
| 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>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.</i> | |
| 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 1-800-326-3838.

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 609-828-4860.
 - 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.