



PEMBERTON TOWNSHIP SCHOOLS

Tony Trongone

Superintendent of Schools

Registration Requirements for Students

Please bring the following documents with you to registration:

1. Birth Certificate - Birth Certificate must have a raised seal on it.
2. Immunization record
3. Transfer card/transcripts and current report card if transferring from another state or district.
4. Proof of Residency
5. Online Pre-registration. Please print the confirmation page and bring with you.

Proof of Residency: Please provide four (4) forms (listed below) to demonstrate Residency.

1. Homeowners:

- One (1) - Property tax bills, deeds, contracts of sale, mortgages, township bills (water, sewer, trash etc.)
- Three (3)-Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location

2. Renters

- Lease
- Three (3)-Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location

3. Military Living on Fort Dix

- Housing authority permit or lease.
NOTE: School Option for Military Personnel will be enforced.

4. Residing with a Pemberton Township Resident:

- Resident who owns the home must file an "Affidavit of Domicile" and proof of residency as a Homeowner.
- Residents who rent the home must provide a copy of their lease and an addendum by the landlord listing the additional person(s) living in the property.

5. Guardianship

- Please provide all court documents pertaining to educational and/or residential custody.



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Student's Name

I, _____, have been informed by the Pemberton Township
(residential parent/guardian)

School District that I can only register students in Pemberton Township Schools if I am a resident of Pemberton Township.

I am aware that any person who makes a false statement or permits false statements to be made for the purpose of allowing a non-resident student to attend Pemberton Township Schools, commits a disorderly persons offense pursuant to N.J. 18A: 38-1 and may be prosecuted by law.

I authorize Pemberton Township Schools to investigate and confirm any and all statements by me and used in the enrollment of the above student. If any information is false I am aware that enrollment in Pemberton Township Schools will be terminated.

A. By initialing I am stating: **Initial one**

- 1. I am a resident of Pemberton Township _____
- 2. I am temporarily residing in Pemberton Township with a resident _____

B. By initialing I am stating that I am the: **Initial one**

- 1. Parent/Guardian _____
- 2. Parent and/or guardian with residential custody (documentation provided) _____
- 3. Sole caretaker (non-parent/guardian) due to economic/family hardship _____

C. By initialing I am stating that I understand: **Initial**

- 1. Any change in residency or custody will be reported immediately _____

Signature of Parent/Guardian

Date

District Official

Date

Pemberton Township School District
STUDENT MEDICAL HISTORY

Since the health of a child can affect his/her ability to learn in school, please assist our school personnel in providing the following information:

Student Name _____ Birthdate _____ M ___ F ___

CURRENT HEALTH INFORMATION - please answer all the following questions by circling Yes or No

Y	N	Is your child now under the care of a physician for a medical or surgical problem?
Y	N	Does your child have any physical limitations or restrictions?
Has your child ever experienced any of the following?		
<u>Circle one</u>		<i>If yes, indicate date, details, and medication</i>
Y	N	Asthma
Y	N	ADD or ADHD (circle one)
Y	N	Medication allergy or sensitivity (circle one)
Y	N	Bee sting- allergy or sensitivity (circle one)
Y	N	Food allergy or sensitivity (circle one)
Y	N	Diabetes
Y	N	Frequent ear infections
Y	N	Frequent bladder or kidney infections
Y	N	Frequent nose bleeds
Y	N	Seizure disorder
Y	N	Headaches
Y	N	High blood pressure
Y	N	Heart conditions
Y	N	Concussion / head injury requiring medical treatment
Y	N	History of fainting with exercise
Y	N	Operations (not stitches for lacerations)
Y	N	Fractures (broken bones) or dislocations
Y	N	Speech problems
Y	N	Mental health concerns
Y	N	Need for hearing aide/implant/ear tubes/hearing concerns
Y	N	Wears glasses and/or contact lenses/vision concerns
Y	N	Any chronic/serious illness not mentioned above
Y	N	*Medication at home or in school

**If medication is needed in school it MUST be brought to the health office in the original container with a physician's order. The child's parent/guardian is required to complete the Student Medication Permission form. Medication orders MUST be renewed EVERY year or participation in ANY activities (after school, field trips etc.) will be denied.*

Y N **Tylenol/Acetaminophen or Motrin/Ibuprofen given by the nurse every 4-6 hours

***Our school physician has written orders for the nurse to give the recommended OTC manufacturer's dosage of Tylenol/acetaminophen or Motrin/ibuprofen every 4-6 hours as needed for pain/fever with your permission as per nurse's assessment. By signing this form you hereby release the Pemberton Township BOE and all school District personnel from liability.*

I understand that relevant information regarding my child's health may be shared with the appropriate school personnel and other health care providers as necessary. In case of serious illness or injury, I request that the school contact me or the physician named. If neither is available, I give the school permission to make all necessary arrangements to obtain emergency care for my child including taking my child to the hospital. I will also call the school when my child is absent.

Signature: _____

Date: _____

Home Phone: _____

Cell Phone: _____

Doctor's Name: _____

Dr.'s Phone: _____

Pemberton Township Schools Student Health History Questionnaire

Today's date: _____

Person completing this form: _____
Relationship to child: _____

GENERAL INFORMATION {please print}

Student's Full Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Sex: Male or Female {check box}

<u>Parent/Guardian Name:</u>	<u>Parent/Guardian Name:</u>
<u>Current Address:</u>	<u>Current Address:</u>

How long at this address: _____ Language(s) spoken at home _____

Who lives in your household: _____

Home Phone Number: _____ Cell Phone Number: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Name of Previous School: _____

Address: _____

Is your child: Biological Child Adopted Child Foster Child Other _____

Child's Physician's Name: _____ Phone Number _____

Physician's Address: _____

II. HEALTH HISTORY - {please check box and provide explanation for only checked responses}

Chicken Pox Explain: _____

Strep Throat/Infections Explain: _____

Lyme Disease Explain: _____

Ear Infections Explain: _____

Asthma Explain: _____

Headaches Explain: _____

Heart Problems Explain: _____

Serious Allergies Explain: _____

Food Allergies Explain: _____

Drug Allergies Explain: _____

Life Threatening Allergies Explain: _____

Chronic Illnesses Explain: _____

(diabetes, cystic fibrosis, muscular dystrophy, kidney disease, cancer, metabolic disorders, etc.)

Speech Problems Explain: _____

Hearing Problems Explain: _____

Vision Problems Explain: _____

Seizures Explain: _____

Orthopedic Problems Explain: _____

Birth Defects Explain: _____

Serious Illness or Accident Explain: _____

Hospitalization or Surgery Explain: _____

Bowel or Bladder Problems Explain: _____

Adaptive aids Explain: _____

(glasses, hearing aid, wheelchair, braces, etc.)

Please check appropriate box below for conditions that describe the health of the child & mother during...

<u>Mother's Pregnancy</u>	<u>Child's Delivery</u>	<u>Child's Condition at Birth</u>
<input type="checkbox"/> No complications	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Induced labor	<input type="checkbox"/> Lack of oxygen
<input type="checkbox"/> Falls	<input type="checkbox"/> C-section	<input type="checkbox"/> Breathing problem
<input type="checkbox"/> Physical injury	<input type="checkbox"/> Breech birth	<input type="checkbox"/> Birth injury/defect
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Unusually long labor (>12 hours)	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Premature # of weeks _____	<input type="checkbox"/> Newborn ICU # of days _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overdue # of weeks _____	<input type="checkbox"/> Other problem (specify) _____ _____ _____
<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Other problem (specify) _____ _____	
<input type="checkbox"/> Toxemia		
<input type="checkbox"/> Alcohol and/or drug use		
<input type="checkbox"/> Use of tobacco		

III. CURRENT HEALTH/DEVELOPMENTAL STATUS

1. Describe the state of your child's current health: Excellent Good Fair Poor
2. Is your child currently taking any medication? Yes No
If yes, please list medications and uses: _____

3. If need be, would you have any objection to your child being placed in a peanut/
tree nut safe classroom? Yes No
4. Does your child sleep in his/her own bed? Yes No
5. Does your child share a room with anyone else? Yes No
6. Does your child use toilet independently? Yes No
If no, describe assistance needed: _____
7. Are there any problems which might affect your child's learning? Yes No
If yes, describe: _____
8. Has your child received any type of therapy (i.e., counseling, speech therapy,
physical therapy, occupational therapy, vision therapy, etc.) Yes No
If yes, describe: _____

9. Has your child ever had trouble walking, climbing, reaching, holding on to things?

Yes No If yes, describe: _____

10. At what age did your child ...?

- Sit up on his/her own _____
- Crawl _____
- Walk _____
- Speak using single words _____
- Speak using 2-3 word sentences _____

11. Can your child speak so that he/she can be understood by others? Yes No

12. Do you have concerns about your child's willingness to try different foods?

Yes No If yes, describe: _____

13. Does your child sleep in his/her own bed? Yes No

14. What time is your child's normal bedtime? _____

15. What time is your child's normal wake up time? _____

16. Do you have concerns about your child's sleeping patterns? Yes No

If yes, describe: _____

17. Is your child highly active? Yes No

18. Is your child very quiet? Yes No

19. Does your child talk with your friends/relatives who visit? Yes No

20. Does your child have opportunities to play with other children? Yes No

21. Any other information that you want to share? Yes No

If yes, describe: _____

****PLEASE RETURN THIS FORM TO THE SCHOOL NURSE****



PEMBERTON TOWNSHIP SCHOOLS

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Dear Parent/Guardian,

The New Jersey Department of Education code states that each student's medical examination shall be conducted at the "medical home" (family physician) and recorded on a form supplied by the school. If the student does not have a "medical home" (family physician), the district shall provide this examination at the school's physician's office or other appropriate facility. Southern Jersey Family Medical Center performs physicals and other medical services. You can make an appointment by calling 1-800-486-0131. A student's "medical home" is defined as a health care provider and that provider's practice site is chosen by the student's parent or guardian for the provision of health care.

Each student shall be examined as REQUIRED below:

1. All students ages 3-5 upon initial entrance to school (initial entrance may be pre-school or kindergarten within the state of New Jersey).
2. All new students from out-of-state within 30 days of entry.
3. Student's participation in sports (Intramural and Interscholastic) grades 6-12. Please see your School Nurse for the specific form that must be used or download it from the district website.

*(A student transferring in from outside of the United States may need to be tested for tuberculosis. Your child's School Nurse will notify you if this applies to your child.)

It is recommended that subsequent physicals be done:

1. Pursuant to a comprehensive Child Study Team evaluation, if recommended.
2. During the student's pre-adolescence fourth through sixth grade.
3. During adolescent (7th through 12th grade).

If you do not have a medical provider (family physician) for your child, please contact your school nurse for information. Thank you for your cooperation.

Phone: 609-893-8141 Ext. 1003

Fax: 609-894-0933

E-mail: ttrongone@pemb.org

Office: One Egbert Street, Pemberton New Jersey 08068

www.pemberton.k12.nj.us

Pemberton Learning Community: Pursuing Excellence One Child at a Time

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <i>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.</i>					
Name of Health Care Provider (Print) _____			Health Care Provider Stamp:		
Signature/Date _____					

New Jersey Department of Health
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	<p>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</p>	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	<p>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</p>	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)	<p>Age 2-11 Months: 2 doses Age 12-59 Months: 1 dose</p>	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	<p>K-Grade 12: 3 doses or Age 11-15 years: 2 doses</p>	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	<p>Age 2-11 months: 2 doses Age 12-59 months: 1 dose</p>	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

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.