FAIRVIEW PUBLIC SCHOOLS REGISTRATION FORM

Student Enrollment Information: Circle One and fill in the appropriate grade

Lincoln Annex (Kindergarten), #3 Annex (Grade ___) #3School (Grade ___) Lincoln School (Grade ___)

Name: _____ Gender: M F NB
(Last) (First) (Circle One)

Date of Birth: _____ Birth City & State _____ Country: _____ (If not United States)

Documentation Provided: ___ Birth Certificate

DOCUMENTATION FOR YOUR CHILD'S BIRTHDATE IS REQUIRED AT TIME OF REGISTRATION

Street Address: _____

Town: Fairview State: NJ Zip Code: 07022 Home Phone Number: _____

Proof of Residency: As proof of residency, I am providing copies of the following (mark with an "X")

__ A notarized lease effective during the current school year showing residence within the Borough of Fairview

OR

__ A recorded deed showing ownership of a residence within the Borough of Fairview

AND

__ Driver's License or NJMV ID with Fairview Address

Two of the following

__ Current Utility Bill

__ Current Property Tax Bill

__ Bank Statement

__ Cell Phone Bill

Other Children in the household

Child's Name	Date of Birth

Fairview Public School District

Parent Information: (Please print clearly)

Parent/Guardian (Father):	Parent/Guardian (Mother):
Name: _____	Name: _____
Street Address: _____	Street Address: _____
City: _____	City: _____
State: ____ Zip Code: _____	State: ____ Zip Code: _____
Home Phone Number: _____	Home Phone Number: _____
Cell Phone Number: _____	Cell Phone Number: _____
Email: _____	Email: _____

Student Family Information:

Ethnicity/Race: (Check all that apply)

__ Hispanic __ Asian __African American __ Native American __ Pacific Islander

Nationality: _____

Primary Language Spoken at home: _____

Home Conditions that may affect pupil (i.e., death, divorce, separation, relatives living the home, etc…)

_____

_____

Previous School Attended (name, address, city, state)

_____

Registration Statement:

I, _____, affirm that I am the (please circle one) natural parent/legal guardian of the student listed above. I further state that this form and the attached documentation constitute true and accurate proof that the student listed above resides with me within the Borough of Fairview. If any student above stops living with me, or if I move my residence out of the Borough of Fairview I will promptly notify the Fairview Board of Education in writing.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Fairview Public School District

Owner/Landlord Information

Last Name _____ First Name _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Tenant Information

Last Name _____ First Name _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Leasing Information

When did tenant(s) move in? _____ Relation to Renter: __ None

How long is the lease agreement? _____ __ Family Member

Type of rental agreement: ___ Yearly ___ Month to Month ___ Rent to Own

List Names of all persons living in the above-named residence

1.	**4.**
2.	**5.**
3.	**6.**

I fully understand that any false answers provided are subject, if proven false, to punitive action. (N.J.S.A. 2C:28-2) I understand that if the residency information that I am providing is found to be false or if I do not notify the Fairview School District of any residency change, I will be responsible for all tuition costs ($15,177) and fees paid by the Fairview Board of Education in addition to any legal fees that may be incurred.

Sworn and subscribed before me

this _____ day of _____.

_____

Signature of Owner/Landlord

_____

Notary Public of New Jersey

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.