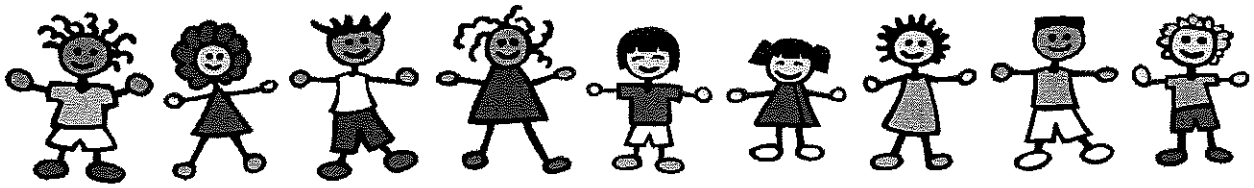

Farmingdale Public School

49 Academy Street
Farmingdale, New Jersey 07727
www.farmingdaleschool.com 732-938-9611

PRE-SCHOOL REGISTRATION & KINDERGARTEN – 8th GRADE REGISTRATION

Registration for children eligible to enter Pre-School and Kindergarten will begin on Tuesday, January 22, 2019

To register, please visit www.farmingdaleschool.com and click on the appropriate Registration Packet link under the **Helpful Links** section on the right side of the page, or call 732-938-9611 to request a Registration packet. Your completed packet will need to include the following:

For Pre-School Students*

1. Completed Application
2. NJ State Demographic and Emergency Information
3. Completed Health Questionnaire
4. Universal Child Health Record which should be completed by your child's physician
5. Copy of your child's most recent immunization records
6. Your child's original birth certificate issued by the Bureau of Vital Statistics (it will be copied and returned to you)
7. $75.00 registration fee

For Kindergarten – 8th Grade Students**

1. Two documents proving Farmingdale residency (see attached form outlining acceptable documents to satisfy both Section A and Section B requirements)
2. NJ State Demographic and Emergency Information
3. Completed Health Questionnaire
4. Universal Child Health Record which should be completed by your child's physician
5. Copy of your child's most recent immunization records
6. Your child's original birth certificate issued by the Bureau of Vital Statistics (it will be copied and returned to you)

* Pre-School: Your child must be 3 years old on or before October 1, 2019, and fully toilet-trained as of the start of school in September.

** Kindergarten: Your child must be 5 years old on or before October 1, 2019 to register.

Farmingdale School District
49 Academy St.
Farmingdale, NJ 07727
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Proof of Residency Requirement

As part of the student registration process, two documents demonstrating residency are required to validate a student's eligibility for enrollment in the district. One document from each section below must be provided. These documents are also required whenever there is a change of address for a previously-enrolled student.

Section A – Primary proof of residency **(must provide one of the following)**:

- Property tax bill
- House deed
- Contract of sale
- Current lease or rental agreement
- Mortgage statement
- Signed, dated, and notarized letter from landlord

Section B – Secondary proof of residency **(must provide one of the following)**:

- Gas bill
- Electric bill
- Water bill
- Sewer bill
- Cable bill
- **Please note that a cell phone bill is not an acceptable proof of residency**

Please be aware that any initial determination of the student's eligibility to attend school in this district is subject to more thorough review and subsequent re-evaluation, and that tuition may be assessed in the event that an initially-admitted student is later found ineligible.

Student's Name _____ Date of birth _____

Parent/Guardian Name _____ Phone number _____

For office use:

Section A Documentation: _____

Section B Documentation: _____

Farmingdale Public School

NJDOE Demographic and Emergency Information

Student's Name: _____
Last Name First Name Middle Name

Birth Date: _____ Gender: _____ Grade: _____ Teacher: _____

Address Where Child Resides: _____

_____

Child Lives With: ( ) Both Parents ( ) Mother ( ) Father
( ) Step-Father ( ) Step-Mother ( ) Other: _____

City of Birth: _____ State of Birth: _____ Country of Birth: _____

Ethnicity: ( ) White ( ) American Indian/Alaskan ( ) Multi
( ) Black ( ) Hawaiian Native/Pacific Islander
( ) Hispanic ( ) Asian

Primary Language of Student: _____ Language Spoken at Home: _____

Mother's Name: _____ Allowed to contact? Yes No

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____

Email Address: _____

Father's Name: _____ Allowed to contact? Yes No

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____

Email Address: _____

Names and Birth Dates of brothers and sisters: _____

Name and Address of Child's Physician: _____

Previous schools attended with dates (include preschool): _____

Does your child have an IEP or receive special services? _____ If so, please describe

_____

Please list two neighbors or nearby relatives who are at home during the day and would be willing to pick up your child at school and/or assume temporary care of your child if you cannot be reached during an emergency. **PLEASE LIST TWO.**

Name: _____ Name: _____

Address: _____ Address: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

Signature of Parent or Guardian: _____ Date: _____

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Farmingdale Health Questionnaire

School Year _____

NAME: _____ **DATE:** _____

This questionnaire will help the doctor and school nurse to find out if your child is in the best of health for school. The questionnaire will become part of your child's personal health record and is confidential. Take the questionnaire to your family doctor when he examines your child, as your answers will help him too.

Please write down any special questions you have regarding your child's health. The doctor or school nurse will help you with any questions you might have with parts of this questionnaire.

PLEASE CIRCLE THE CORRECT ANSWER. EXPLAIN IF ANSWER IS YES.

1.	Has your child had Headaches or Dizzy Spells?	**No**	**Yes**
2.	Convulsions or other seizures?	**No**	**Yes**
3.	Trouble with eyes or with seeing?	**No**	**Yes**
4.	Trouble with ears or with hearing?	**No**	**Yes**
5.	Nose bleeds, constant colds, sore throats, or sinus?	**No**	**Yes**
6.	Frequent swollen glands?	**No**	**Yes**
7.	Asthma, wheezing, cough, bronchitis, pneumonia? If YES – medication for the above	**No**	**Yes**
8.	Heart trouble?	**No**	**Yes**
9.	Frequent upset stomach or bowel trouble?	**No**	**Yes**
10.	Trouble with urination or making water?	**No**	**Yes**
11.	Kidney or bladder infection?	**No**	**Yes**
12.	Any exposure to Tuberculosis?	**No**	**Yes**
13.	Any previous illness at any age?	**No**	**Yes**
14.	Special doctoring at any age?	**No**	**Yes**
15.	Diabetes?	**No**	**Yes**
16.	Mumps, Measles, Chickenpox, Whooping Cough or German Measles? **(Circle)**	**No**	**Yes**
17.	Any stays in a hospital? (If YES, explain) Why: _____ _____ When:	**No**	**Yes**

18.	Any operations? Date: What Kind:	**No**	**Yes**
19.	Any bad accidents or broken bones?	**No**	**Yes**
20.	Hay Fever, Hives, or Eczema?	**No**	**Yes**
21.	Allergies?	**No**	**Yes**
	_____ Medication for above:		
22.	Tires easily, loss of vigor, or trouble fighting-off infections?	**No**	**Yes**
23.	Any trouble sleeping or nightmares?	**No**	**Yes**
24.	Bed wetting or day wetting?	**No**	**Yes**
25.	Thumb sucking, nail biting, stammering, stuttering?	**No**	**Yes**
26.	Other speech problems?	**No**	**Yes**
27.	Nervous habits, high-strung, easily upset, temper tantrums?	**No**	**Yes**
28.	Shy, glum, sulky or feelings easily hurt?	**No**	**Yes**
29	Wanting too much attention – disobedient?	**No**	**Yes**

Please answer these questions about the history of pregnancy, birth and early life:

1.	Was there a sickness or complication during pregnancy? **(Optional)**	**No**	**Yes**
2.	Did you have any infections or viruses during pregnancy? **(Optional)**	**No**	**Yes**
3.	Did you have high blood pressure or extra water retention during pregnancy? **(Optional)**	**No**	**Yes**
4.	Did you take medication during pregnancy? **(Optional)**	**No**	**Yes**
5.	Was there trouble with the labor and/or delivery? **(Optional)**	**No**	**Yes**
6.	Was the baby abnormal at birth or was there a birth defect?	**No**	**Yes**
7.	Did the baby do well for the first few months?	**No**	**Yes**
8.	Was there any problem with colic, crying, vomiting, sleeping, or settling the baby?	**No**	**Yes**
9.	At what hospital was the baby born? Birth weight:	**Address:**	
10.	Who is your child's family physician? Address:		
11.	How many times has your child seen a doctor in the last year?		
12.	When was your child's last check-up?		

FARMINGDALE PUBLIC SCHOOL

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:			Scollosis		

☐ ***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	

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.