CHESTER SCHOOLS
New Enrollment Registration & Health History

STUDENT INFORMATION County: 27 Dist: 0820 School:

Office Use:	HOMEROOM TEACHER:	District ID:
	District Entry Date: School Entry:	State ID:

STUDENT LAST NAME: _____ MIDDLE: _____
STUDENT FIRST: _____ GENERATION: _____ (Jr, III, etc.)
_____
BIRTH INFO: _____
DATE: _____ NICKNAME: _____
CITY/STATE: _____
COUNTRY: _____ GENDER: _____
GRADE:

PHYSICAL ADDRESS (Resident)

STREET ADDRESS: _____ Appt, Rm, etc _____
CITY: _____ STATE: _____ _____
Township or Borough: COUNTY:

MAILING ADDRESS

STREET ADDRESS: _____ PO Box, etc. _____
CITY: _____ STATE: _____ ZIP: _____
COUNTY: Country

PARENT / GUARDIAN INFORMATION

MOTHER'S NAME: _____ MOTHER'S HOME PHONE: _____
Maiden Name MOTHER'S CELL PHONE: _____
Employer _____ MOHTER'S BUSINESS PHONE: _____
MOTHER'S EMAIL ADDRESS:

FATHER'S NAME: _____ FATHER'S HOME PHONE: _____
FATHER'S CELL PHONE: _____
Employer _____ FATHER'S BUSINESS PHONE: _____
FATHER'S EMAIL ADDRESS:

EMERGENCY CONTACT (not a parent)

In case of illness, etc., list alternates in the area other than father and mother to be called.

NAME: _____ PHONE #: _____ RELATIONSHIP: _____
NAME: _____ PHONE #: _____ RELATIONSHIP: _____
NAME: _____ PHONE #: _____ RELATIONSHIP: _____

Sibling(s)

Name: _____DOB: _____ Grade: _____	Name: _____DOB: _____ Grade: _____	Name: _____ DOB: _____ Grade: _____

Required by the State of New Jersey – ETHNIC BACKGROUND:

HISPANIC	Yes:		No:						
Race:	☐ White	☐Black or African American		☐Asian		☐Pacific		☐American Indian	

Required by the State of New Jersey – MILITARY CONNECTED STUDENT INDICATOR:

Indicate whether the student's parent or guardian is not military connected, is on Active Duty, is in the National Guard, or is in the Reserve components of the United States military services from the list below:

☐ 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, or Coast Guard.
☐ 3. National Guard or Reserve – Student is a dependent of a member of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard).
☐ 4. Unknown – It is unknown whether or not the student is military connected.

CHESTER SCHOOL DISTRICT
HEALTH ASSESSMENT RECORD
(This form must be completed within 30 days)

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Universal Child Health Record).

State law requires complete primary immunization and a medical examination by a physician licensed to practice medicine or osteopathy, a certified registered nurse practitioner/clinical nurse specialist or licensed physician's assistant prior to school entrance in a New Jersey school district.

Preschool entrance physicals must be completed prior to entry and submitted to the school nurse, Mrs. Deborah Borchert by June 1, 2016. Students moving into the district are allowed up to 60 days from date of registration to provide the school nurse with the completed Health Assessment Record. Transfer students must provide a complete immunization record within 30 days of registration.

This examination must be performed no more than 365 days prior to entry.

Please Print

Name of Student (Last, First, Middle)	Social Security #	Birth Date	Sex
Address (Street)	Home Phone # (including area code)	Cell Phone #	
Town and Zip Code	Student's Physician or Primary Health Care Provider		
Parent/Guardian – Mother (Last, First, Middle)	Parent/Guardian – Father (Last, First, Middle)		

Part I – To be completed by parent – *Important:* Complete Part I before your child is examined.
Take this form with you to the health care provider's office.

Please check yes or no to the following questions (explain all "yes" answers in the space provided below.)

	Yes	No	
1.	**____**	**____**	Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)?
2.	____	____	Does your child have any other specific illness, physical deformity or health condition (asthma, diabetes, heart murmur, seizures, etc.)?
3.	____	____	Does your child have any restrictions on physical activity?
4.	____	____	Does your child have any allergies (food, insects, medication, etc.)?
5.	____	____	Does your child take any medication (daily or occasionally)?
6.	____	____	Does your child have any difficulty with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
7.	____	____	Has your child had any hospitalization, operation, or major illness (specify)?
8.	____	____	Has your child had any significant injury or accident (specify)?
9.	____	____	Are you claiming exemption from immunization guidelines?
10.	____	____	Have there been any recent changes in the family (relocation, death, divorce, etc.)?
11.	____	____	Would you like to discuss anything about your child's health with the school nurse?

This child is number _____of _____children.

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

_____

_____

_____

I give limited permission for release of essential information on this form for **confidential** use in the school for meeting my child's health and educational needs.

_____ _____

Signature of Parent/Guardian Date

Health Insurance: Yes _____ No ____ Health Insurance Provider: _____

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare program to contact me about health insurance.

UNIVERSAL CHILD HEALTH RECORD

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

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	

HOME LANGUAGE

STUDENT NAME:	_____	DOB:	_____
ADDRESS:	_____	TELEPHONE:	_____
ETHNICITY:	_____	SEX:	_____
HOMEROOM TEACHER:		GRADE:	

1. What language did your child first speak? _____
2. What language do you most often use when speaking to your child? _____
3. What language did your child first use for communication? _____
4. What language does your child use when speaking to brothers, sisters, and other children at home? _____
5. What language does your child often use when speaking with you or other adults in the home (grandparents, aunts, uncles)?_____
6. What language does your child most often use when speaking with friends at home? _____

In which language do you wish to receive communication? _____

FATHER/GUARDIAN SIGNATURE: _____DATE: _____

MOTHER/GUARDIAN SIGNATURE: _____DATE: _____

- Definition of native language from New Jersey Department of Education: The language first used by student, or the language most often spoken at home regardless of the language spoken by the student.

FOR SCHOOL USE: Code:
Language: _____ _____

CHESTER PUBLIC SCHOOLS
CHESTER, NEW JERSEY 07930

I, the undersigned parent or legal guardian of

_____
Student Name)

authorizes _____**,** Chester, New Jersey 07930 to obtain from
(School Name)

_____
(Former School Name)

any and all information concerning this child (including health& Child Study Team information).

_____ _____
Date Parent/Guardian Signature

Dickerson Elementary School	(908) 879-5313
Fax Number	(908) 879-7018
Bragg School	(908) 879-5324
Fax Number	(908) 879- 5438
Black River Middle School	(908) 879- 6363
Fax Number	(908) 879- 9085

KINDERGARTEN ENROLLMENT ONLY:

To register, please bring:

1. ***Original birth certificate with the raised seal showing that he/she is five years old on or before October 1st.***
2. ***A copy of proof of immunization signed by a physician. This Copy cannot be returned, as it become a part of your child's permanent health record.***
3. ***Proof of residency, i.e., utility bill, library card – not a driver's license.***
4. ***Enclosed papers completely filled out.***

Immunization dates must include month, day, and year. NJ State guideline require every student to have had a minimum of 4 doses of DPT, one does of which shall have been given on or after the 4th birthday, **at least 3 doses of polio** (with one given on or after the 4th birthday), **2 doses of M.M.R. vaccine** (with the first dose on or after the 1st birthday and the second dose no less than one month after the first does), **and 1 dose of Varicella vaccine administered on or after the first birthday (or a physician's or parental statement of previous Varicella disease), 3 doses of hepatitis B vaccine prior to school entrance.** Also included in your packet is a physical form to be completed by your child's physician.