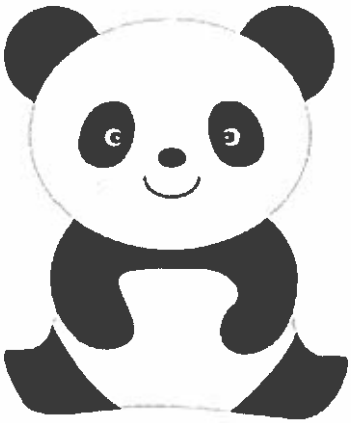
OLD BRIDGE TOWNSHIP
OTPS
OB
PUBLIC SCHOOLS

Old Bridge Township Public Schools

John H. Glenn Jr. School
185 Cindy Street
Old Bridge, NJ 08857

Southwood Elementary School
64 Southwood Drive
Old Bridge, NJ 08857

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

FOR OFFICE USE ONLY

_____Mortgage Statement/ Sales Contract

_____Current Lease/Notarized Form From Landlord/Owner

_____Non-Resident Student

_____Affidavit of Domicile

_____Tuition

_____Other

Verified By: _____

_____AM _____AS

_____H _____NH

_____B _____W

Child's Name _____
Last First M.I.

_____ _____ _____
Date of Birth Place of Birth Verification

_____ _____
Sex Grade

Address: _____

City/State: _____ Zip Code: _____

Home Phone #: _____ Development: _____

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

Old Bridge Public Schools

John Glenn School
185 Cindy Street
Old Bridge, NJ 08857
(732)360-1021/4308

Southwood Elementary School
64 Southwood Drive
Old Bridge, NJ 08857
(732)360-4539

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 responsibkility of each family to make certain they are registered with the Honeywell Alert System.

Old Bridge Public Schools - Tuition Preschool

Glenn/Southwood	Entry Date	Gender	AM/PM	Full Day	Drop

STUDENT DEMOGRAPHIC INFORMATION

First Name	Middle Name	Last Name	Address	City	State

Date of Birth	City of Birth	State of Birth	Country of Birth

Ethnicity – Please Circle One

AMERICAN INDIAN OR ALSAKAN 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, Samoa 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

Homeroom:	Transfer From:	School:	Birthplace:
Child's Name:		Sex: M F	Date of Birth:
		Child's Address:	
Lives With:		Home Phone:	
Mother's/Guardian's Name		Father's/Guardian's Name	
Home Ph. ( )	Work Ph. ( )	Home Ph. ( )	Work Ph. ( )

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

Illness	Dates/Explain	Illness	Date/Explain
Asthma		Chickenpox Disease	
Diabetes		Epilepsy/Seizures	
Mononucleosis		Lyme Disease	
Rheumatic Fever		Ear Infections	
Hepatitis		Cancer	
Bleeding Problems		Depression	
Skin Condition		Migraines	
Appetite Problems		Sleep Problems	
Other			

If your child has Down's Syndrome:	Neck X-ray: ☐ YES ☐ NO	Result:

DOES YOUR CHILD HAVE? EXPLAIN

Physical Handicap	Explain:
Mental/Emotional Condition	(Dev.Delay, Autism, Hyper) Explain:
Congenital Defect	Explain:
Heart Problem	Explain:
Neuromuscular Problem	Explain:
Other:	Explain:

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

ALLERGIES TO:		LIST ANY (when & why)	
Medication		Hospitalizations	
Food		Operations	
Environmental		Broken Bones/fractures	
Type of Reaction?		Dietary Preferences	

HAS YOUR CHILD BEEN EXAMINED BY A PROFESSIONAL FOR?			
Vision ☐ YES ☐ NO	Where:	When:	Result:
Does he/she wear glasses? ☐ YES ☐ NO			
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's/Guardian's 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 and Senior Services, Immunization Program at 609-588-7512.
   - 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.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.

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	

OLD BRIDGE TOWNSHIP PUBLIC SCHOOLS
HEALTH SERVICES

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