HOPEWELL VALLEY REGIONAL SCHOOL DISTRICT
OFFICE OF CENTRAL REGISTRATION

REGISTRATION FORMS FOR GRADES 6 through 12

(This section assigned by Registrar)

Student ID: _____ State ID: _____

Date of Registration: _____ Date of Entrance: _____

Signed Lease, Deed, Tax Bill, or Signed Contract (Future Residency Contract), NJ Driver's License (w/ sibling in district)

Date of District Residency: _____ Residency Verified: _____ Birth certificate verified: _____

Grade Placement in Hopewell Valley: _____

Signature of School District Registrar: _____ **HV School:** _____

Student Information

First Name: _____ Last Name: _____

(As it appears on birth certificate - no abbreviations)

Middle Name: _____ Generation Code (Jr, Sr, II, etc.): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Tax Municipality **(circle one):** Hopewell Township Hopewell Borough Pennington Borough

Date of Birth: _____ Country of Birth: _____

City of Birth: _____ State of Birth: _____

Gender **(circle one):** Male Female Non-Binary/Undesignated

Former Home Address: _____

_____

School last attended: _____ Public or Private

School Address: _____

_____ School Phone: _____

Grade last attended: _____ Previous School Contact: _____

Phone number: _____

Immigrant Status **(circle one):** Student born in the United States

Student born outside the US and has been in a US school more than 3 full academic years

Student born outside the US and has been in a US school less than 3 full academic years

First entry date into a school in the United States: _____

Predominant language spoken at home: _____

Does the student have migrant status: **Yes or No** A migrant student is defined as a student who is:

- 21 years of age or younger **AND;**
- Whose parent/guardian is a migratory fisher, dairy worker, or agricultural worker; **AND**
- Who in the past 36 month has moved from one school district to another in order for the worker to obtain temporary or seasonal agricultural or fishing work.

Family History

Family Status of Student **(circle):**

Living with both parents Living with mother Living with father
Living with stepfather Living with stepmother

Other (specify): _____

Parent 1: Last Name: _____ First: Name: _____

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Parent 2: Last Name: _____ First Name: _____

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Legal Guardian, Last Name: _____ First Name: _____

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Street Address of Parent if outside the Primary Household:

_____

City: _____ State: _____ Zip: _____

Military Status of Parents/Legal Guardians listed above**. Circle one**

1 = Not Active Military Connected: Student is a dependent of someone *not* in the full-time active duty military.

2 = Active Military Connected: Student is a dependent of someone in the full-time, active duty military.

3 = National Guard or Reserves Connected: Student is a dependent of a member of the National Guard or Reserves.

4 = Unknown: It is unknown whether the student is military connected.

Do you have children attending Hopewell Valley Public School(s)? **Yes or No** If yes, which school(s)?

Bear Tavern Elementary	Hopewell Elementary	Stony Brook Elementary	Toll Gate Grammar	Timberlane Middle School	Central High School

Please list children living in house between the ages of 0 – 20, beginning with the oldest:

First Name/Last Name	Birth date	Grade	School Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has **this student** previously registered with the Hopewell Valley Regional School District? **Yes or No**
If yes, what school and grade? _____

Does the student have any Individual Educational Programs (IEP) or 504 plans? **Yes or No**
If yes, **(circle):** IEP or 504

Does this student require any support with reading, writing, or understanding the English language? **Yes or No**

Has the student been identified as an English language learner in a previous program? **Yes or No**
If yes, date of entry: _____ and/or date of exit: _____

Does the student speak/comprehend more than one language? **Yes or No**
If yes, list languages: _____

Please indicate the student's native language if other than English. (Native language is defined as the language first spoken by the student or the language most often spoken in the student's home.)

Native Language: _____

Ethnicity: The information obtained will be used for District and State reports and for federal funding to comply with Affirmative Action Laws ONLY. Is the student Hispanic or Latino: **Yes or No**

Race: What is the student's race? Mark one or more races that apply.

____ **White** - *A person having origins of the original people of Europe, the Middle East, and North Africa*.
____ **Black or African American** - *A person having origins in any of the black racial groups of Africa.*
____ **Asian** - *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*
____ **Native Hawaiian or Other Pacific Islander** - *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
____ **Hispanic or Latino** - *A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*
____ **American Indian or Alaska Native** - *A person having origins in any of the original peoples of North and South American (including Central America) and who maintains tribal affiliation or community attachment.*

Family Physician: _____ Physician Phone: _____
Student Allergies/Medical Alerts: _____
_____

Health - related Information*: The information below will be used by the New Jersey Department of Human Services.*
Health Insurance: Does the student has health insurance coverage (circle one): **Yes or No**
Heath Insurance Provider: _____

Emergency Contact Information*: These contact numbers will be used **first** in the event of an emergency, (illness, injury, early dismissal).*
1st Contact Name: _____
1st phone number to call: _____

2nd Contact Name: _____
2nd phone number to call: _____

Other Contacts: If 1st or 2nd contacts above cannot be reached, the individuals listed here will assume care for your child in the event of an emergency.

Name: _____ relationship to student: _____
Cell phone: _____ work: _____ home: _____

Name: _____ relationship to student: _____
Cell phone: _____ work: _____ home: _____

Parent/Guardian Signature: _____ Date: _____

SUMMARY OF SCHOOL RESIDENCY LAW: N.J.S. 18:38-1

N.J.S.A. States that a district must provide a free public education to the following persons over five and under twenty years of age:

- Any person who is domiciled within the district. A student is considered domiciled within a school district if his/her parents reside there.
- Any person who is kept in the home of another person domiciled within the school district and is supported by such other person gratis as if he/she were such other person's child. This arrangement is commonly referred to as an *Affidavit Pupil.*
- Any person for whom the Division of Youth and Family Services in the Department of Human Services is acting as a guardian and who is placed in the district by said Bureau.
- Any person whose parent or guardian moves from one school district to another school district as a result of being homeless and whose district of residence is determined pursuant to the N.J.A.C. 6:3-7.10.
- Any person who is a nonresident in a school district placed in the home of another person who is resident in the district, under court order [18A:38-2].

CONDITIONS OF RESIDENCY FOR AN AFFIDAVIT PUPIL

The district resident with whom the student(s) lives shall:

- Complete a student registration form.
- Provide proof of residency. Proof of residency shall include a) a copy of the lease, or b) a sworn statement by his/her landlord acknowledging that, indeed the person rents at the address stated , or c) deed or sales contract. Other proof of residency may include but not be limited to a) voter's registration or b) driver's license.
- Sign an agreement of understanding regarding student residency requirements, conditions of residency, and penalties for false registration and enrollment.
- Submit a notarized "Affidavit of Resident Host Family of a Student" certifying that the child is being supported gratis, that the district resident will assume all personal obligations for the child relative to school requirements, and that the district resident intends to keep and support the child gratuitously for a longer time than the school term. Supporting documentation may be required.
- Submit from the child's natural parent(s) or legal guardian(s) a notarized "Affidavit of Non-Resident Parent/Guardian" certifying that the parent(s) or guardian(s) are "not capable of supporting or caring for the child because of economic or family hardship" and that "the child has not been sent to live in the district solely to receive a free public education from the district." Supporting documentation may be required.
- If the board of education determines that the evidence does not support the claim for an affidavit student, the board of education may deny the student admission to school and, at the same time, notify the resident of his/her right to contest the decision before the Commissioner of Education within 21 days. Once the petition is filed, the student must be permitted to attend school while the matter is pending before the Commissioner. The resident has the burden of proof in establishing that the student has the right to a free public education in the district. In the event the Commissioner decides that the resident's claim is unsubstantiated, the Commissioner must order the resident to pay tuition for the time the child unlawfully attended school in the district. [18A:38-1b(1)]
- When it has been determined that a student who is already enrolled is not domiciled within the district, the Superintendent may apply to the board of education for removal of the student. The parent or guardian are entitled to a hearing before the board. If the board determines that the parents or guardians are not domiciled in the district or the child is not kept in the home of another person domiciled in the district and supported by him or her gratis, as described in the affidavits, the board may remove the student from school. Should the parents or guardians wish to challenge the decision of the board, they have 21 days to bring action before the Commissioner. Once the petition is filed, the student must be permitted to attend school while the matter is pending before the Commissioner. In the event the Commissioner decides that the resident's clami is unsubstantiated, the Commissioner must order the resident to pay tuition for the time the child unlawfully attended school in the district. [18A:38-1b92)]
- Any person who fraudulently allows a child of another person to use his residence and is not the primary financial supporter of that child and any person who fraudulently claims to have given up custody of his/her child to a person in another district commits a disorderly person's offense. [18A:381d]

ACKNOWLEDGEMENT OF RESIDENCY NOTICE

I have read the Summary of the School Residency Law for the State of New Jersey. I declare that the attached school registration form and supporting documents are true, correct, and complete.

Name of Student:_____

Signature of Parent/Guardian:_____ Date:_____

REGISTRATION INFORMATION FOR PARENTS

IF YOUR FAMILY LIVES IN ANY OF THE FOLLOWING SITUATIONS:

- In a shelter
- In a motel or campground due to lack of an alternative adequate accommodation
- In a car, park, abandoned building, or bus or train station
- Doubled up with other people due to loss of housing or economic hardship

Your school-age children may qualify for certain rights and protections under the federal McKinney-Vento Act.

Your eligible children have the right to:

Receive a free, appropriate public education

Enroll in school immediately, even if lacking documents normally required for enrollment;

Enroll in school and attend classes while the school gathers needed documents; and

Enroll in a local school; or continue attending their school of origin (the school they attended when permanently housed or the school in which the were last enrolled), if that is your preference and is feasible.

(If the school district believes that the school you select is not in the best interest of your children, then the district must provide you with a written explanation of its position and inform you of your right to appeal its decision.)

Receive transportation to and from the school of origin, if you request this.

Receive educational services comparable to those provided to other students, according to your children's needs.

Access to free meals, Title I, and other educational programs, transportation to extra-curricular activities to the same extent that is offered to other students in the district.

If you think your children may be eligible, you may speak to a school-based district homeless liaison by checking the box below. Would you like to discuss this matter?

- ❑ Yes
- ❑ No

HOPEWELL VALLEY REGIONAL SCHOOL DISTRICT

AUTHORIZATION FOR PUPIL RECORDS

☐ **HOPEWELL VALLEY CENTRAL HIGH SCHOOL**
259 Pennington-Titusville Rd
Pennington NJ 08534
(609) 737-4003
(609) 737-6546 (fax)

☐ **TIMBERLANE MIDDLE SCHOOL**
51 South Timberlane Dr
Pennington NJ 08534
(609) 737-4004
(609) 737-4489 (Fax)

☐ **TOLL GATE GRAMMAR SCHOOL**
275 South Main St
Pennington NJ 08534
(609) 737-4008
(609) 737-7348 (Fax)

☐ **BEAR TAVERN ELEMENTARY SCHOOL**
1162 Bear Tavern Rd
Titusville NJ 08560
(609) 737-4005
(609) 737-7351 (Fax)

☐ **HOPEWELL ELEMENTARY SCHOOL**
35 Princeton Ave
Hopewell NJ 08525
(609) 737-4007
(609) 466-8095 (Fax)

☐ **STONY BROOK ELEMENTARY SCHOOL**
20 Stephenson Rd
Pennington NJ 08534
Phone: 609-737-4006
609-730-3888 (Fax)

☐ **PUPIL SERVICES**
425 South Main St
Pennington NJ 08534
(609) 737-4002 ext: 2607
(609) 730-0340 (Fax)

STUDENT'S NAME: _____ Current Grade _____

_____ **I hereby authorize the Hopewell Valley Regional School District to <u>REQUEST</u> all pupil records from (to include health records, IEPs, cumulative record):**

School Name: _____

Address: _____

Phone: _____ Fax: _____

_____ **I hereby authorize the Hopewell Valley Regional School District to <u>RELEASE</u> all pupil records to (please provide name, address, phone and fax of the source):**

School Name: _____

Address: _____

Phone: _____ Fax: _____

Forwarding Residence Address (forwarding address must be completed for the records to be transferred):

Address: _____

Phone: _____

_____ _____ _____
Please Print Name of Parent/Legal Guardian **Signature of Parent/Legal Guardian** **Date**

_____ _____
Name of Building Principal **Date**

HOME LANGUAGE SURVEY

Student Information

Student Name:

Date of Birth (MM/DD/YYYY):

Current Address:

Questions

1. List all languages used in the student's home:

2. Was the first language used by the student a language other than English?

No

Yes

3. Does the student speak or understand a language other than English?

No

Yes

4. When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English *most of the time*?

No

Yes

5. When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English *most of the time*?

Yes

No

ANTI BIG BROTHER ACT

State Code 18A:36-39 N0.

Notification by school to certain persons using certain electronic devices; fine.

1. A school district or charter school that furnishes a student with a laptop computer, cellular telephone, or other electronic device shall provide the student with written or electronic notification that the electronic device may record or collect information on the student's activity or the student's use of the device if the electronic device is equipped with a camera, global positioning system, or other feature capable of recording or collecting information on the student's activity or use of the device. The notification shall also include a statement that the school district or charter school shall not use any of the capabilities in a manner that would violate the privacy rights of the student or any individual residing with the student. The parent or guardian of the student shall acknowledge receipt of the notification. The school district or charter school shall retain the acknowledgement as long as the student retains the use of the electronic device.

   A school district or charter school failing to provide the notification required by this section shall be subject to a fine of $250 per student, per incident. The fine shall be remitted to the Department of Education, and shall be deposited in a fund that shall be used to provide laptop or other portable computer equipment to at-risk pupils, as defined in section 3 of P.L.2007, c.260 (C.18A:7F-45).

2. This act shall take effect on the first July 1 following the date of enactment. Approved April 15, 2013.

HOPEWELL VALLEY REGIONAL SCHOOL DISTRICT'S ANTI-BIG BROTHER ACT ACKNOWLEDGEMENT 2020-21

By my signature below, I acknowledge that I have been notified by the Hopewell Valley Regional School District that the technology device provided to my child by the school district may record or collect information on the pupil's activity or the pupil's use of the technology device if the device is equipped with a camera, global positioning system, or other feature capable of recording or collecting information on the pupil's activity or use of the device.

The district shall not use any of the capabilities in a manner that would violate the privacy rights of the pupil or any individual residing with the pupil.

Student Last Name:

Student First Name:

Parent/Guardian Last Name:

Parent/Guardian First Name:

Parent/Guardian Signature:

Hopewell Valley Regional School District

PUBLICITY and TECHNOLOGY POLICIES CONSENT FORM

Publicity Release

I grant permission to HVRSD to release information about my child(ren) through school-related publicity releases to media outlets such as the Hopewell Valley News, Hopewell Express, Mercer Me, The Times of Trenton, etc. The release may include information such as name, school, grade/teacher, performance role, name of course or activity, work product and photograph. The release also includes athletic and extracurricular activities. This includes permission for my child(ren)'s photo image/video and other personal identifiers, such as name, to be published on HVRSD online resources. **I understand that this acknowledgement will apply for the rest of my child's schooling in HVRSD unless I choose to change or cancel.** I further certify that I am the parent or legal guardian of the student(s) named on this form (below).

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Technology Responsible Use Policy

Your child will be engaging with a variety of information technology services, including internet access, provided by Hopewell Valley Regional School District. As the parent/guardian, please ensure you have read the technology policies on the HVRSD website (www.hvrsd.org and click on Menu > OFFICES > TECHNOLOGY > Technology Guidelines & Policies). Students K-12 receive age-appropriate instruction on the HVRSD Responsible Use Policy (RUP) and their use is restricted when appropriate and is monitored. Students are expected to use technology to enhance their learning and are expected to use the technologies available to them in a safe and ethical manner at all times. You can view the district's approved technology by on the HVRSD Approved Technology List. Changes to the HVRSD Responsible Use Policy will be communicated to parents/guardians whenever there is a change made to the policy. **I understand that this acknowledgement will apply for the rest of my child's schooling in HVRSD unless I choose to change or cancel**. I further certify that I am the parent or legal guardian of the student(s) named on this form (below).

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Parents/guardians, please list your children that are enrolled in the Hopewell Valley Regional School District:

Student 1: _____ Student 2: _____

Student 3: _____ Student 4: _____

Student 5: _____ Student 6: _____

Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

PERMISSION TO DISCLOSE MEDICAL INFORMATION ON A NEED-TO-KNOW BASIS

Dear Parents / Guardians:

Due to current privacy legislation, medical information given to the school nurse or other school personnel may not be shared with any other school personnel, even when required for emergency services, without your WRITTEN permission. This restriction includes information that you have shared with the district via the Internet, in writing, on the telephone or in a personal conversation.

Sharing important medical information with school personnel on a need-to-know basis can greatly enhance your child's academic performance and ensure your child's safety. We encourage all parents to sign this release regardless of your child's current medical condition as important information could arise throughout the school year. Be assured that this information will be shared only on a need-to-know basis and will not be subject to general distribution.

COMPLETE ONE FORM FOR EACH STUDENT IN THE HOUSEHOLD AND RETURN TO THE NURSE'S OFFICE.

Medical information provided to the district pertaining to my child **MAY** be shared with school personnel and emergency services when necessary.

_____
Student Name (please print)

_____ _____
Signature of Parent / Guardian Date

Hopewell Valley Regional School District

Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

CONFIDENTIAL HEALTH HISTORY

(to be completed by parent or guardian)

I. Identifying Information

Child's Last Name _____ First _____ Middle _____ Gender _____ Birth date (month/day/year) _____

Address (Number – Street, City and Zip) _____

Parent/Guardian Name _____ Home phone / business phone _____

Parent/Guardian Name _____ Home phone / business phone _____

Child lives with: _____

II. Pregnancy and Birth History

A. Pregnancy

1. Illness of mother during pregnancy YES NO
2. Injury of mother during pregnancy YES NO

B. Birth History

1. Premature YES NO
2. Long labor YES NO
3. Instrument delivery YES NO
4. C-section YES NO
5. Birth weight: _____
6. Oxygen given during birth YES NO
7. Incubator used YES NO
8. Bili lights used YES NO
9. Illness of baby during first 28 days? YES NO

If your response has been YES to any of the above items, please specify the nature of the problem in the space below.

_____

_____

III. Previous Exams

A. What is the date of your child's last physical exam? _____

B. What is the date of your child's last dental exam? _____

C. What is the date of your child's last eye exam? _____

Has your child ever been treated for a visual disorder? YES NO If yes, please explain:

_____

_____

Has your child been prescribed glasses or contact lenses? YES NO If yes, please explain:

_____

_____

IV. Mental, Emotional and Social Health History

A. Has your child been treated for emotional issues? YES NO

B. Has your child been treated for behavioral difficulties? YES NO

C. Briefly describe your child's play habits alone and with peers/siblings. _____

_____

V. Medical History

A. Has your child had problems in any of the following areas? Please check **YES** or **NO**.

Yes	No		Yes	No		Yes	No		Yes	No	
		Cancer			Eyes			Arthritis			Headaches
		Diabetes			Ears			Joint pain			Blackouts
		Down's syndrome			Nose			Growth problems			Dizziness
		High blood pressure			Throat			Hives			Fainting spells
		Seizure disorder			Jaws / teeth			Skin disorders			Ringing in ears
		Frequent nose bleeds			Wrists			Fungus infections			Lungs
		Tuberculosis			Hands			Nervous disorders			Shortness of breath
		Heart (rheumatic fever, etc.)			Fingers			Hernia (rupture)			Wheezing
		Stomach (ulcer, etc.)			Leg			Diabetes			Persistent cough
		Neuro-muscular condition			Hip			Epilepsy (convulsions)			Asthma
		Liver (hepatitis, etc.)			Knee			Blood in urine			Hay fever
		Enuresis (bed wetting)			Ankle			Diarrhea			Mononucleosis
		Bladder problem			Back / spine			Orthopedic problem			Chicken pox
		Fatigue & undue tiredness			Foot			Genitalia issues			Lyme disease
		Eating disorder			Toes			Autism			Tourette syndrome
		Head injury									

If you answered **YES** to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any conditions or medical history not listed. You may attach additional sheets and medical records if necessary.

_____

_____

B. Has your child ever received speech therapy? YES NO If yes, please explain:

_____

_____

C. Has your child ever been treated for a hearing disorder? YES NO If yes, please explain:

Does your child have a hearing aid? YES NO

_____

_____

D. Does your child have any eating problems or special diets? YES NO If yes, please explain:

_____

_____

E. Does your child have any condition which might limit his/her activities at school? YES NO If yes, please explain:

_____

_____

F. What medication does your child take daily? _____

G. What medications are given frequently, but not daily? _____

H. Allergies: Please list and describe any allergies and the reactions:

Medication: _____

Food: _____

Plants / animals / latex / bee sting / other: _____

I. Please list any surgeries, hospital admissions (medical or psychiatric), serious diseases, accidents or emergency room visits:

_____

_____

VI. Family History

Please circle and indicate relationship:

Diabetes	_____	Asthma	_____
Cancer	_____	Epilepsy	_____
Kidney disease	_____	Speech disorder	_____
High blood pressure	_____	Vision disorder	_____
Heart disease	_____	Hearing disorder	_____
Allergies	_____	Nervous/emotional disorder	_____

VII. Comments / Concerns

If you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the school to be aware of, please explain.

_____

_____

_____

_____ _____

Signature of Parent / Guardian Date

New Jersey Department of Health and Senior Services
MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP//DTP	**Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. **Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
Tdap	**Grade 6** (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	**Age 1-6 years**: 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. **Age 7 or Older:** Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus influenzae B (Hib)	**Age 2-11 Months**: 2 doses **Age 12-59 Months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	**K-Grade 12**: 3 doses or **Age 11-15 years**: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	**Age 2-11 months**: 2 doses **Age 12-59 months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	**Ages 6-59 Months**: 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

New Jersey Department of Health and Senior Services

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

*** Footnote**: The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote**: Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote**: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability	
2. Date of disability	
3. Classification (if available)	
4. Cause of disability (birth, disease, accident/trauma, other)	
5. List the sports you are interested in playing	

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscollosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____ (Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

REQUIRED TUBERCULIN TESTING IN NEW JERSEY SCHOOLS

Students born in **ANY** country that is **NOT** listed below and who are entering a U. S. school for the first time **OR** students transferring into a NJ school directly from **ANY** country **NOT** listed below must have a Mantoux tuberculin skin test or IGRA unless they meet an exception criterion.

Albania
America Samoa
Andorra
Antigua and Barbuda
Australia
Austria
Barbados
Belgium
Bermuda
British Virgin Islands
Canada
Cayman Islands
Chile
Cook Islands
Costa Rica
Cuba
Cyprus
Czech Republic
Denmark
Dominica
Finland
France
Germany
Greece
Greenland
Grenada
Iceland
Ireland
Israel
Italy
Hungary
Jamaica
Jordan
Lebanon
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
North Ireland
Norway
Oman
Puerto Rico
Saint Kitts and Nevis
St. Lucia
Samoa
San Marino
Slovakia
Slovenia
Sweden
Switzerland
Trinidad and Tobago
Turks and Caicos Islands
United Arab Emirates
United Kingdom of Great Britain and Northern Ireland
United States of America
United States Virgin Islands

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING:

_____ _____
Child's Name Place of Birth

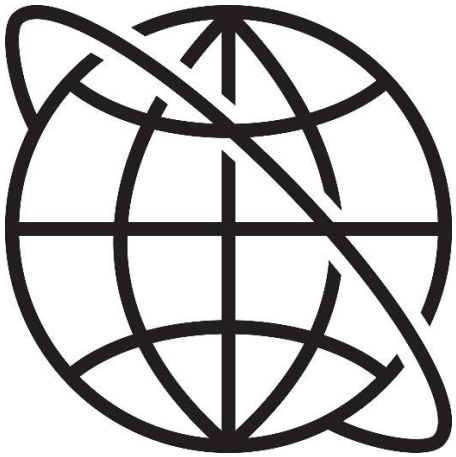
_____ _____ _____ mm
Date Mantoux Test Placed Date Mantoux Test Read Result (mm)

--- OR ---

_____ _____
Date of IGRA test Result of IGRA test

_____
Physician's Signature

Low Income Internet Programs Available Through Verizon and Xfinity



More information can be found using the following links and phone numbers:

Verizon: https://www.verizon.com/info/low-income-internet/
1-800-234-9473

Xfinity: https://www.xfinity.com/support/articles/comcast-broadband-opportunity-program
1-855-846-8376