Document Checklist – Kindergarten

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. ☐ Child must be 5 years old by October 1st of the current school year
7. ☐ Transfer from previous school
8. ☐ If your child has been accepted into a Charter School please return to the web-site and download the Charter School Registration Packet
9. ☐ If your child has an active/current IEP please call (973) 266-5785 to make an appointment with the Special Education Department.

For 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 with one dose given on or after the 4th birthday or any 5 doses
- 3 doses Polio with one dose given on or after the 4th birthday or any 4 doses
- 2 doses of MMR
- 1 dose HIB (age 12-59 months) minimum 1 dose given after the 1st birthday
- 3 doses of Hepatitis B
- 1 dose Varicella (Chicken Pox)
- 1 dose of PCV7/13 (age 12-59 months) minimum of 1 dose after the 1st birthday
- 1 dose Influenza (age 6-59 months) annually between September 1st to December 31st each year

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.

Kindergarten

To register your child for school they must be at least 5 years old by October 1st. **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 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 with one dose given on or after the 4th birthday or any 5 doses 3
- doses Polio with one dose given on or after the 4th birthday or any 4 doses 2 doses
- of MMR
- 1 dose HIB (age 12-59 months) minimum 1 dose given after the 1st birthday
- 3 doses of Hepatitis B
- 1 dose Varicella (Chicken Pox)
- 1 dose of PCV7/13 (age 12-59 months) minimum of 1 dose after the 1st birthday 1 dose
- Influenza (age 6-59 months) annually between September 1st to December 31st each year
- Current physical

Charter Schools

If your child has been accepted to a Charter school please click here

Special Education

If your child has an active/current IEP you must contact the Special Education Department for registration requirements at (973) 266-5785

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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
HOME LANGUAGE SURVEY FORM

INTRODUCTION: This survey is the first of three (3) steps to identify whether or not a student is eligible to be an English-Language Learner (ELL). Start with "Part 1" and continue until the Home Language Survey is complete. Select the answer for each part and follow the directions.

STUDENT INFORMATION

Student Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Student Birthdate: _____ Phone number: _____

SURVEY QUESTIONS

Part 1
What was the first language used by the student?
☐ A language other than English – Proceed to Part **2a** ☐ English – Proceed to Part **2b**

Part 2a
At home, does the student hear or use a language other than English more than half of the time?
☐ Yes – Proceed to Part 7 ☐ No – Proceed to Part 4

Part 2b
At home, does the student hear or use a language other than English more than half of the time?
☐ Yes – Proceed to Part 4 ☐ No – Proceed to Part 3

Part 3
Does the student understand a language other than English?
☐ Yes – Proceed to Part 4 ☐ No – Proceed to Part 9

Part 4
When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?
☐ Yes – Proceed to Part 7 ☐ No – Proceed to Part 5

Part 5
When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?
☐ Yes ☐ No

Part 6
Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?
☐ Yes ☐ No

Part 7
List all languages spoken at home and proceed to Part 8

Part 8

PROCEED TO STEP 2: RECORDS REVIEW PROCESS.
HOME LANGUAGE SURVEY IS COMPLETE.

Part 9

DO NOT PROCEED TO STEP 2: RECORDS REVIEW PROCESS.
HOME LANGUAGE SURVEY IS COMPLETE.
STUDENT IS NOT AN ENGLISH-LANGUAGE LEARNER (ELL)

Sign: _____ **Date:** _____

EAST ORANGE SCHOOL DISTRICT
FORMULARIO DE ENCUESTA DE LENGUAJE DE HOGAR

INTRODUCCION: Esta encuesta es el primer de tres (3) etapas para identificar si el/la estudiante califica para participar en el programa de aprendizaje de ingles (ELL). Comience en la "Parte 1" y continue hasta que la encuesta de lenguaje en el hogar sea completa. Seleccione la respuesta para cada parte y siga las instrucciones.

INFORMACION DEL ESTUDIANTE

Nombre del Estudiante: _____
Dirección Postal: _____
Ciudad: _____ Estado: _____ Código Postal: _____
Fecha de Nacimiento del Estudiante: _____ Numero de Teléfono: _____

PREGUNTAS DE LA ENCUESTA

Parte 1
¿Cuál es el primer lenguaje que fue utilizado por el/la estudiante?
☐ Una lengua que no sea inglés– proceda a la Parte **2a** ☐ Ingles – proceda a la Parte **2b**

Parte 2a
¿En casa, el/la estudiante oye o utiliza algún otro idioma que no sea ingles más de la ½ del tiempo?
☐ Si – proceda a la Parte 7 ☐ No – proceda a la parte 4

Parte 2b
¿En casa, el/la estudiante oye o utiliza algún otro idioma que no sea ingles más de la ½ del tiempo?
☐ Si – proceda a la Parte 4 ☐ No – proceda a la parte 3

Parte 3
El/la estudiante entiende algún idioma diferente al Ingles?
☐ Si – proceda a la parte 4 ☐ No – proceda a la parte 9

Parte 4
¿Cuando esta interactuando con sus padres o tutores, el /la estudiante utiliza algún otro idioma que no sea ingles más de la mitad del tiempo?
☐ Si – proceda a la parte 7 ☐ No – proceda a la parte 5

Parte 5
¿Cuando esta interactuando con proveedores de cuidado aparte de sus padres o tutores, el/la estudiante utiliza algún otro idioma que no sea ingles más de la mitad del tiempo?
☐ Si ☐ No

Parte 6
¿E/la Estudiante se ha trasladado recientemente de algún otro distrito escolar/escuela chárter donde el/ella fue identificada para recibir aprendizaje de ingles?
☐ Si ☐ No

Parte 7
Enumere todos los idiomas que se hablan en casa y proceda la parte 8

Parte 8

PROCEDA A LA 2DA ETAPA: PROCESO DE REVISIÓN DE REGISTROS
LA INCUESTA DE IDIOMA NATAL ESTA COMPLETA

Parte 9

NO PROCEDA A LA 2DA ETAPA: PROCESO DE REVISIÓN DE REGISTROS.
LA INCUESTA DE IDIOMA NATAL ESTA COMPLETA.
EL ALUMNO NO ES ESTUDIANTE DE IDIOMA INGLES (ELL)

Firma: _____ **Fecha:** _____

EAST ORANGE SCHOOL DISTRICT
FORMULAIRE DE SONGADE DE LANGUE FAMILIALE

INTRODUCTION: Ce sondage est le premier des trois étapes pour déterminer si oui ou nom un (e) étudiant (e) est qualifie (e) d'être un (e) apprenant (e) d'Anglais. Commencez avec la première partie et continuez jusqu'a ce que le formulaire de sondage de langue familiale est complété. Sélectionnez la réponse pour chaque partie et suivez les directives.

INFORMATION SUR L'ELEVE

Nom De L'eleve: _____

Adresse Postale: _____

Ville: _____ Etat: _____ Code Postal: _____

Date de Naissance de l'élève: _____ Numéro de téléphone: _____

QUESTIONS DE SONDAGE

Partie 1

Quelle était la première langue utilisée par l'élève?

☐ Une Langue autre que Anglais – Passez à la partie 2a ☐ Anglais – Passez à la partie 2b

Partie 2a

A la maison, est-ce que l'élève entend ou utilise une langue autre que Anglais plus que la moitié du temps?

☐ Oui – Passez à la Partie 7 ☐ Non – Passez à la Partie 4

Partie 2b

A la maison, est-ce que l'élève entend ou utilise une langue autre que Anglais plus que la moitié du temps?

☐ Oui – Passez à la Partie 4 ☐ Non- Passez à la partie 3

Partie 3

Est-ce que l'élève comprend une langue autre que Anglais?

☐ Oui – Passez à la Partie 4 ☐ Non – Passez à la Partie 9

Partie 4

Est-ce que l'élève entend ou utilise une langue autre que Anglais plus que la moitié du temps lorsqu'ils interagissent aves ses parents ou tuteurs?

☐ Oui – *Passez à la Partie 7* ☐ Non --*Passez à la Partie 5*

Partie 5

Est-ce que l'élève utilise une langue autre que Anglais plus que la moitie du temps lorsqu'ils interagissent avec des soignants autre que ses parents ou tuteurs?

☐ Oui ☐ Non

Partie 6

Est-ce que l'élève a récemment déménagé d'un autre district scolaire ou école a charte la ou il/elle a été identifie/e comme un/e apprenant/e de langue Anglaise?

☐ Oui ☐ Non

Partie 7

Veuillez enumérer toutes les langues parlées a la maison et proceder a la partie 8.

Partie 8

PROCÉDEZ A ETAPE 2: PROCESSUS DE RÉVISION DE DOSSIERS
SONDAGE DE LA LANGUE MATERNELLE EST ACHEVÉ

Partie 9

NE PROCÉDEZ PAS A L'ETAPE 2: PROCESSUS DE RÉVISION DE DOSSIERS
SONDAGE DE LA LANGUE MATERNELLE EST
L'ÉLÈVE N'EST PAS UN (E) APPRENANT (E) DE LANGUE ANGLAISE (ELL)

Signez: _____ **Date:** _____

EAST ORANGE SCHOOL DISTRICT
SONDAJ LANG NATIF-NATAL

Yon ti rale: Sondag sa se se premye nan twa (3) etap pou idantifye si, yon elèv kalifye kom yon elèv k ap aprann lang angle. Kòmanse avèk pati 1 e kontinye jiska sondaj lang natif la fini. Chwazi repons pou chak pati e suiv direksyon yo.

ENFÒMASYON ELÈV

Non Elev: _____

Adrès: _____

Vil: _____ Eta: _____ Kòd postal: _____

Dat fèt Elèv la: _____ Nimewo telefòn: _____

KESYON SONDAJ

Pati 1

Ki pwemye lang elèv la te itilize

☐ Yon lang Ki pa Angle – Kontinye pou pati **2a** ☐ Angle – Kontinye pou pati **2b**

Lakay, èske elèv la tande oubyen itilize yon lot lang ki pa Angle plis pase mwatye fwa?

☐ Wi – Kontinye pou pati 7 ☐ Non – Kontinye pou pati 4

Pati 2b

Lakay, èske elèv la tande oubyen itilize yon lot lang ki pa Angle plis pase mwatye fwa?

☐ Wi – Kontinye pou pati 4 ☐ Non – Kontinye pou pati 3

Pati 3

èske elèv la konprann yon lot lang ki pa Angle?

☐ Wi – Kontinye pou pati 4 ☐ Non – Kontinye pou pati 9

Pati 4

Lè gen interaction ak paran oubyen gadyen li , èske elèv la itilize yon lot lang ki pa Angle plis pase mwatye fwa?

☐ Wi – Kontinye pou pati 7 ☐ Non – Kontinye pou pati 5

Pati 5

Lè gen interaction ak lot moun ki ba li swen ki pa paran oubyen gadyen li, èske elèv la itilize yon lot lang ki pa Angle plis pase mwatye fwa?

☐ Wi ☐ Non

Pati 6

Eske elèv la te fek soti nan yon lot distri lekòl/ lekòl charte kote yo te idantifye li kòm yon elèv k ap aprann Angle?

☐ Wi ☐ Non

Pati 7

Ekri tout lang ke yo pale la kay e Kontinye pou pati 8

Pati 8

***KONTINYE* POU ETAP 2: PWOSESIS REVIZYON DOSYE.**
SONDAJ LANG NATIF-NATAL LA FINI.

Pati 9

***PA ALE NAN* ETAP 2: PWOSESIS REVIZYON DOSYE.**
SONDAJ LANG NATIF-NATAL LA FINI.
ELÈVE SA SE PAS YON ELÈV KAP APRANN ANGLE (ELL)

Siyen: _____ **Dat:** _____

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
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

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.