Student ID #: _____ *School:* _____ *Family Code:* _____

Escuelas Publicas de North Brunswick Township

Instrucciones para el padre / tutor: La información solicitada a continuación es necesaria para completar el proceso de inscripción. En algunos casos por razones de privacidad, no puedan responder a una pregunta. El padre / tutor debe entender que sus respuestas a estas preguntas serán de gran ayuda para el distrito y el estado en la planificación de un programa que satisfaga las necesidades únicas de su hijo. Si el padre / tutor se niega a responder una pregunta, la escuela debe tomar una determinación sobre algunos elementos que se dejan en blanco. Por favor, haga todo lo posible para responder de la mejor manera posible a fin de agilizar el proceso y para evitar contactos de seguimiento para obtener más información.

Nombre del estudiante:: _____
Apellido Primer Nombre medio nombre

Dirección del estudiante:

_____Cuidad, estado, codico _____

alquiler:: _____ Fecha de *Exp* _____ Dueño: _____ # de Lote _____ # Bloque # _____ Typo de casa:_____ Affidavit: si ____No ____

Cuál fue el último grado que atendió su hijo? _____

Escuela anterior:_____ Grado anterior: _____ Numero telefonico: _____

Direccion: _____ Cuidad/estadol: _____

INFORMATION de Padres

Estado matrimonial: casado ___ Divorciado ___ Separado ___ Soltero ___ segunda nupcias ___ Custodia/el nino vive con:_____

Derechos de CUSTODIA: Nombre: _____Relacion:_____ tiene custodia legal del nino.
documentos legales deben estar en archivo en la escuela que atiende el niño.. El otro padre puede o no pude hablar con el niño. □ *SI* □ *NO* y puede firmar salida para el niño. Identificación es obligatorio.

Niños en la familia (incluyendo estudiante) en orden de edad, mayor a menor…

Nombre Género fecha de nacimiento nombre de escuela, estado Grado

1. _____
2. _____
3. _____
4. _____
5. _____

Tiene su niño un IEP? si ____ no ____ Si tiene un IEP, puede dar una copia? si ____ no ____ Tiene hogar su hijo? si ___ no ___

Hay algun problema educativo que debemos saber? si____ no ____ Por favor especifica _____
_____

Recibe su hijo ayuda federal de inmigrantes? si ___ no ___ es su hijo inmigrante? si ___ no ___ Un inmigrante es un estudiante **que tiene 3 a 21 años y No nació en los EE. Y no ha asistido a uno o más escuelas en los EE por más de 3 anos academicos.**

Fecha de entrada a EE: :_____ Fecha de entrada a la primera escuela en los EE: :_____

Información de salud

Enumera cualquier alergia: _____ enumere cualquier medicamentos: _____

Enumere cualquier condicion medica o discapacidad que pueda interferir con el aprendisaje de su hijo en la clase: _____

Special health recommendations you wish the school to consider: _____

Nombre del Doctor_____ direcion _____

Telefono del doctor: _____

Circule donde corresponda : · su hijo usa lentes de contacto: si / no duros / suaves

Tiene alergias su hijo: si / no

Usa su hijo implantes dentales si / no

INFORMACIÓN DE EMERGENCIA:

Si nadie su puede contactar en caso de emergencia que su hijo/a se enferme or este herido , que desea que la escuela haga?

_____

En caso de emergencia cuál centro médico prefiere?

Escoja uno: **Robert Wood Johnson Hospital** or **St. Peter's University Hospital**

Firma de Padre/Guardian: _____ fecha: _____

Certifico que las declaraciones anteriores hechas por mí son verdaderas. Soy consciente de que si alguno de ellos es deliberadamente falso, estaré sujeto a acciones legales. Según la ley estatal y la política de la Junta, si se descubre que mi hijo (s) está (n) asistiendo ilegalmente a las escuelas de North Brunswick y no vive en North Brunswick, seré responsable del pago de las tasas de matrícula acumuladas. Además, reconozco que seré responsable de los gastos legales incurridos por la Junta de Educación de North Brunswick en relación con la situación.
Importante:
Entiendo que en la disposición final de una emergencia prevalecerá el juicio de las autoridades escolares. La recomendación del padre / tutor, como se indica aquí será respetada siempre que sea posible.

For Office Use Only *Grade:_____ New Entry:____ Re-Entry:____ Entry Code:_____ Year of Graduation:_____ Class of:_____*

Custody Issue: Yes____ No____ Copy of Custody Papers: Yes____ No____ Docket #:_____ Program Type:_____ School Entry Date:_____

Registrar: _____ Entered by: _____ Date Entered_____

Copies to: ___Transportation ____Special Services ___Technology

Escuelas del Condado de North Brunswick

North Brunswick, New Jersey 08902

EVALUACIÓN MÉDICA DEL ESTUDIANTE

Escuela : ☐JA ☐JD ☐LP ☐Prsns ☐LMS ☐NBTHS Fecha:

Estudiante (Apellido, Nombre) _____ FDN _____ Grado _____

☐Padre☐Tutor _____

Dirección _____

Teléfono Hogar # _____ Trabajo # _____ Celular # _____ Otro Día# _____

Médico _____ Teléfono # _____

Dirección _____

Nombre del Odontólogo _____ Teléfono # _____

LISTA DE OTROS NIÑOS EN LA FAMILIA:

Nombre _____ FDN _____ Nombre _____ FDN _____

Nombre _____ FDN _____ Nombre _____ FDN _____

HISTORIA MÉDICA

PARA TODAS LAS RESPUESTAS AFIRMATIVAS: POR FAVOR BRINDE INFORMACIÓN DETALLADA AL RESPALDO.

	Sí	No		Sí	No		Sí	No
Problemas en el embarazo			Nacimiento Prematuro			La madre tiene enfermedad crónica o grave		
Retrasos para caminar			Problemas en el parto			El padre tiene enfermedad crónica o grave		
Retrasos para hablar								

SU HIJO (A) TIENE:						HAS YOUR CHILD *EVER* HAD):					
	Sí	No		Sí	No		Sí	No		Sí	No
Resfriados frecuentes			Problemas de la Visión			Convulsiones			Hábitos nerviosos		
Dolores de garganta frecuentes			Gafas			Desmayos epilépticos			Enfermedad Grave		
Alergias que amenazan su vida (envíe documentación médica)			Problemas Auditivos			Problemas de coordinación			Varicela		
			Dispositivos auditivos			Operación (explique)			Otra (explique)		
Alergias (explique)			Problemas emocionales			Lesión grave					
Asma			Malos hábitos alimenticios			Dolores de estomago frecuentes					
			Malos patrones de sueño			Dolores de cabeza frecuentes					

Actualmente, ¿está su hijo (a) bajo tratamiento médico? (¿SI? Explique)		
¿Su hijo (a) tiene algún medicamento? (¿SI? Explique)		
¿Ha sido su hijo (a) *alguna vez* remitido a un médico para mayor cuidado de la VISIÓN, ESCUCHA, y/o SCOLIOSIS?		

POR FAVOR USE EL RESPALDO PARA APUNTAR CUALQUIER COSA ACERCA DE SU HIJO (A) QUE PUEDA PRESENTAR ALGUN PROBLEMA

Firma del Padre/Tutor _____ Relación con el Niño _____ Fecha _____

Firma del Padre/Tutor _____ Relación con el Niño _____ Fecha _____

Por favor, lleve este formulario al doctor
para completar
y lleve con usted a su cita del registro de su hijo

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

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

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

North Brunswick Township School District - Permission to Request/Transfer Student Records

John Adams Elementary School
1450 Redmond Street
North Brunswick, NJ 08902
732-289-3100 Fax: 732-249-4521

Livingston Park Elementary School
1128 Livingston Avenue
North Brunswick, NJ 08902
732-289-3300 Fax: 732-249-5283

Linwood Middle School
25 Linwood Place
North Brunswick, NJ 08902
732-289-3600 Fax: 732-247-7033

Judd Elementary School
1601 Roosevelt Ave.
North Brunswick, NJ 08902
732-289-3200 Fax: 732-297-0036

Parsons Elementary School
899 Hollywood St.
North Brunswick, NJ 08902
732-289-3400 Fax: 732-435-1709

North Brunswick Twp. High School
98 Raider Road
North Brunswick, NJ 08902
732-289-3700 Fax: 732-289-3784

No. Brunswick Twp. Early Childhood Ctr.
44 Cleveland Avenue
Milltown, NJ 08850
732-317-6300 Fax: 732-317-6319

Please send transfer records to the school circled above. Attn.: _____

Student Transferring to North Brunswick **(Request records from previous school)**

SID Number _____

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

North Brunswick School: _____

Current Address: _____

Previous Address: _____

Previous School's Name and Address _____

_____

Student Transferring from North Brunswick **(Transfer records to new school)**

SID Number _____

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

Student's Last Day of Attendance _____ North Brunswick School: _____

Previous Address: _____

Current Address: _____

New School's Name and Address _____

_____

Parent/Guardian Name (print): _____

Parent/Guardian Phone Number: _____

Parent/Guardian Signature: _____ **Date:** _____
Original Signature Is Required