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 (973) 266-5785 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 (973)-266-5785

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/his 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]
**Non elèv la**: _______________  

**Dat Jodi a**: _______________  

**Nom de l’élève**: _______________  

**Date d’Entrée**: _______________  

**Personne qui rempli le Sondage**:  

- [ ] Mère  
- [ ] Père  
- [ ] Grandparent  
- [ ] Gardien  
- [ ] Autre: _______________

**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  
   - [ ] Une autre langue: _______________

2. **Èke elèv ke’w ap enskri jodia pale yon lòt lang ke anglè?**  
   (Pa konte lang etranje ke li aprann nanlekol.)  
   - [ ] Non  
   - [ ] Wi  
   Si’w reponn wi: Ki lang sa-a? _______________

3. **Nan ki lang ou [gadyen an] pale tout tan?**  
   - [ ] Anglè  
   - [ ] Yon lòt lang  
   - [ ] Une autre langue: _______________

4. **Nan ki lang piti ou a pale ak ou [gadyen an] tout tan?**  
   - [ ] Anglè  
   - [ ] Yon lòt lang  
   - [ ] Une autre langue: _______________

5. **Nan ki lang èske piti ou a pale ak frèl/sèl tout tan?**  
   - [ ] Anglè  
   - [ ] Yon lòt lang  
   - [ ] Une autre langue: _______________

6. **Nan ki lang ou pale pi souvan lè ou ap pale ak piti ou a?**  
   - [ ] Anglè  
   - [ ] Yon lòt lang  
   - [ ] Une autre langue: _______________

7. **Nan ki lang ou [gadyen an] ta renmen resevwa kominikasyon de lekòl la?**  
   - [ ] Anglè  
   - [ ] Yon lòt lang  
   - [ ] Une autre langue: _______________

**Siyati Paran/Gadyen**: _______________  

**Nom de l’élève**: _______________  

**Date d’Entrée**: _______________  

**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: _______________

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: _______________

4. Quelle langue est-ce que vous le parent [gardien] parle à votre enfant la plupart du temps?  
   - [ ] anglais  
   - [ ] français  
   - [ ] Une autre langue: _______________

5. En quelle langue est-ce que votre enfant parle avec ses frères et soeurs?  
   - [ ] anglais  
   - [ ] français  
   - [ ] Une autre langue: _______________

6. En quelle langue est-ce que l’élève parle avec ses amis le plus souvent?  
   - [ ] anglais  
   - [ ] français  
   - [ ] Une autre langue: _______________

7. Dans quelle langue est-ce que vous aimeriez recevoir les communications de l’école?  
   - [ ] anglais  
   - [ ] français  
   - [ ] Une autre langue: _______________

**Signature du Parent/tuteur**: _______________  

**Date du jour**: _______________
SCHOOL HEALTH SERVICES
HEALTH HISTORY QUESTIONNAIRE

☐ Early Intervention

Today’s Date: ____________________________ Date of Birth: __________
Student Name: __________________________________________________________
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 ___________

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 YES NO
- Asthma - Relationship - High Blood Pressure - Other: ___________
- Cancer - ___________ - Seizures/Epilepsy - ___________
- Heart Disease - ___________ - Other: ___________

__________________________
Signature of Physician/School Nurse

Form M-31
Revised: 5/2014
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: ___________________________ Address: ___________________________
Daytime 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

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)  Gender  Date of Birth
(First)              Male  Female  /  /

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

☐ None  ☐ Special Care Plan Attached

Chronic Medical Conditions/Related Surgeries
☐ List medical conditions/ongoing surgical concerns:

Medications/Treatments
☐ List medications/treatments:

Limitations to Physical Activity
☐ List limitations/special considerations:

Special Equipment Needs
☐ List items necessary for daily activities

Allergies/Sensitivities
☐ List allergies:

Special Diet/Vitamin & Mineral Supplements
☐ List dietary specifications:

Behavioral Issues/Mental Health Diagnosis
☐ List behavioral/mental health issues/concerns:

Emergency Plans
☐ List emergency plan that might be needed and
the signs/symptoms to watch for:

Comments

☐ None  ☐ Special Care Plan Attached

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 '22

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 breastfeeding 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.).
   a. 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.
   b. 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.
   c. Head Circumference - Only enter if the child is less than 2 years.
   d. 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.
   a. The Immunization record must be attached for the form to be valid.
   b. "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 issues blocks that follow. A generic care plan (CH-15) can be downloaded at www.nl.gov/dept/orms/ch-15.doc 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 medications such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.
   c. PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

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.
   a. For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   b. For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   c. Scoliosis screenings are done bimonthly 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)
   a. Print the health care provider's name.
   b. Stamp with health care site's name, address and phone number.

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 permission 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 slings 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 908-887-9240.

   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.