Document Checklist – Pre-Kdg

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 Residency Requirements List
4. Proof of immunizations (shot records) & a current physical
   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. Child must be at least 3 or 4 years old by ***October 1st*** of the current school year
7. If your child is in the process of being evaluated for any services in the district please call (862) - 233-7300 ext. 28337 to make an appointment with the Special Education Department.

Pre-Kdg placement is either in the neighborhood school or a collaborating pre-school provider

For Pre-kindergarten, your child must have a current record of immunizations (shot records) that is age appropriate. These shots are required and are without exception:

18 months-4 years

- 4 doses DTaP
- 3 doses Polio
- 1 dose MMR
- 1 dose HIB (minimum of 1 dose after the 1st birthday)
- 1 dose Varicella
- 1 dose PCV7 (minimum of 1 dose after the 1st birthday)
- 1 dose Influenza (annually between September 1st to December 31st each year)
- 3 doses of Hepatitis B

Lead Testing

The state of New Jersey requires all Pre-Kdg students get lead tested. Please have your child tested prior to registering. Lead Poisoning can cause learning and behavior problems in children. Lead can also cause slowed growth, anemia and hearing problems. A child might have lead in his or her blood, but still look healthy. Prevent lead poisoning. Know your child's lead number by talking with your physician or your local health department. (East Orange Health Department Lead Program 973-266-5489).

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.

Pre-kindergarten

To register your child for this school year they must be at least 3 or 4 years old by October 1st of the current school year. **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**. 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 Pre-kindergarten, your child must have a current record of immunization (shot) records that are age appropriate. These shots are required and are without exception:

- 4 doses DTap
- 3 doses Polio
- 1 dose MMR
- 1 dose HIB (minimum of 1 dose after the 1st birthday)
- 1 dose Varicella (Chicken Pox)
- 1 dose PCV7/13 (minimum of 1 dose after the 1st birthday)
- 1 dose Influenza (annually between September 1st to December 31st each year)
- 3 doses of Hepatitis B
- Current physical

Lead Testing

The state of New Jersey requires all Pre-Kindergarten students get lead tested. Please have your child tested prior to registering. Lead Poisoning can cause learning and behavior problems in children. Lead can also cause slowed growth, anemia and hearing problems. A child might have lead in his or her blood, but still look healthy. Prevent lead poisoning. Know your child's lead number by talking with your physician or your local health department.

East Orange Health Department Lead Program — (973)-266-5489

Special Education

If your child is in the process of being evaluated for any services in the school district please contact the Special Education Department to schedule an appointment for registration 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)

Home Language Survey*
Parent/Guardian Language Questionnaire

Student 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]

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

Nombre del estudiante: _____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]: _____
2. ¿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]

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 [ ] Lòt: _____

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 rempli 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 QUESTIONAIRE

☐ 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:

YES	NO		YES	NO		YES	NO		YES	NO	
___	___	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:

YES	NO		RELATIONSHIP	YES	NO		RELATIONSHIP
___	___	Asthma	_____	___	___	High Blood Pressure	_____
___	___	Cancer	_____	___	___	Seizures/Epilepsy	_____
___	___	Heart Disease	_____	___	___	Other: _____	_____

_____
Signature of Physician/School Nurse

EAST ORANGE SCHOOL DISTRICT
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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 ☐ 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 JUL 12 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.