Old Bridge Preschool Registration Information

Please call (732) 360-1021 to schedule your registration appointment either in person or via phone.

Please complete the following pages and return to Glenn School during your registration appointment.
OLD BRIDGE TOWNSHIP PUBLIC SCHOOLS
Student Registration Form

Child's Name

Last

First

M.I.

Date of Birth

Place of Birth

Verification

Sex

Grade

Address:

City/State:

Zip Code:

Home Phone #:

Developments:

Mother's Cell #:

Father's Cell #:

List children in family, not including above child:

Name

Sex

DOB

School/Grade

Father/Guardian's Name:

Mother/Guardian's Name:

Employer:

Employer:

Business Phone:

Business Phone:

Schools child previously attended (Include Old Bridge if appropriate)

Name of School:

Grade:

Phone:

Address:

City/State:

Zip Code:

Additional services received (i.e., speech, gifted & talented, remedial, etc.)

Date

Parent/Guardian Signature

07/09
EMERGENCY SCHOOL CLOSING CONTACT INFORMATION

(Please complete a separate form for each child)

Student’s Name: ___________________________ Grade: ___ Teacher: ______________

Siblings Name: ___________________________ Grade: ___ Teacher: ______________

_____________________________ Grade: ___ Teacher: ______________

Parent/Guardian Name(s):________________________ Relationship: ______________

_____________________________ Relationship: ______________

Home Telephone:_______________ Email address:_____________________

Mother’s Work Phone:___________ Mother’s Cell Phone:_______________

Father’s Work Phone:_____________ Father’s Cell Phone:_______________

The following person(s) have agreed to accept my child during an emergency school closing in my absence: (PLEASE PRINT)

1. Name:_________________ Telephone No.:____________ Cell Phone:___________

2. Name:_________________ Telephone No.:____________ Cell Phone:___________

3. Name:_________________ Telephone No.:____________ Cell Phone:___________

Changes in any emergency phone number must be reported in writing in the Main Office.

IMPORTANT INFORMATION: YOUR CHILD WILL ONLY BE RELEASED TO THE PERSON(S) LISTED ABOVE. REMEMBER TO CONFIRM EACH PERSON LISTED SO THAT THEY AGREE TO BE RESPONSIBLE FOR YOUR CHILD IN THE EVENT OF AN EMERGENCY CLOSING. Note: BUS STUDENT WILL ONLY BE TRANSPORTED HOME ON THEIR REGULARLY ASSIGNED BUS. THERE ARE NO EXCEPTIONS.

Please note: Along with the emergency information above, it is the responsibility of each family to make certain they are registered with the Honeywell Alert System.
Old Bridge Public Schools - Tuition Preschool

<table>
<thead>
<tr>
<th>Glenn/Southwood</th>
<th>Entry Date</th>
<th>Gender</th>
<th>AM/PM</th>
<th>Full Day</th>
<th>Drop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STUDENT DEMOGRAPHIC INFORMATION**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>City of Birth</th>
<th>State of Birth</th>
<th>Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ethnicity – Please Circle One**

**AMERICAN INDIAN OR ALASKAN NATIVE:**
A person having origins in any of the original Peoples of North or South America (including Central America) who maintains a tribal Affiliation or community attachment

**HISPANIC/LATINO:**
A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.

**BLACK/AFRICAN AMERICAN:**
A person having origins in any of the black racial groups of Africa.

**ASIAN:**
A person having origins in any of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand & Viet Nam.

**NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:**
A person having origins in any of the original peoples of Hawaii, Guam, Samoan or other Pacific Islands.

**WHITE:**
A person having origins in any of the original peoples of Europe, the Middle East or North America.

**PARENT/GUARDIAN #1 INFORMATION**

Name: ___________________________

Relationship: _____________________

Address: _________________________

City: __________ State: ___ Zip: ______

Home #: _______ Cell #: __________

Work #: _______ -

Emergency Contact: _______________________

Physician Information: _______________________

**PARENT/GUARDIAN #2 INFORMATION**

Name: ___________________________

Relationship: _____________________

Address: _________________________

City: __________ State: ___ Zip: ______

Home #: _______ Cell #: __________

Work #: _______ -

Telephone #: ______________________
OLD BRIDGE TOWNSHIP PUBLIC SCHOOLS
Office of the Supervisor of Business, Design Technologies, Family Consumer Science, Media Specialists and Nursing Services
Karen Hicks
Ellen McDermott Grade Nine Center
4205 Route 516
Matawan, New Jersey 07747
732-290-3900 ext 1995

New Student Physical Examination

Dear Parent/Guardian:

The Old Bridge Township Board of Education requires each new student entering the school district to submit proof of a physical examination. The entrance physical must be dated and signed by your health care provider and submitted to the nurse within 30 days of entrance. If the physical form is not returned within 30 days, your child will be excluded from school.

Candidates for middle school and high school athletic teams will need to submit evidence of a physical examination on a special district approved athletic physical examination form before being permitted to participate. This form is available by contacting the school nurse or the high school athletic office and must be completed by your health care provider.

In addition we would like to remind you about the importance of obtaining subsequent medical examinations for your child at least once during each developmental stage, at early childhood (pre-school through grade three), pre-adolescence (grade four through six) and adolescence (grades 7 through 12).

If you do not have a health care provider, or if you have any further questions, please contact the nurse in your child’s school.

School: ____________________________
Name: ____________________________
Grade/Teacher: ______________________
Date of Entrance: ___________________
Date of Exclusion: ___________________

Sincerely,

Karen Hicks

Karen Hicks
Supervisor of Business, Design Technologies, Family Consumer Science, Media Specialist and Nursing Services
# Old Bridge Township Public Schools

**Patrick A. Torre Administration Building**

4209 Route 516
Matawan, NJ 07747
Phone: 732-566-1000

---

**THIS FORM MUST BE COMPLETED FOR STUDENTS IN PRE-SCHOOL THROUGH GRADE 5 (LEAVE NO BLANKS)**

---

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Homeroom:</th>
<th>Transfer From:</th>
<th>School:</th>
<th>Birthplace:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Sex: M F</th>
<th>Date of Birth:</th>
<th>Child's Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lives With:</th>
<th>Home Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother's/Guardian's Name</th>
<th>Father's/Guardian's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Ph.</th>
<th>Work Ph.</th>
<th>Home Ph.</th>
<th>Work Ph.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HAS YOUR CHILD HAD? Yes/No, List dates & Explain

<table>
<thead>
<tr>
<th>Illness</th>
<th>Dates/Explain</th>
<th>Illness</th>
<th>Date/Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td>Chickenpox Disease</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Epilepsy/Seizures</td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
<td>Lyme Disease</td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td>Ear Infections</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Bleeding Problems</td>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Skin Condition</td>
<td></td>
<td>Migraines</td>
<td></td>
</tr>
<tr>
<td>Appetite Problems</td>
<td></td>
<td>Sleep Problems</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your child has Down's Syndrome: ☐ YES ☐ NO

Neck X-ray: ___________ Result: ___________

### DOES YOUR CHILD HAVE? EXPLAIN

<table>
<thead>
<tr>
<th>Physical Handicap</th>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental/Emotional Condition</th>
<th>(Dev. Delay, Autism, Hyper) Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Congenital Defect</th>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart Problem</th>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuromuscular Problem</th>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is your child toilet trained? (check) ☐ YES ☐ NO

Does your child have a current IEP? (check) ☐ YES ☐ NO

Is your child currently receiving speech therapy? ☐ YES ☐ NO

---

*Revised March 2017 – Technology Dept.*
<table>
<thead>
<tr>
<th>ALLERGIES TO:</th>
<th>LIST ANY (when &amp; why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Hospitalizations</td>
</tr>
<tr>
<td>Food</td>
<td>Operations</td>
</tr>
<tr>
<td>Environmental</td>
<td>Broken</td>
</tr>
<tr>
<td></td>
<td>Bones/fractures</td>
</tr>
<tr>
<td>Type of Reaction?</td>
<td>Dietary Preferences</td>
</tr>
</tbody>
</table>

**HAS YOUR CHILD BEEN EXAMINED BY A PROFESSIONAL FOR?**

- **Vision**  □ YES  □ NO  
  - Where:  
  - When:  
  - Result:  

- **Does he/she wear glasses?**  □ YES  □ NO  
  - Where:  
  - When:  
  - Result:  

- **Hearing**  □ YES  □ NO  
  - Where:  
  - When:  
  - Result:  

- **Does your child have any restrictions?**  □ YES  □ NO  
  - What?  

- **Is your child taking any medication?**  □ YES  □ NO  
  - What?  

- **Birth Weight?**  
  - Length of Pregnancy?  

- **How many days did newborn spend in hospital?**  
  - Complications  

**Any additional information you feel we should know?**

---

Your signature on this form means that you agree that medical conditions identified during school enrollment can & will be shared with appropriate school personnel as needed, during their school enrollment.

Parent/Guardian's Signature:  

Date:  

Revised March 2017 – Technology Dept.
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 (MMR-8) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 800-598-7512.
   - 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.state.nj.us/health/forms/ch-15.doc or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 809-262-5666.
   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 permission 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.pascnj.org or by phone at 908-887-9340.

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.
# Universal Child Health Record

## Section I: To Be Completed by Parent(s)

<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:**
- 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:
  - □ None
  - □ Special Care Plan Attached

- Medications/Treatments:
  - □ None
  - □ Special Care Plan Attached

- Limitations to Physical Activity:
  - □ None
  - □ Special Care Plan Attached

- Special Equipment Needs:
  - □ None
  - □ Special Care Plan Attached

- Allergies/Sensitivities:
  - □ None
  - □ Special Care Plan Attached

- Special Diet/Vitamin & Mineral Supplements:
  - □ None
  - □ Special Care Plan Attached

- Behavioral Issues/Mental Health Diagnosis:
  - □ None
  - □ Special Care Plan Attached

- Emergency Plans:
  - □ None
  - □ Special Care Plan Attached

### Preventive Health Screenings

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead</td>
<td>□ Capillary □ Venous</td>
<td></td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td>Developmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

**Name of Health Care Provider (Print)**

**Health Care Provider Stamp:**

**Signature/Date**

---

**Distribution:**
- Original-Child Care Provider
- Copy-Parent/Guardian
- Copy-Health Care Provider
Dear Parent/Guardian:
At the time of registration, please submit proof of the following information to the Health Office.

1. **Physical Examination Record** within the past 365 days (1 year) of date of entry. You are encouraged to
go to your "medical home" (private M.D.) to complete this physical. Enclosed is a physical examination
form for your convenience.

2. **Immunization record** consisting of dates of Primary Series and booster doses. N.J.S.S.C. Chapter 14
requires that immunizations must be complete and up-to-date, otherwise, the student may be excluded
from school.

   **DPT:** Diphtheria and Tetanus Toxoids and Pertussis (DTP) Vaccine
   a. **FOUR (4) doses for children less than 7 years of age.** One dose must have been administered
      on or after the fourth birthday.....or any 5 doses.
   b. **THREE (3) doses for children 7 years of age or older.**
   c. **Tdap:** Required on all sixth grade students born on or after January 1, 1997, effective 9/1/08

   **Polio Virus Vaccine**
   a. **THREE (3) doses for those children less than 7 years of age OPV or enhanced IPV is**
      required provided at least one dose is given on or after the fourth birthday......or any 4 doses.
   b. **THREE (3) doses for children 7-17 years old, OPV or IPV will satisfy the polio vaccine**
      requirement.

   **Measles Vaccine**
   Two (2) doses of a measles-containing vaccine given on or after the first birthday.
   (Preschool requires a minimum of one (1) dose).

   **Rubella Vaccine:** Mumps Vaccine
   **ONE (1) dose rubella and mumps vaccine administered on or after the first birthday.**

   **Hepatitis B Vaccine - kindergarten through Grade 12**
   Appropriate 2 or 3 dose Hepatitis Vaccine, or laboratory evidence of immunity.

   **Varicella (Chicken Pox) Vaccine**
   a. **One (1) dose after the first birthday is required starting Sept. 2004 for all pre-school,**
      Kindergarten and Grade One students.....OR....
   b. **Statement of past history of chicken pox or laboratory evidence of immunity is required.**

   **Meningococcal Vaccine:** One dose required on all sixth grade students born on or after January 1,
   1997, effective 9/1/08

   **Preschool Only**

   **Haemophilus Influenzae B (HIB) - One (1) dose required after 1st birthday**

   **Pneumococcal - minimum One(1) dose after first birthday**

   **Flu (Influenza) vaccine - One (1) dose annually between Sept 1st and December 31st.**

3. **Mantoux Tuberculin Test:** Required ONLY on those students entering the Old Bridge School System
coming directly from a high TB incidence country, according to the most current NJ state
guidelines.

Students entering this district are **REQUIRED** to provide appropriate immunization records prior to entry.

Sincerely,

Principal

School Nurse

__________________________________________________________________________________________

I have read and I understand the rules of registration concerning immunization requirements.

Parent/Guardian Signature: ___________________________________________ Date: __________________

Student's Name: _______________________________________________ Grade: __________________

1/10