

## PRE-K REGISTRATION CHECKLIST

*Please bring these items with you to your registration appointment*

Students are not considered fully registered until all items from A, B, and E are submitted.

A	Original birth Certificate (or Certified Copy) within 30 days of enrollment. Valid Passport *A copy will be made at your registration appointment	[ ]
B	Proof of residency with the last name noted on the proof ( <b>5 items in total</b> ). <ul style="list-style-type: none"> <li>• Deed or Lease Agreement, Contract of Sale, or Landlord Certification form</li> <li>• Must bring appropriate completed residency affidavit (available during on-line pre-registration on the Hillsdale registration website)</li> <li>• Choose three supplemental items such as: tax bills, mortgage, voter registration, vehicle registration, licenses, permits, bank statements, utility bills, credit card bills, phone bills, and cancelled checks.</li> </ul>	[ ] [ ] [ ]
C	Speech / Language Information Form	[ ]
D	Learning Experiences (If applicable, from parents and/or outside facility and send directly to school)	[ ]
E	Universal Child Health Record Form <ul style="list-style-type: none"> <li>• Physical and Immunizations (completed by physician)</li> <li>• Current records must be submitted at registration appointment</li> </ul>	[ ]
F	Health Questionnaire	[ ]
G	Health Insurance Form	[ ]

ADMISSION

AFFIDAVIT OF APPLICANT/GUARDIAN  
RESIDENT OF HILLSDALE, NEW JERSEY 07642

(Part one)

STATE OF NEW JERSEY:

AFFIDAVIT

COUNTY OF BERGEN:

Note: If applicant is married, this affidavit must  
be signed by both husband and wife.

Sworn statement for Right of Non-tuition School Attendance

\_\_\_\_\_ and \_\_\_\_\_

of full age and being duly sworn according to law and under oath say/s:

1. My/our domicile (permanent home) is in Hillsdale, New Jersey at

\_\_\_\_\_ (address).

2. I/we am/are supporting gratuitously, as if s/he were my/our child, the child named

\_\_\_\_\_. The child has resided with me/us since \_\_\_\_\_.

I/we receive no contributions or payment either in money or in food, clothing, recreation, medical expenses, lodging or any other thing or service of value in connection with the support maintenance and education of the child named above. The gratuitous support of the child named above shall continue for a period longer than merely through the school year.

3. I/we will assume all personal obligations for the child named above with respect to school requirements.

4. The answers, statements, and declaration made in the application for admission of said child are absolutely true in all respects.

5. The affidavit, together with the application for admission, is made specifically to induce the Hillsdale Board of Education to accept the child named above as a legally qualified pupil in the Hillsdale School District public schools and without payment of tuition, knowing that the Hillsdale Board of Education will rely upon the truth of the statements herein contained.

6. I/we agree to furnish any documentation that may be required by the Hillsdale Board of Education and/or its administration to confirm the accuracy of any of my/our representatives.

7. I/we fully understand and agree that any false or fraudulent statements, answers or declarations contained in this affidavit or in the application for admission may render me/us personally liable to the Hillsdale Board of Education for the payment of tuition for the school year which is \$\_\_\_\_\_ for the 20\_\_\_\_/\_\_\_\_ school year.

**ADMISSION** (continued)

8. I/we fully understand and agree that, if I/we fraudulently allow the child named above to use our residence and I/we am/are not the primary financial supporter of this child, I/we will have committed a disorderly persons offense. If I/we am/are convicted of such an offense, I/we may be fined up to \$1,000.00 and/or be imprisoned for up to six months.
9. I/we fully understand and agree that any false statements, answers, or declarations contained in this affidavit or in the application for admission may subject me/us to criminal prosecution for the crime of false swearing in violation on N.J.S.A. 2C:28-2. If I/we am/are convicted for such a crime, I/we may be punished by a fine of up to \$7,500.00 and/or be imprisoned for up to 18 months.
10. I/we are owner of or rent the foregoing property. This has been my/our permanent residence since \_\_\_\_\_. A copy of my/our deed or lease, whichever is applicable, is attached hereto. If I/we do not have a lease, then I/we understand that I/we have to produce a sworn statement from my/our landlord which acknowledges my/our tenancy.

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Signature

\_\_\_\_\_  
Applicant/Guardian Signature

Sworn and subscribed  
before me on this \_\_\_\_ day  
of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
A Notary Public of the State of New Jersey

My Commission expires \_\_\_\_\_

(SEAL)

Approved: November 19, 2007  
Revised:

**ADMISSION**

**APPLICATION BY A RESIDENT OF HILLSDALE, NEW JERSEY 07642  
FOR THE ADMISSION OF A CHILD WHOSE PARENTS ARE NONRESIDENTS**

(Part two)

Note: All questions must be answered. If no information can be provided for an item, enter none in the space. If applicant is married, both applicants must sign this application.

**Sworn statement for Right of Non-Tuition School Attendance**

TO: Principal of \_\_\_\_\_ School and Board of Education of the Hillsdale Public School District.

I certify that the statements made by me/us in this certification are true and I/we am/are aware that if any statements made by me/us are false that I/we may be subject to civil and criminal penalties.

Signature: \_\_\_\_\_ (applicant/guardian)

Signature: \_\_\_\_\_ (applicant/guardian)

Date: \_\_\_\_\_

**QUESTIONS CONCERNIN THE CHILD TO BE ADMITTED TO THE DISTRICT**

1. Full name \_\_\_\_\_
2. Sex \_\_\_\_\_
3. Date of birth \_\_\_\_\_
4. Date child moved into the Hillsdale School District address \_\_\_\_\_
5. a. Has child continuously resided at the Hillsdale Public School District address since that date? \_\_\_\_\_  
b. If not, state the address, length of time, and with whom the child has been residing.  
\_\_\_\_\_
6. State residence and with whom child resided for the past five (5) years immediately preceding the date of this application. \_\_\_\_\_  
\_\_\_\_\_

7. a. Will the child be claimed as a dependent child on the applicant's Federal Income Tax Return during the time s/he resides with the applicant? \_\_\_\_\_
- b. If not, set forth the name and address of the person who will claim the exemption of the child.  
\_\_\_\_\_

**QUESTIONS CONCERNING THE PARENTS AND FAMILY OF THE CHILD**

1. Name and address of parent: \_\_\_\_\_  
\_\_\_\_\_
2. Occupation, name and address of employer: \_\_\_\_\_  
\_\_\_\_\_
3. Name and address of parent: \_\_\_\_\_  
\_\_\_\_\_
4. Occupation, name and address of employer: \_\_\_\_\_  
\_\_\_\_\_
5. a. Marital status of parents (married, divorced, separated, widowed).  
(circle one)
- b. If parent(s) is/are divorced or separated, who has legal custody of the child? \_\_\_\_\_  
\_\_\_\_\_
- c. Attach a copy of the court order which establishes the custody of the child.
6. Name, address and age of any brother(s) and sister(s) of the child. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Names and address of the schools each of the brother(s) or sister(s) will attend this year. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Set forth in detail all reasons why neither parent is capable of caring for the child who seeks admission to the Hillsdale Public School District. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**QUESTIONS CONCERNING THE APPLICANT(S)**

1. Name and address of the applicant(s). \_\_\_\_\_  
\_\_\_\_\_
2. Date applicant became a resident of the Hillsdale Public School District. \_\_\_\_\_  
If less than five (5) years, set forth all residences of applicant during the past five (5) years.  
\_\_\_\_\_  
\_\_\_\_\_
3. Name, age and address of applicant's children. \_\_\_\_\_  
\_\_\_\_\_
4. Name and address of school that applicant's children are attending this year. \_\_\_\_\_  
\_\_\_\_\_
5. a. Number of rooms in applicant's residence. \_\_\_\_\_  
b. Number of bedrooms in applicant's residence. \_\_\_\_\_
6. Set forth in detail the reason why the child is residing with the applicant and not with the parent or legal guardian. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Signature

\_\_\_\_\_  
Applicant/Guardian Signature

Sworn and subscribed  
before me on this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
A Notary Public of the State of New Jersey

My Commission expires \_\_\_\_\_

(SEAL)

Approved: November 19, 2007  
Revised:

ADMISSION

SWORN STATEMENT OF NONRESIDENT PARENTS WHO HAVE GIVEN CUSTODY OF  
THEIR CHILD TO A RESIDENT OF THE HILLSDALE PUBLIC SCHOOL DISTRICT

(Part three)

STATE OF NEW JERSEY:

AFFIDAVIT

COUNTY OF BERGEN:

\_\_\_\_\_ and \_\_\_\_\_  
of full age and being duly sworn according to law and under oath say/s:

1. Complete one of the following:

- a. We are the parents of the child named \_\_\_\_\_
- b. I am the only living parent of the child named \_\_\_\_\_  
The child's other parent \_\_\_\_\_ died on or about \_\_\_\_\_
- c. I am the parent of the child named \_\_\_\_\_. I am separated / divorced (circle one) and I have the legal custody of the said child. A copy of the court order which established the custody of the child is attached.

2. I/We am/are the owners of or rent property located at \_\_\_\_\_  
and have resided at this address since \_\_\_\_\_

3. I/We have carefully read the foregoing affidavit (Part 1) and the application (Part 2) made by \_\_\_\_\_  
name(s), and the answers, statements, and declarations set forth in said affidavit and application are absolutely true in all respects.

4. On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ I/we gave custody of my/our child to \_\_\_\_\_  
name(s)), hereinafter referred to as the guardian(s).  
My/Our child is presently residing with the foregoing person(s) at \_\_\_\_\_  
My/Our child is not residing with the foregoing person(s) for the sole purpose of  
receiving a free public education in the Hillsdale Public School District.

5. I/We am/are not capable of supporting or providing care for my/our child due to a family or economic  
hardship for the following reasons: \_\_\_\_\_

I/We will make no contribution or payment, either in money or in kind for food, clothing, recreation,  
medical expense, lodging, or anything or service of value, or other costs and expenses in connection  
with the support, maintenance or education of the said child.

6. The said guardian(s) \_\_\_\_\_ (name(s)), will keep and support  
the said child gratuitously as if the said child were their own with no contributions or payment, either in  
money or in kind for food, clothing, recreation, medical expense, lodging, or anything or service of  
value, or other costs and expenses in connection with the support, maintenance or education of the  
said child.

- 7. The said child **will not** be claimed as a dependent child on my/our Federal or State Income Tax Return during the time the child resides with the guardian(s).
- 8. This affidavit, together with the application for admission (Part 2) and affidavit of applicant guardian resident of \_\_\_\_\_ (Part 1), is made specifically to induce the Hillsdale Board of Education to accept the child named as a legally qualified pupil in the Hillsdale District public schools and without payment of tuition, knowing that the Hillsdale Board of Education will rely upon the truth of the statements contained herein.
- 9. I/We fully understand and agree that any false or fraudulent statements, answers, or declarations contained in this affidavit or in the application for admission may render me/us personally liable to the Hillsdale Board of Education for the payment of tuition for the school year, which is \$ \_\_\_\_\_ for the 20\_\_\_\_/\_\_\_\_ school year.
- 10. I/We fully understand and agree that:
  - a. If I/we fraudulently claim to have given up custody of my/our said child to the said guardian(s), I/we will have committed a disorderly persons offense and upon conviction thereof, I/we may be punished by a fine of up to \$1,000 and/or be imprisoned for up to six (6) months.
  - b. I/We have read and understand the affidavit and application of the applicant/guardian (Parts 1 and 2), and any false statements, answers or declarations contained in this affidavit (Part 3), or in the affidavit and/or application of the applicant/guardian (Parts 1 and 2), may subject me/us to criminal prosecution for the crime of false swearing in violation of N.J.S.A. 2C:28-2, and upon conviction thereof, I/we may be punished by a fine of up to \$7,500 and/or be imprisoned for up to 18 months.
  - c. I/We agree to furnish any documentation that may be required by the Hillsdale Board of Education and/or its administration to confirm the accuracy of my/our representations.

In all references herein to any parties or persons, the use of any particular gender or the plural of singular number is intended to include the appropriate gender or number as the test of the within instrument may require.

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Print

\_\_\_\_\_  
Applicant/Guardian Signature

\_\_\_\_\_  
Applicant/Guardian Signature

Sworn and subscribed  
before me on this \_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
A Notary Public of the State of New Jersey

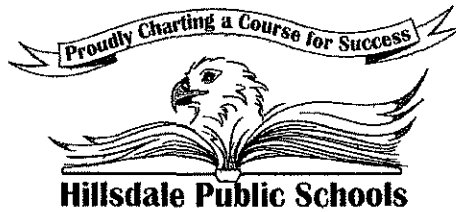
My Commission expires \_\_\_\_\_

(SEAL)

Approved: November 19, 2007  
Revised:







As part of the screening process, your child's speech/language will be assessed.

The screening will provide the classroom teacher with information on overall receptive and expressive language skills, along with listening skills and following directions.

The section below is for your input. If you feel your child has speech or language areas which concern you, please tell us about them.

Please return this page with the registration packet.

**Speech/Language Information**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

My child speaks English: Yes [ ] No [ ]

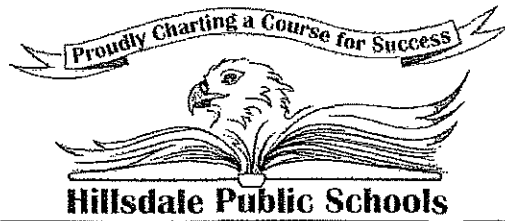
My child speaks another language. It is \_\_\_\_\_

Describe your child's speech or language skills: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any information you could share which might be relevant to development of speech, such as birth or milestone history. Use the back of page if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Required Medical Documents**

In accordance to NJ State laws, the Hillsdale Board of Education requires that all registrants submit a completed physical examination form and an immunization record before the start of the school year. The physical form must be dated within 365 days from the start of the school year. (x) Check off each item

A	<p><b><u>Physical Form – completed by physician</u></b></p> <ul style="list-style-type: none"> <li>• A current physical should be submitted upon registration.</li> <li>• If physical was not performed within the 365 days from the start of the school year, a new one must be submitted immediately upon completion.</li> </ul>	
B	<p><b><u>Immunization Form – completed by physician</u></b></p> <ul style="list-style-type: none"> <li>• A current immunization record must be submitted at registration, regardless of physical exam date.</li> <li>• Any subsequent immunization data should also be submitted immediately upon completion.</li> </ul> <p><b><u>For Pre-School (3 - 4 years) your child must have:</u></b></p> <ol style="list-style-type: none"> <li>1. DTaP – 4 doses</li> <li>2. Polio – 3 doses</li> <li>3. MMR – 1 dose</li> <li>4. Hib – 1 dose after 1<sup>st</sup> birthday</li> <li>5. Varicella (Chicken Pox) – 1 dose</li> <li>6. PCV7 (Pneumococcal vaccine) – 1 dose (given after 1<sup>st</sup> birthday)</li> <li>7. Influenza – 1 dose annually (6-59 months-given after 1<sup>st</sup> birthday)</li> </ol> <p><b><u>For Kindergarten your child must have:</u></b></p> <ol style="list-style-type: none"> <li>1. DTaP – 4 doses with one dose given on or after the 4<sup>th</sup> birthday or any 5 doses. If DT is substituted for DTaP, a written explanation from the child’s physician MUST be provided.</li> <li>2. Polio – 3 doses with one dose given on or after the 4<sup>th</sup> birthday or any 4 doses.</li> <li>3. Measles – 2 doses</li> <li>4. Mumps and Rubella – 1 dose of each.</li> <li>5. Hepatitis B – 3 doses.</li> <li>6. Varicella – 1 dose for chickenpox or laboratory evidence of immunity.</li> </ol>	

# UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health

## SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)
	Height (must be taken within 30 days for WIC)
	Head Circumference (if <2 Years)
	Blood Pressure (if >3 Years)

<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:
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### 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		

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	

# 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.

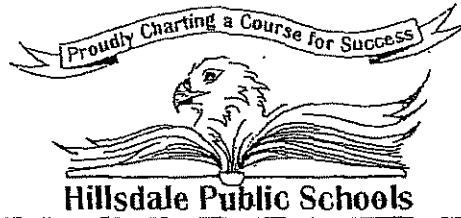
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place 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.



The nursery, pre-school or in-home-care giver who has spent time with your child can often offer information useful to the screening committee. If you would like to have these experiences shared with us, please have the appropriate person fill out the form below. Please send form directly to your child's school.

Parents please indicate which school this form should be returned to:

Ann Blanche Smith School  
1000 Hillsdale Avenue  
Hillsdale, NJ 07642  
201-664-1188

Meadowbrook School  
50 Piermont Avenue  
Hillsdale, NJ 07642  
201-664-8088

\*Preschool Teacher please return this form to the address above no later than April 1<sup>st</sup>.

Pre-School Experiences

Child's Name \_\_\_\_\_ Date: \_\_\_\_\_

Pre-School: \_\_\_\_\_ Phone: \_\_\_\_\_

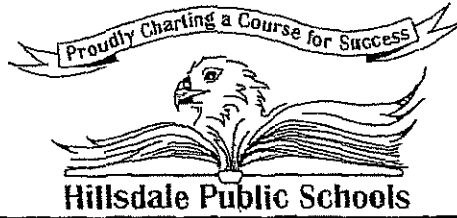
Teacher or Caregiver: \_\_\_\_\_

1. How long have you worked with this child? \_\_\_\_\_
2. Is the child in a full day or part day, full week or part week program? \_\_\_\_\_
3. Is the program Montessori, developmentally or academically bases? \_\_\_\_\_
4. School readiness skills (social, emotional, and physical development). Areas which you might address are: friendships, self-image, maturity, independence, attention span, following directions, speech articulation, expressive and receptive language, large and fine motor skills, and special strengths.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Please specify areas which should receive attention during screening or in determining appropriate school programming. (Articulation, language, maturity, following directions, etc. (Please continue on back of this page.)

\_\_\_\_\_  
\_\_\_\_\_



KINDERGARTEN

REPORT OF DENTAL EXAMINATION

*(Optional)*

IT IS RECOMMENDED THAT CHILDREN HAVE BEEN TO THEIR DENTIST FOR AN EXAMINATION BY THE TIME THEY ENTER KINDERGARTEN.

PLEASE HAVE YOUR CHILD'S DENTIST COMPLETE THE FOLLOWING AND RETURN THIS FORM TO THE SCHOOL NURSE.

\*\*\*\*\*

I HAVE EXAMINED : \_\_\_\_\_

(CHILD'S NAME)

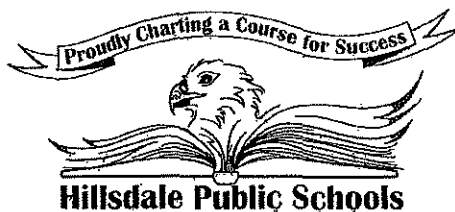
TEETH ON \_\_\_\_\_, AND REPORT THE FOLLOWING:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF DENTIST: \_\_\_\_\_

\_\_\_\_\_

(Print or stamp name and address)



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## HEALTH INSURANCE INFORMATION FORM

STUDENT'S NAME: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

**Does child have Health Insurance?**

Yes \_\_\_\_\_ If Yes, name of insurance  
company \_\_\_\_\_

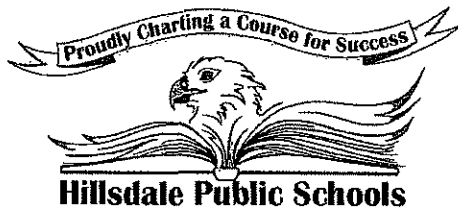
No \_\_\_\_\_ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.  
For more information call 1-800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online.  
You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

*Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).*





## HEALTH QUESTIONNAIRE

TODAY'S DATE: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

SIBLINGS (Please specify name, gender, and age):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OTHERS LIVING IN HOUSEHOLD (Please state name and relationship):

\_\_\_\_\_  
\_\_\_\_\_

LANGUAGE(S) SPOKEN IN THE HOME:

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

PRE- and POST-NATAL HISTORY:

Pregnancy (Please check one): Full-term \_\_\_\_\_ Premature \_\_\_\_\_

Complications: \_\_\_\_\_ Birthweight: \_\_\_\_\_ lbs. \_\_\_\_\_ ounces

PARENT/SIBLING HISTORY:

Do the student's parents or siblings have any significant medical problems, illnesses, or allergies?

Parent: \_\_\_\_\_

Parent: \_\_\_\_\_

Siblings: \_\_\_\_\_

MEDICATIONS:

Does your child take any medications or need an EpiPen/Twinjet for allergic reactions?

Daily medications: \_\_\_\_\_

Medications needed at school: \_\_\_\_\_

EpiPen/Twinjet (please indicate yes or no): \_\_\_\_\_ Last time used: \_\_\_\_\_

**STUDENT ALLERGY HISTORY:**

**Reaction to Allergen**

Food(s): _____	_____
_____	_____
_____	_____
Environmental: _____	_____
Insect Stings: _____	_____
Latex: _____	_____
Medications: _____	_____

**INJURIES/SURGERY:**

Fractures: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Head Injuries: \_\_\_\_\_ Sutures: \_\_\_\_\_  
Has your child ever visited the Emergency Room? Yes \_\_\_\_\_ No \_\_\_\_\_  
How many times? \_\_\_\_\_ Reason: \_\_\_\_\_  
Other: \_\_\_\_\_

**ILLNESSES (Please check if applicable):**

Asthma _____	Epilepsy/Convulsions _____	Respiratory Infections _____
Chicken Pox _____	Febrile Seizures _____	Skin Problems _____
Diabetes _____	Mononucleosis _____	Strep Throat _____
Ear Infections _____	Other _____	

**SPECIAL CONSIDERATIONS:**

Developmental Delay: YES _____	NO _____
Hearing Problems _____	Hearing Aid _____
Vision Problems _____	Glasses/Contacts _____
Bowel/Bladder Problems _____	
Physical Therapy _____	Occupational Therapy _____
Speech Difficulties _____	Speech Therapy _____
Emotional Issues _____	
Other _____	

**IS THERE ANY ADDITIONAL INFORMATION (health status, home situation, or behavior) that you feel would be helpful in planning your child's school year?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_