Marian Emmons McKeown Elementary School
PRESCHOOL ENROLLMENT PACKET CHECK LIST

Welcome to McKeown School! Below you will find a check list of all the information that is required for your child or children to begin their school experience at McKeown.

- ○ Student Data Form (both sides)
- ○ Residency Form (both sides)
- ○ Home Language Survey
- ○ Bus Transportation Form
- ○ Student Birth Certificate

3 Forms of Residency Documentation (copy of):

- ○ Tax Bill, Deed or Rental Agreement *(you must present one of these documents)* ***and***
- ○ 2 Utility Bills ***or***
- ○ 1 Utility Bill and a Copy of Driver's License *(DL must reflect the address on application)*

If Applicable a copy of:

- ○ Custody Agreement

Can be handed in at a later date:

- ○ Universal Child Health Record Form and Immunization Record
- ○ Over the Counter Medication Consent Form (both sides)

Please submit your completed packets by Tuesday, February 18th. Proof of residency must be provided and verified, and your completed registration packet must be handed in to be placed on the waitlist. Packets can be returned in person, Monday through Friday, from 9:00 AM to 2:00 PM, or by email to batelli@mckeown.org.

Please call the main office at (973) 383-5300 should you have any questions.

PRELIMINARY INFORMATION: PLEASE READ BEFORE PROCEEDING

The questions asked in the following pages will enable us to determine your student's eligibility to attend school in this district in accordance with New Jersey law. *Please be aware that N.J.S.A. 18A:38-1 and N.J.A.C. 6A:22 require that a free public education be provided to students between the ages of 5 and 20, and to certain students under 5 and over 20 as specified in other applicable law, who are:*

- Domiciled in the district, i.e., the child of a parent or guardian, or an adult student, whose permanent home is located within the district. A home is permanent when the parent, guardian or adult student intends to return to it when absent and has no present intent of moving from it, notwithstanding the existence of homes or residences elsewhere

- Living with a person, other than the parent or guardian, who is domiciled in the district and is supporting the student without compensation, as if the student were his or her own child, because the parent cannot support the child due to family or economic hardship

- Living with a person domiciled in the district, other than the parent or guardian, where the parent/guardian is a member of the New Jersey National Guard or the reserve component of the U.S. armed forces and has been ordered into active military service in the U.S. armed forces in time of war or national emergency

- Living with a parent or guardian who is temporarily residing in the district

- The child of a parent or guardian who moves to another district as the result of being homeless

- Placed in the home of a district resident by court order pursuant to N.J.S.A. 18A:38-2

- The child of a parent or guardian who previously resided in the district but is a member of the New Jersey National Guard or the United States reserves and has been ordered to active service in time of war or national emergency, resulting in relocation of the student, pursuant to N.J.S.A. 18A:38-3(b)

- Residing on federal property within the State pursuant to N.J.S.A. 18A:38-7.7 et seq.

Note that "guardian" means a person to whom a court of competent jurisdiction has awarded guardianship or custody of a child, provided that a residential custody order shall entitle a child to attend school in the residential custodian's school district subject to a rebuttable presumption that the child is actually living with such custodian; it also means the Department of Children and Families for purposes of N.J.S.A. 18A:38-1(e). Also note that a student is entitled to attend school in the district of domicile notwithstanding that the student is qualified to attend school in a different district as an "affidavit" student or temporary resident.

Note that the following do ***not*** *affect a student's eligibility to enroll in school:*

- Physical condition of housing or compliance with local housing ordinances or terms of lease

- Immigration/visa status, except for students holding or seeking a visa (F-1) issued specifically for the purpose of limited study on a tuition basis in a United States public secondary school

- Absence of a certified copy of birth certificate or other proof of a student's identity, although these must be provided within 30 days of initial enrollment pursuant to N.J.S.A. 18A: 36-25.1

- Absence of student medical information, although actual attendance at school may be deferred as necessary in compliance with rules regarding immunization of students, N.J.A.C. 8:57-4.1 et seq.

- Absence of a student's prior educational record, although the initial educational placement of the student may be subject to revision upon receipt of records or further assessment by the district

The following forms of documentation may demonstrate a student's eligibility for enrollment in the district. Particular documentation necessary to demonstrate eligibility under specific provisions in law will be indicated in the appropriate section of the registration form.

- Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency
- Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location
- Court orders, State agency agreements and other evidence of court or agency placements or directives
- Receipts, bills, cancelled checks and other evidence of expenditures demonstrating personal attachment to a particular location, or, where applicable, to support of the student
- Medical reports, counselor or social worker assessments, employment documents, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency
- Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, guardian, person keeping an "affidavit student," adult student, person(s) with whom a family is living, or others as appropriate
- Documents pertaining to military status and assignment
- Any business record or document issued by a governmental entity
- Any other form of documentation relevant to demonstrating entitlement to attend school

The totality of information and documentation you offer will be considered in evaluating an application, and, unless expressly required by law, the student will not be denied enrollment based on your inability to provide certain form(s) of documentation where other acceptable evidence is presented.

You will *not* be asked for any information or document protected from disclosure by law, or pertaining to criteria which are not legitimate bases for determining eligibility to attend school. You may *voluntarily* disclose any document or information you believe will help establish that the student meets the requirements of law for entitlement to attend school in the district, but *we may not, directly or indirectly, require or request*:

- Income tax returns
- Documentation/information relating to citizenship or immigration/visa status, unless the student holds or is applying for an F-1 visa
- Documentation/information relating to compliance with local housing ordinances or conditions of tenancy
- Social security numbers

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. If your student is found ineligible, now or later, you will be provided the reasons for our decision and instructions on how to appeal.

[Optional note if district permits attendance by nonresidents on a tuition basis: State law allows school districts to admit nonresident students, through policies adopted at Board discretion, on a tuition basis. If your student is not eligible to attend school in this district free of charge, he or she may enroll on a tuition basis by … (*instructions on how to obtain more information, or register for enrollment as a nonresident student.*)]

If you experience difficulties with the enrollment process, please call The McKeown main office at 973-383-5300 for assistance.

Hampton Township School District
Marian E. McKeown Elementary School
Student Data Form

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

Student Educational Plan:

Regular Education YES/NO Special Education Services YES/NO
504 Accommodations YES/NO Speech Accommodations YES/NO
**If Special Education or 504 student, please attach the latest Plan*

Student Profile/Current Residence:

Present Grade *Gender* *Date of Birth* *City of Birth* *State of Birth*

Country of Birth if other than the United States *Entry date into the United States* *1st Entry date into an US School*

Street Address *Town/City* *State* *Zip Code*

Race/Ethnicity (circle one):
American Indian/Alaskan *Asian* *Hispanic or Latino* *White* *Hawaiian/Pacific Islander* *Black*

Home Language: _____ ***Native Language:*** _____

Residency:

_____ ***I own the home I am residing in Hampton Township***
(Deed/or Tax Bill along with 2 utility bills or 1 utility bill and a copy of your driver's license reflecting your current address will need to be provided)
_____ ***I rent/lease the home I am residing in Hampton Township***
(Current Rental Agreement/Lease along with 2 utility bills or 1 utility bill and a copy of your driver's license reflecting your current address will need to be provided)
_____ ***Other*** *(other documentation will be required depending on the situation)*

First Parent/Legal Guardian Information **Relationship to Student:** _____

Full Name *Employer*
Street Address *Work Phone*
Town/City *Personal Email Address*
Home Phone Number *Cell Phone Number*

Marital Status:
Married _____
Separated _____
Divorced _____
Single _____

Second Parent/Legal Guardian Information **Relationship to Student:** _____

Full Name *Employer*
Street Address *Work Phone*
Town/City *Personal Email Address*
Home Phone Number *Cell Phone Number*

Marital Status:
Married _____
Separated _____
Divorced _____
Single _____

Hampton Township School District
Marian E. McKeown Elementary School
Student Data Form

If divorced, please confirm your information and attach a copy of your latest custody agreement.

Custodial Parent:	_____ Mother	_____ Father	_____ Joint
Designated Physical Custody:	_____ Mother	_____ Father	_____ Guardian
Student primarily resides with:	_____ Mother	_____ Father	_____ Guardian

Any stipulations the school should be aware of: _____

Household Information:

Children:	Birthdate	School Attending:	Grade:

Schools previously attended: (most recent first)

Name of School:	City & State:	Grade:

Emergency Contact Information:

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Contact #1		Contact #2	
Contact Name	Relationship to Student	Contact Name	Relationship to Student
Address	City, State	Address	City, State
Phone – Cell	Phone – Work	Phone – Cell	Phone – Work

Doctor:_____ **Address:** _____ **Telephone:**_____

Dentist:_____ **Address:** _____ **Telephone:**_____

Hospital:_____ **Address:**_____ **Telephone:**_____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially

Does this child have any Health Insurance including NJ Family Care/Medicaid, Medicare, private or other?

☐ **NO**, my child **does not** have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance. **SIGNATURE:** _____ **PRINT NAME:**_____ **DATE:**_____

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

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 800-701-0710

☐ **YES**, my child has health insurance **Health Insurance Provider** _____ **Policy #** _____

I attest that all of the information provided on this form is true and correct:

_____

Parent/Guardian Signature **Date**

Hampton Township School District

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One School Road
Newton, New Jersey 07860-6733
(973) 383-5300 * Fax (973) 383-3835

Dr. Craig M. Hutcheson
Superintendent

Dr. Janet Goodwin
Principal

Joseph Coladarci
Assistant Principal/
Supervisor of Special Services

Kate Fedge
Business Administrator/
Board Secretary

According to New Jersey Statute 18A:38-1, Public Schools shall be free to any person between the ages of five and twenty who is domiciled within the school district. Domiciled means "the place where you sleep at night." It does not mean the township in which you may own or rent out property to someone other than yourself. This document is to verify that the student is domiciled in Hampton Township at the present time.

Our per month tuition charge for the 2024/2025 school year for preschool/kindergarten students is approximately $1684, Grade 1 up to Grade 5 $1918, and 6th Grade students $2134 per student. (Rates are subject to change as per the NJDOE guidelines.)

Student's Name: _____ ID#_____
Date of Birth: _____ Age: _____ Grade: _____ Sex: _____
Parent/Guardian Name(s): _____
Phone number(s): (home)_____(cell)_____
Address:_____
Home School (based on current residence):_____
School of Origin (last school attended): _____

Siblings of student:

Name	School
_____	_____
_____	_____
_____	_____

Please answer the following questions:

1. Is this student's home address a temporary living arrangement? □Yes □No
2. Is this a temporary living arrangement due to loss of housing or economic hardship? □Yes □No
3. Is this student in temporary or emergency foster care placement? □Yes □No
4. As a student, are you living with someone other than your parent or legal guardian? □Yes □No

If you answered YES to **any** of the above questions, please complete the remainder of this form.
If you answered NO to all of the above questions, you may stop here.

---

1. Where is this student currently living? *(check box)*
   - □In a motel/hotel- Name of motel/hotel: _____
   - □In a shelter- Name of shelter: _____
   - □Transitional Housing- Name of transitional housing: _____
   - □Group Home- Name of group home:_____
   - □Temporary/emergency foster home
   - □With more than one family in a house or apartment
   - □Moving from place to place
   - □In a location not designed for sleeping accommodations such as a car, park, or campsite

2. How long have you lived at this residence? _____

3. How long do you plan to live at this residence?_____

4. With whom does the student currently live: *(check box)*

□Both parents
□One parent- Which parent?_____
□One parent and another adult- Which parent?_____
□A relative- Specify which (e.g. grandmother) _____
□Friends or other adults- please identify_____
□An adult who is not a parent or legal guardian- please identify _____

5. Describe the current living situation in detail: _____
_____
_____

6. Any possibility of violence or abuse in home? If so, describe. What were the school's actions?
_____

7. In your child's previous school, did he/she receive any of the following? *(check all that apply)*

□Special Education/Exceptional Children's Services- Describe: _____
□504 Accommodation Plan- Describe: _____
□English As a Second Language (ESL) services
□Help for Behavior Improvement
□Tutoring Services
□Academically or Intellectually Gifted services
□Counseling services

8. At this time, what is the greatest need for your child? *(check all that apply)*

□School supplies
□School uniform or clothing
□Help for academic improvement
□Help for behavior improvement
□Referral for food assistance
□Medical referral/immunizations
□Mental health/counseling referral
□Other- Please describe: _____

My signature below affirms the following: (1) the information I have provided on this form is true and accurate to the best of my knowledge or belief; (2) the same information, as well as other information that may identify my child(ren), may be shared by my signature below as consent with community and governmental agencies pursuant to an interagency collaboration between this school district and (3) the same information, as well as other information that may identify my child(ren), may be shared by my signature below as consent for a legitimate educational purpose. In addition, my signature affirms that I have received a copy of my rights under the McKinney-Vento law.

Parent/Guardian Signature: _____ Date: _____
(Or Unaccompanied Youth)

MCV School Liaison Signature: _____ Date: _____



Hampton Township School District

Marian E. McKeown Elementary School

Home Language Survey

Student Information

Student name: _____ Student birth date:_____

Street Address: _____ School: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____

Survey Questions

The person completing the survey: [ ]Mother [ ]Father [ ]Grandparent [ ]Guardian [ ]Other

Please tell us about your child:

What language did the child learn when he/she first began to talk? _____

What language does the family speak at home most of the time? _____

What language (s) does the primary caregiver (s) speak to the child most of the time? _____

What language (s) does the child speak to his/her primary caregiver (s) most of the time? _____

What language (s) does the child speak to his/her brothers and sisters most of the time? _____

What language does the child speak to his/her friends most of the time? _____

In which language do you wish to receive information from the school? _____

What name do you use for your child (if different from above)? _____

Preschool Students Only:

Please list any preschool program(s) your child attended before coming to our program:

_____

Office Use Only

Date of school entrance: _____

Grade upon entrance: _____

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Assistant Principal/
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Kate Fedge
Business Administrator/
Board Secretary

BUS TRANSPORTATION FORM

PLEASE PRINT

_____
DATE

_____( )M ( )F _____ _____
Student Name Present Grade Date of Birth

_____
Name of Parent/Guardian

_____ _____ _____
Home Phone *Cell Phone* *Email Address*

_____
Mailing Address

_____
Street Name ***VERY IMPORTANT***

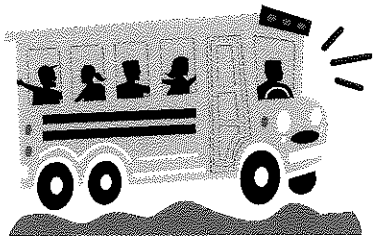
_____ _____
Nearest Intersection Township in which you reside

_____
Signature of Parent/Guardian

FOR OFFICE USE ONLY

Mileage from student's home to McKeown School: _____ Bus _____

Bus Stop:_____



Hampton Township Board of Education
1 School Road Newton , NJ 07860
Phone: (973) 383-5300 Fax: (973) 383-3835

Hampton Township School District

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Superintendent

Dr. Janet Goodwin
Principal

Mr. Brandt Anderson
Assistant Principal

Ms. Kate Fedge
Business Administrator/
Board Secretary

Dear Parents/Guardians:

In accordance with the State of New Jersey's Vaccine Preventable Disease Program, the following vaccines are mandatory for students in New Jersey Public Preschools:

- **FLU VACCINE: Mandated for all children enrolled in child care, pre-school, or pre-kindergarten programs and must be given between September 1st and December 31st of each year.**

If your child has not received the flu vaccine, please follow up with your physician for an appointment. The flu vaccine must be received, and **documentation must be provided** to the McKeown Elementary School Nurse's Office by **December 31st.** The NJ Department of Education determines this deadline.

If your child lacks the flu vaccine on the first day of school in January, please understand that **your child will not be permitted to return to school.**

If you have any questions, please contact me at my office at 973-383-5300, ext. 225.

Thank you,

JD Verheeck, APN-C
School Nurse

Hampton Township School District

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OVER-THE-COUNTER MEDICATION CONSENT FORM

School Year: _____

In the event of a minor medical problem, the following medications have been approved by the School Physician to be administered by the School Nurse. Parent/Guardian signature is required in order for the School Nurse to administer these medications to your child. Parental Permission is valid for the **current school year only.**

Please check the medications you approve for your child to receive during school hours if needed:

_____ Acetaminophen (Tylenol)

_____ Orajel/Anbesol

_____ Benadryl

_____ Ibuprofen (Advil)

_____ Throat Lozenges (cough drops)

_____ Tums

_____ I DO NOT wish for my child to receive medications at school.

Please list any pertinent medical conditions, medications, or allergies (or write None):

_____

*Before administering any medications, a phone call may be made to a parent/guardian to ensure no medications were given prior to school hours. All dosing will be in accordance with package instructions.

Student Name (Last, First):_____ GRADE: _____

Parent/Guardian Signature: _____ DATE: _____

**** ALL OTHER OVER-THE-COUNTER and PRESCRIPTION medications require a physician's written order *and* written consent form the parent/guardian. All medications must be in the original container and delivered to the school nurse by a parent/guardian. Students are NOT permitted to transport medications. ****

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School Year _____

Name of Student:_____ **Date of Birth:**_____ **Grade:**_____

Pediatrician:_____ **Date of Last Physical:**_____

Dentist:_____ **Date of Last Dental Visit:**_____

Daily Medications:

YES / NO Medications needed at home (list):_____

YES / NO Medication needed at school (list):_____

Allergies:

YES / NO Allergies (list): _____

Type of reaction/treatment:_____

Asthma

YES / NO Regularly takes medication (list):_____
YES /NO Takes medication only when needed (list):_____
YES/NO Needs medications at school (list): _____

Diabetes

YES / NO Year diagnosed:_____

Seizure Disorder

YES / NO Type of seizure and date of last seizure:_____
YES / NO Requires emergency or daily medication:_____

Other Health Concerns

YES / NO Heart Condition:_____
Activity clearance (include doctor note if necessary):_____
YES / NO Behavior/Emotional Concerns:_____
YES / NO Other health concerns/chronic or recurring illness:_____

All health information is considered confidential. In order to ensure the health and safety of your child, the above information may be shared with staff and health care providers as needed during the time your child is enrolled in McKeown Elementary School.

YES / NO I give permission for the school nurse to share information with my child's teachers as necessary
YES / NO I give permission for the school nurse to contact my child's health care provider if necessary

Parent 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.

FOR SCHOOLS AND PARENTS: K-12 IMMUNIZATION REQUIREMENTS

NJ Department of Health (NJDOH)
Vaccine Preventable Disease Program

Summary of NJ School Immunization Requirements

Listed in the chart below are the minimum required number of doses your child must have to attend a NJ school.* This is strictly a summary document. Exceptions to these requirements (i.e. provisional admission, grace periods, and exemptions) are specified in the Immunization of Pupils in School rules, New Jersey Administrative Code (N.J.A.C. 8:57-4). Please reference the administrative rules for more details https://www.nj.gov/health/cd/imm_requirements/acode/. Additional vaccines are recommended by Advisory Committee on Immunization Practices (ACIP) for optimal protection. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

Grade/level child enters school:		**Minimum Number of Doses for Each Vaccine**						
		DTaP Diphtheria, Tetanus, acellular Pertussis	**Polio Inactivated Polio Vaccine (IPV)**	**MMR (Measles, Mumps, Rubella)**	**Varicella (Chickenpox)**	**Hepatitis B**	**Meningococcal**	**Tdap (Tetanus, diphtheria, acellular pertussis)**
Kindergarten – 1st grade		A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses†	A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses†	2 doses†	1 dose†	3 doses	None	None
2nd – 5th grade		3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Td. For use of Tdap, see footnote.* †	3 doses	2 doses	1 dose	3 doses	None	See footnote†
6th grade and higher		3 doses	3 doses	2 doses	1 dose	3 doses	1 dose required for children born on or after 1/1/97 given no earlier than ten years of age†	1 dose required for children born on or after 1/1/97†

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	