

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

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

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:

- Contact you for directions. If you wish to have a doctor called, they will ask you to call him/her.
- Call the school doctor for emergency treatment if it is impossible to reach you.
- 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.
- 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: _____
Fecha

Student: _____
Estudiante

Grade: _____
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

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: 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. ADG/home3c

PENNS GROVE-CARNEYS POINT REGIONAL SCHOOL DISTRICT

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 (v) 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 INFORMATION: (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

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

**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 withdraws, 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 is 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
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Student’s Printed Name	Student’s Grade
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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

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.

*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

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 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. <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)		

IMMUNIZATIONS	<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		

<input type="checkbox"/> 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 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.