

# How to Register a Child

## New To East Orange

Complete an on-line application

<http://eosd.focusschoolsoftware.com/focus/auth>

Or

Go to

East Orange School District

[www.eastorange.k12.nj.us](http://www.eastorange.k12.nj.us)

Click on "School Info"

Then click on "Enrollment"

Please have all the documents ready to

Upload

## Returning to East Orange

Visit the Enrollment Center website

at <http://enrollment.eastorange.k12.nj.us>

to view registration details and

download the Registration Packet

THEN

Submit required documents along

with the completed Registration

Packet and forward to the Email

address listed below:

[enrollment@eastorange.k12.nj.us](mailto:enrollment@eastorange.k12.nj.us)

## General Registration Requirements by Grade

### 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 registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

### Kindergarten

To register your child for this school year, they must be at least 5 years old by October 1<sup>st</sup> of the current school year. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time.)A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

### Grades 1 through 5

To register your child for this school year, they must present a transfer from another school district, a current report card. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

### Grades 6 through 8

To register your child for this school year, they must present a transfer from another school district, a current report card. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

## Grade 9

To register your child for the 9th grade, they must have an 8th-grade diploma and a final report card. If your child is coming from a school that does not issue 8th grade diplomas, you must present the last report card that shows your child has completed the 8th grade and is eligible for promotion to the 9th grade. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

## Grades 10 through 12

To register your child for grades 10 through 12, you will need their unofficial transcript, transfer from another school district, and a current report card. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D., birth certificates, immunization (shot) records, and a current physical is mandatory. Three (3) proofs of residency in East Orange are required.

## Charter/ Vocational School

To register your child for Charter/Vocational School, you must have an Acceptance Letter signed by the Charter/Vocational School your child will attend. If your child is transferring from an East Orange public school, you must have a transfer. All children must be registered by a parent or a legal guardian (guardianship papers must be available at the registration time). A parent or legal guardian must have a valid photo I.D. Birth certificates are mandatory. Three (3) proofs of residency in East Orange are required.

For further information, please visit the Enrollment Center website:

<https://enrollment.eastorange.k12.ni.us>

## Proof of Residency List

All persons registering children into the East Orange School district must provide **three (3) current proofs of residency**.

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 live 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 a child in the home of East Orange resident
- Child Placed in East Orange by Child Welfare Agency – Document of child welfare agency ordering the placement of a child in the home of an 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
- 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/pay stub
- Hospital/Medical bills
- Postal Change of Address

**A parent/legal guardian must complete the registration**

EAST ORANGE SCHOOL DISTRICT  
FORMULAIRE DE SONDAGE DE LANGUE FAMILIALE

EAST ORANGE SCHOOL DISTRICT  
SONDAJ LANG NATIF-NATAL

**INTRODUCTION:** Ce sondage est le premier des trois étapes pour déterminer si oui ou non un (e) étudiant (e) est qualifié (e) d'être un (e) apprenant (e) d'Anglais. Commencez avec la première partie et continuez jusqu'à 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 avec 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 moitié 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 identifié/e comme un/e apprenant/e de langue Anglaise?

Oui       Non

**Partie 7**

Veillez énumérer toutes les langues parlées a la maison et proceder a la partie 8.

**Partie 8**

**PROCÉDEZ A ETAP 2: PROCESSUS DE RÉVISION DE DOSSIERS  
SONDAGE DE LA LANGUE MATERNELLE EST ACHÉVÉ**

**Partie 9**

**NE PROCÉDEZ PAS A L'ETAP 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: \_\_\_\_\_

**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. Kòmansè avèk pati 1 e kontinye jiska sonda j 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.  
ELÈV SA SE PAS YON ELÈV KAP APRANN ANGLE (ELL)**

Siyen: \_\_\_\_\_ Dat: \_\_\_\_\_

**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 continúe 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 2<sup>PA</sup> ETAPA: PROCESO DE REVISIÓN DE REGISTROS  
LA INCUESTA DE IDIOMA NATAL ESTA COMPLETA**

**Parte 9**  
**NO PROCEDA A LA 2<sup>PA</sup> 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**  
**Division of Operations, Compliance &**  
**Educational Support Services**  
*Department of Special Education Services*  
 199 Fourth Avenue  
 East Orange, New Jersey 07017-1026  
 Phone (973) 266-5785 FAX 973-266-5805  
[www.eastorange.k12.nj.us](http://www.eastorange.k12.nj.us)

**Director**  
 Tonya H. Santos

[t.hardin@eastorange.k12.nj.us](mailto: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:

<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>	
_____	_____	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:

<b>YES</b>	<b>NO</b>	<b>RELATIONSHIP</b>	<b>YES</b>	<b>NO</b>	<b>RELATIONSHIP</b>
_____	_____	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

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**PARENT NOTIFICATION FOR PHYSICAL EXAMINATION**

STUDENT: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

Dear Parent/Guardian:

The State of New Jersey Public Law N.J.S.A. (19A:40-4) requires all students to have physical examination at least once during each of his/her development stages:

- Early Childhood (preschool through grade 3)
- Pre-adolescence (grade 4 through grade 5)
- Adolescence (grade 7 through grade 12)

The East Orange School District require ALL new students, preschool/kindergarten, grades 3, 5, 8 and 11 to have a recent physical examination, in order to comply with this new rule.

If you have a medical provider you **MUST** present the school with written proof of a recent physical examination, signed and dated by the provider.

I give permission for the school nurse to call the child's physician for verification or if there is an emergency.

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_

If you do not have a medical provider and wish to have a physical examination done at school please sign the emergency card attached and return within seven (7) days.

Rev: 8/2018

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**SCHOOL YEAR**  
20\_\_\_\_ - 20\_\_\_\_

**SCHOOL HEALTH SERVICE**  
**PARENT/GUARDIAN MEDICAL CONSENT DURING SCHOOL HOURS**

I give permission to the East Orange Board of Education medical and/or nursing staff to perform the following services for my child: \_\_\_\_\_ . I understand, the purpose of these services is preventing and/or treating disease and other medical conditions or emergencies:

- Administer Medical Treatment
- Administer Medication
- Administer Mantoux (TB) Skin Test
- Physical Examination
- Screen (i.e.: Height, Weight, Hearing, Vision, Scoliosis, Blood Pressure, Dental Observations, etc.)
- Post my child's allergies in a prominent location(s) in the school
- Dental Screening
- Other: \_\_\_\_\_

\_\_\_\_\_  
Dr. F. Eatman, MD, School Physician

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Location

\_\_\_\_\_  
Parent/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (Print Name)

Do you wish to be present during any of the above procedures?

**Yes, I want to be present\***

**No, I do not want to be present.**

\*If yes, please check the box (above) the procedure for which you would like to be present.

**Do you grant permission for medical information to be released/exchanged with other personnel?**  
(Examples: Sharing necessary medical information (i.e.: allergies, asthma, etc.) with school personnel on an "as needed basis". Contacting your child's physician to verify medical information should the need arise).

**Yes, you may exchange information.**

**No, you may not exchange information.**

# 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	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>					
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)		
<b>IMMUNIZATIONS</b>		<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"/> <b>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.</b>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

# Instructions for Completing the Universal Child Health Record (CH-14)

## Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

## Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.

- The Immunization record must be attached for the form to be valid.
- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at [www.nj.gov/health/forms/ch-15.dot](http://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](http://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.