PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

____ LP (PreK-K) ____ FSS (1-3) ____ PWC (4-5) ____ PGMS (6-8) ____ PGHS (9-12) ____ OOD

Has your child ever attended the PG-CP School District before? ____ No ____ Yes If yes, what year and grade: _____

STUDENT INFORMATION 2019-2020

Student ID#: _____ Student State of NJ ID#: _____ Current Grade: _____

(*Legal name as it appears on Certificate of Birth)

*First Name *Middle Name *Last Name Suffix

_____ Date of Birth: MM/DD/YYYY Gender: ☐ Male ☐ Female

First Entry Date into a U.S. School: _____

Does your child have an IEP or 504 Plan: **Y or N**

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic

Name of Previous School:	Address:
City:	State: Zip:

Language first acquired by student:_____ Language most spoken by student:_____

Does the student understand a language other than English? **Y or N** Language most spoken by student at home:_____

Has the student recently moved from another school district where he/she was identified as an English Language learner? **Y or N**

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:_____

Street Address City State Zip

Name of Parent/Guardian #1:	Contact Number: ____Home ____Cell	Email Address:
Name of Employer:	Work Number:	Relationship to Student:

Name of Parent/Guardian #2:	Contact Number: ____Home ____Cell	Email Address:
Name of Employer:	Work Number:	Relationship to Student:

Residential Status:

☐ **Own** ☐ **Rent** ☐ **Foster/Resource Family Home** ☐ **Living with Family/Friend** ☐ **Shelter/Motel**

Name of all children living in the home:

Name	Date of Birth	Grade

MILITARY STATUS

Please circle the number below that corresponds to the military status of the student's parent or guardian:

1 = Not Military Connected: Student is not military-connected.

2 = Active Duty: Student is a dependent of a member of the Active Duty Forces (full-time) – Army, Navy, Air Force, Marine Corps, Alternatively, Coast Guard.

3 = National Guard or Reserve: Student is a dependent of a member of the National Guard or Reserve Forces – Army, Navy, and Air Force, Marine Corps, or Coast Guard.

4 = Unknown: It is unknown whether or not the student is military-connected.

EMERGENCY CONTACT/MEDICAL DATA

Does your child have Health Insurance? _____ YES _____ NO	If yes, name of Health Insurance Company:

***If no insurance**, you may release my name and address to the NJ Family Care Program to contact me about health insurance. NJ Family Care provides free or low health insurance for uninsured children and certain low-income parents. For more information visit www.njfamilycare.org to apply on line or call 1-800-701-0710.* **_____ YES _____ NO**

Name of person(s) other than parent/guardian who may assume temporary care of student if parent/guardian cannot be reached.

Contact #1	***Contact Name (Last, First)***	***Relationship to Student***	***Phone Number***	***Cell Phone Number***
Contact #2	***Contact Name (Last, First)***	***Relationship to Student***	***Phone Number***	***Cell Phone Number***
Contact #3	***Contact Name (Last, First)***	***Relationship to Student***	***Phone Number***	***Cell Phone Number***

Doctor's Name	Phone Number

List any health conditions such as heart disease, diabetes, seizure disorder, severe allergies, eye or ear problems or any chronic condition that you as a parent/guardian feel should be shared with the student's teacher or school nurse.

Special Medical Considerations:
Allergies:

In the event of a serious illness or accident to your child during the regular school day, the school will:

1. Contact you for directions. If you wish to have a doctor called, they will ask you to call him/her.
2. Call the school doctor for emergency treatment if it is impossible to reach you.
3. Contact the local ambulance and transport the child to the Memorial Hospital of Salem County in the event that the responsible school official cannot successfully complete steps one and/or two above.
4. If the parent is not readily available to take a student for drug testing, the school physician shall have the authority to authorize the appropriate test.

We think it is important that we have clear-cut procedures in this regard and that everyone understands them. Such emergencies do occur, unfortunately, in any group endeavor involving large numbers of students, even though we do all we can to avoid them. The financial responsibility for all such care belongs to the parent(s)/guardian(s).

Signature of Parent/Guardian:	Date:

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

Penns Grove, New Jersey

Date:_____ Student:_____ Grade:_____
Fecha *Estudiante* *Grado*

I hereby authorize the release of **any and all school records**, including Academic, State Test Scores, CST, Medical, Discipline, Attendance, and Confidential, for the student named above, to the **Penns Grove-Carneys Point Regional School District**.

Por la presente autorizo la divulgación de todos y cada uno de los registros escolares, incluidos los resultados académicos, estatales, CST, médicos, disciplinarios, de asistencia y confidenciales, para el estudiante mencionado anteriormente, al Distrito Escolar Regional de Penns Grove-Carneys Point

Signature Parent/Guardian:_____
Firma padre/madre/encargado

Previous School Name:_____
Nombre de la escuela anterior

Address:_____
Dirección

City, State, Zip: _____
Ciudad, Estado, Código postal

Please mail records to the address indicated.

Por favor envíe los registros a la dirección indicada

____ ***Lafayette-Pershing School***
237 Shell Road
Carneys Point, NJ 08069
856-299-3230 Fax: 856-299-2180

____ ***Field Street School***
144 Field Street
Carneys Point, NJ 08069
856-299-0170 Fax: 856-299-1833

____ ***Paul W. Carleton School***
251 Maple Avenue
Penns Grove, NJ 08069
856-299-1706 Fax: 856-299-1545

____ ***Penns Grove Middle School***
351 Maple Avenue
Penns Grove, NJ 08069
856-299-0576 Fax: 856-299-4378

____ ***Penns Grove High School***
334 Harding Highway
Carneys Point, NJ 08069
856-299-6300 Fax: 856-299-6959

____ ***Penns Grove-Carneys Point***
Regional School District
Child Study Team Department
100 Iona Avenue
Penns Grove, NJ 08069
856-299-4250 ext. 1131

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

2019-2020 STUDENT SERVICES QUESTIONNAIRE

In accordance with Section 722(g)(4) of the *Elementary and Secondary Education Act*, the parents/guardians of students who are entering the district for the first time are required to complete this questionnaire.

Student Name _____ Date of Birth _____

School _____ Prior School (if any) _____

We want to make sure your child continues to get all of the services that prior schools have given him or her. To do this, we need your help. Please tell us the following:

1. What was the last grade level your child attended? _____

   Has your child ever been retained (held back a grade)? _____ Yes _____ No

2. When your child was last in school, did he/she get:

   a. Special services for students with disabilities? _____ Yes _____ No

      If yes, what kind of services did your child get? Please check all that apply.

      ___ My child had an individualized (IEP) or special plan for his/her education.

      ___ My child had a Section 504 Accommodation Plan.

      ___ My child got equipment, extra time on tests, or other help (Section 504).

      ___ My child got help for behavior improvement.

      ___ Other (please specify) _____

   b. Help with English, if English is not your child's primary language? ___ Yes ___ No

      If yes, what is your child's primary language? Please check appropriate language.

      ___ Spanish ___ Chinese ___ Gujarati ___ Panjabi (Punjabi) ___ Turkish

      ___ Other (please specify) _____

   c. Other special program (please check all that apply)

      ___ Vocational-technical ("vo-tech") education ___ Help to improve attendance

      ___ Programs for gifted or advanced students ___ Tutoring ___ Counseling

      ___ Basic skills instruction ___ Bilingual/ESL instruction ___ Speech therapy

      ___ Other (please specify) _____

Parent signature _____ Date_____

SCHOOL DISTRICT STAFF: <u>Please send this questionnaire along with the Enrollment Residency Questionnaire and student's enrollment permit to the Director of Early Childhood & Federal/State Programs within two days after completion</u>. ADG/home3c

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

2019-2020 ENROLLMENT RESIDENCY QUESTIONNAIRE

In accordance with New Jersey state law (*N.J.S.A.* 18A:38-1 and *N.J.A.C.* 6A:22-3.4) and in conjunction with the *McKinney-Vento Homeless Education Assistance Act,* proof of residency documentation is required to determine your child's eligibility for enrollment. In order to determine the appropriate residency documentation needed, please check (√) below where your child is currently residing (CHECK ONLY ONE).

Student's Name (please print): _____ School: _____

___ 1. hotel/motel – Name: _____ (provide copy of bill receipt)

___ 2. rented apartment or house (MUST provide copy of lease or letter from landlord)

___ 3. home owned by child's parent (MUST provide copy of deed, mortgage or bill of sale)

___ 4. foster home/resource family home (MUST provide copy of DCP&P placement letter)

___ 5. shelter or domestic violence shelter

___ 6. transitional housing facility

___ 7. runaway youth shelter

___ 8. home for adolescent school-age mothers

___ 9. migrant family dwelling

__ 10. residing in the home of a (*please circle one*) grandparent, aunt, uncle, brother, sister, cousin, or friend out of either economic necessity or family hardship. *Proof of residency (e.g., utility bill, lease, tax bill, etc.) is required for the person whose name is printed below.*
If "10" is checked, the following information is REQUIRED: *Printed name* of the person with whom you or your child is residing: _____
***Printed address*: _____**
***Month/day/year* when you or your child moved into this home: _____**

Do you or your child plan on residing at the above address on a temporary or permanent basis (A person's domicile is a permanent home from which he or she does not intend to move.)? *Please circle either temporary or permanent.*

REQUIRED PARENT/GUARDIAN INFORMATON: (1) Are you residing at the above address with your child? Please check ___ Yes or ___ No. If "No," print below the address where you are currently living (street/apartment number/town/state/zip code):
_____

(2) Please print below the last address where you owned, rented, were included on a lease, or resided for a minimum of one year (street/apartment no./town/state/zip code):
_____

Required parent/guardian signature _____ Date_____ ADG/home3b

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

2019-2020 REASONS FOR LEAVING LAST PERMANENT RESIDENCE

If you checked number 10 on the Enrollment Residency Questionnaire and indicated you and/or your child/children are residing in the home of a family member or friend out of economic necessity or family hardship, then please review the reasons listed below and CHECK (√) ALL that apply. Failure to provide a reason and requested documents may result in a decision that your child/children is/are not eligible to attend school in our district, pursuant to Board policy and state law.

Child/Children's Name(s):_____

Residing at: _____

___ 1. evicted by landlord or by court order from apartment, home or hotel/motel room

___ 2. received eviction notice from landlord or court

___ 3. left residence due to inability to pay rent, mortgage, etc. before being evicted

___ 4. currently unemployed

___ 5. currently unable to economically afford to rent an apartment or house

___ 6. currently lack the resources or support networks needed to obtain permanent housing

___ 7. left residence due to domestic violence

___ 8. left residence because of chronic physical or mental health conditions, substance abuse, or other disability

___ 9. required to leave residence shared with another person(s)

___ 10. home was foreclosed

___ 11. have experienced persistent instability as measured by frequent moves

___ 12. have experienced a long-term period without living independently in permanent housing

___ 13. other reason(s): _____

_____

_____

Once completed, please sign, date, and return this form to the secretary who registered your child/children in school. Thank you.

Signature of parent/guardian: _____ Date_____

ADG/residencyreason

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

2019-2020 PARENT/GUARDIAN/CAREGIVER NOTIFICATION STUDENT ATTENDANCE, ENROLLMENT/REGISTRATION, AND TRANSFER/WITHDRAWAL REQUIREMENTS

New Jersey's Compulsory Education Law: *N.J.S.A.* 18A:38-25 *et seq.* requires students between the ages of 6 and 16 to attend school on a regular basis. Parents, guardians or caregivers who fail to have their children attend school regularly may be brought to court and fined.

Consecutive Unexcused Absences from School: *N.J.S.A.* 18A:36-25.2 requires school officials to conduct an investigation whenever a student is absent from school for five (5) consecutive unexcused days to determine the reason for the absences. If child abuse or neglect is suspected as defined in Title 9:6-8.9, school officials are required to notify the Division of Youth and Family Services (DYFS) and local law enforcement agencies. Parents, guardians or caregivers who fail to have their children attend school on a regular basis may be charged with child neglect or abuse in accordance with law.

Enrollment/Registration of Students: Students between the ages of 4 and 20 living in Penns Grove or Carneys Point are entitled to attend district schools. The following documents are to be provided at the time of the student's enrollment – birth certificate, immunization records, transfer card and transcripts, a current report card if transferring from another district, proof of guardianship or natural parent, and proof of residency/eligibility. If any of these documents are not available at the time of enrollment, the parent, guardian or caregiver is to provide the missing documents to the school within 30 days, pursuant to *N.J.S.A.* 18A:36-25.1.

The following three forms are **required** to be completed and submitted at the time a student enrolls in school:
(1) **School's Enrollment Form** – includes the parent/guardian/caregiver's name; current address; current telephone number(s); student's name; date of birth; student's grade; name of student's former school, town and state; medical information; and identification of any other language other than English spoken by the student or in the student's home;
(2) **Enrollment Residency Questionnaire** – (a) if living with a relative or friend out of economic or family hardship, the name of that person must be provided; (b) if renting an apartment or home, a copy of the lease must be provided; and (c) if living in a hotel or motel, please provide its name; and
(3) **Student Services Questionnaire** – identify any additional services the student may need due to a disability, language barrier, etc.

Change of Address: The parent, guardian or caregiver must contact the student's school and complete a Change of Address form and Enrollment Residency Questionnaire within five school days after the student moves to a new address. Failure to promptly notify the school and provide adequate proof may result in the removal of the student from school, in accordance with *N.J.S.A.* 18A:38-1(a) or (b).

Students Transferring or Withdrawing from School District: The parent, guardian or caregiver of a student who is withdrawing from school is required by law to provide the name and location of the school district in which the student will be subsequently enrolled and the expected date of enrollment in the new school district. Also, the student's new address and a telephone number where the family can be reached are to be provided, if available. If the new school's name, location, and student's expected enrollment date are not provided at the time the student withdrawals, then the parent, guardian or caregiver is to provide this information within 10 calendar days after the student has withdrawn from school. If this information if not received within this 10-day period, the district will be required to notify the Division of Youth and Family Services (DYFS), in accordance with state law (Public Law 2007, Chapter 248).

I acknowledge that I have received a copy of this form.

_____	_____	_____
Parent/Guardian/Caregiver Printed Name	Parent/Guardian/Caregiver Signature	Date

_____	_____
Student's Printed Name	Student's Grade

NOTE: A copy of this notice is to be provided to the parent, guardian or caregiver at the time of the student's enrollment/registration. The original, signed copy of this notice is to be placed in the student's cumulative folder.

Penns Grove-Carneys Point Regional School District
Child Study Team

100 Iona Ave., Penns Grove, New Jersey 08069

(856) 299-4250 Fax: (856) 299-5226

Mr. Sage Schmidt, MPA
Director of Special Services

Deborah Clair (ext. 1131), Secretary

Medicaid Annual Notification Regarding Parental Consent 2019-2020

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.
In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

Evaluations	Physical Therapy	Nursing
Speech Therapy	Occupational Therapy	Specialized Transportation
Psychological Counseling	Audiology	

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) ____Mailed to parent(s) ____Emailed to parent(s) ____IEP meeting ____ Hand Delivered

Penns Grove-Carneys Point Regional School District
Child Study Team

100 Iona Ave., Penns Grove, New Jersey 08069
(856) 299-4250 Fax: (856) 299-5226

Mr. Sage Schmidt, MPA
Director of Special Services

Deborah Clair (ext. 1131), Secretary

Special Education Medicaid Initiative (SEMI) Parental Consent Form

The Penns Grove-Carneys Point Regional School District is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____ Child's Date of Birth: _____/_____/_____

Parent/Guardian: _____

Date: ____/_____/_____ I give consent to bill for SEMI: **(circle one) Yes No**

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Sincerely,

Mr. Sage R. Schmidt, MPA
Director of Special Services
Phone (856) 299-4250 ext. 1124

PENNS GROVE-CARNEY'S POINT REGIONAL SCHOOL DISTRICT
HEALTH SERVICES QUESTIONNAIRE
STUDENT HEALTH HISTORY FORM

Student Name:_____ Date of Birth:_____
Home/Cell Number:_____

Birth History

Full Term? _____ If not, how many weeks premature? _____
Complications during pregnancy or at
birth?_____

NOTE: If any of the following are answered with a YES, please notify the school nurse of the appropriate building.

Past Medical History:

Allergies:

Does your child have any allergies to the following items? If yes, please explain the reaction and treatment used:

Medication/Drugs (specify what medication): _____
Bee/wasp sting: _____
Peanut products: _____
Other foods (specify): _____
Seasonal allergies (when, symptoms, treatment): _____

Has your child ever required the use of an EPI pen for a severe allergic reaction? _____
If yes, please give details:_____

Asthma:

Has your child been diagnosed with Asthma?_____ If yes, What are the child's triggers (allergies, colds, exercise, heat, etc.) and what is the treatment?_____
_____
When was the last asthma attack? _____

Seizures:

Has your child ever had a seizure?_____ If yes, what type of seizure, the last time they had a seizure, and does your child take medications for seizures?_____
_____

Other:

If your child has any of the following conditions, please write 'yes' and the treatment for the conditions.

ADD/ADHD?_____
Heavy Nosebleeds? _____
Migraines/frequent headaches?_____
Heart Condition? (Be specific and any testing done)
_____
Diabetes? _____
Any other health concerns/conditions?_____

Recent Injuries?_____

Surgical History (type and date)
_____

Does your child wear glasses or contacts? _____
Does your child require any assistive devices (orthopedic, hearing aids, etc.):_____
_____

Medications:

Does your child take any medications on a daily basis, including over the counter medications?
If yes, please specify the medication, dosage, and what the medication is for_____
_____

Who is your child's doctor?_____ Phone Number:_____

If you sign below, you are giving permission for the school nurse to share any/all pertinent information on this form, as needed, to the appropriate school staff. This is for the safety and well-being of your child. The staff member will be instructed to keep this information confidential. If you choose not to have the information shared, please return the form in a sealed envelope to the school nurse's attention.

_____
Printed Name

_____ _____
Parent's Signature Date

APPENDIX H

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	

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.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71