Irvington Public Schools
Office of Early Childhood
97 Augusta Street, Second Floor, Suite 219, Irvington, New Jersey 07111
Phone: 973-399-3942 EXT. 1514

Tawana Moreland, Director Lia Varsalona, Supervisor

***MUST BE AN IRVINGTON RESIDENT TO BE ELIGIBLE**
DEBE SER RESIDENTE DE IRVINGTON PARA SER ELEGIBLE
DWE YON REZIDAN IRVINGTON POU KA KLIJI

2023-2024 Registration and Enrollment Application

Step 1. Complete Online Preregistration at or Scan the QR Code
https://irvington.k12.nj.us/curriculum/early-childhood/ec-registration/
Step 2: You will receive a confirmation email after completing and submitting the Online Pre-Registration Form.
Step 3: Within 48 hours, you will receive a call and/or email to schedule an appointment.
Step 4: During the Registration appointment, you will need to bring the Registration Enrollment Application and all required documentation.

To register for the September 2023-2024 Preschool Program, the child must be 3 or 4 years old on or before October 1st.
Para inscribirse en el programa preescolar de 2023-2024, el niño debe tener 3 o 4 años antes del 1 de octubre.
Pou enskri nan Pwogram Lekòl Matènèl 2023-2024 la, timoun nan dwe gen 3 oswa 4 zan nan dat 1ye oktòb oswa anvan.

The following items must be submitted to complete your child's registration:
Los siguientes elementos deben enviarse para completar el registro de su hijo:
Yo dwe soumèt atik sa yo pou konplete enskripsyon pitit ou a:

❒ **Birth Certificate/Passport/Visa/Green Card** *Certificado de Nacimiento/Pasaporte/Tarjeta de Residencia - Batistè/Paspò/Kat Rezidans*
❒ **Immunization Record** *Cartilla de vacunación - Dosye Vaksinasyon*
❒ **Physical Health Form (Completed, Dated, Signed/Stamped By Physician)** *Formulario de chequeo físico (completado, con fecha y firmado con sello del médico) Fòm Sante Fizik (Konplete, Date, Siyen/Stampye Pa Doktè)*
❒ **Lead Level Test with date and results -** *Prueba de nivel de plomo con fecha y resultado - Tès Nivo Plon ak dat ak rezilta yo*
❒ **Influenza Vaccine (Received on or after August 1st, 2023)** *Vacuna contra la influenza (recibida a partir del 1 de agosto de 2023) Vaksen kont Grip (Resevwa nan oswa apre 1ye Out 2023)*
❒ **Current Proof of Residency (ONLY ONE PROOF IS NEEDED FROM THE LIST BELOW):** *Comprobante de domicilio actual (SOLO SE NECESITA UNA PRUEBA DE LA LISTA A CONTINUACIÓN) Prèv Adrès Aktyèl (SÈLMAN YON PREV BEZWEN NAN LIS ANBA A*

❒ **Current PSE&G Bill** *Factura actual de gas y luz/Aktyèl bòdwo gaz ak limyè*
❒**Current Cable Bill** *Factura actual de cable Aktyèl Kab Bill*
❒ **Current Mortgage Statement** *Declaración de hipoteca actual/Deklarasyon ipotèk aktyèl la*
❒ **Homeowner's Tax Bill** *Factura de impuestos del propietario/Bòdwo taks pwopriyetè kay*

Preschool Attendance Policy: Parents must contact the school by 9:00 am if your child will be absent. Schools must attempt to contact parents/guardians within 2 hours after it has been determined that their child is not in attendance and the school has not been notified. Family workers/social workers/teachers will contact families and document the call. After the second unexcused absence, the parent/guardian will meet with the Director/Administrator. The Director/Administrator's role is to explain the importance of students attending school daily, and the valuable instruction lost when their child is absent. The Director will explain that they are required to drop students from the program after (ten) 10 consecutive days of absences. This does not include students with medical issues.

Política de Asistencia Preescolar: Los padres deben comunicarse con la escuela antes de las 9:00 am si su hijo estará ausente. Las escuelas deben intentar comunicarse con los padres/tutores dentro de las 2 horas posteriores a la determinación de que su hijo no asiste y la escuela no ha sido notificada. Los trabajadores familiares/trabajadores sociales/maestros se comunicarán con las familias y documentarán la llamada. Después de la segunda ausencia injustificada, el padre/tutor se reunirá con el Director/Administrador. El papel del Director/Administrador es explicar la importancia de que los estudiantes asistan a la escuela todos los días y la valiosa instrucción que se pierde cuando su hijo está ausente. El Director explicará que están obligados a dar de baja a los estudiantes del programa después de (diez) 10 días consecutivos de ausencias. Esto no incluye a los estudiantes con problemas médicos.

Règ sou Prezans Lekòl Matènè: Paran yo dwe kontakte lekòl la anvan 9:00 am si pitit ou a pral absan. Lekòl yo dwe eseye kontakte paran/gadyen nan lespas 2 èdtan apre yo fin detèmine ke pitit yo pa prezan epi lekòl la pa te avèti. Travayè fanmi/travayè sosyal/pwofesè yo pral kontakte fanmi yo epi dokimante apèl la. Apre dezyèm absans san eskiz la, paran/gadyen an ap rankontre ak Direktè/Administratè a. Wòl Direktè/Administratè a se eksplike enpòtans pou elèv yo ale lekòl chak jou, ak ansèyman enpòtan yo pèdi lè pitit yo absan. Direktè a pral eksplike ke yo oblije abandone elèv yo nan pwogram nan apre (dis) 10 jou youn apre lòt nan absans. Sa a pa enkli elèv ki gen pwoblèm medika

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2023-2024 Registration Enrollment Application (English) *(please print in blue or black ink)*

Student Information ☐ **Re-Registration** ☐ **New Registration**			
Last Name:	**First Name:**	**Middle Name:**	**Date of Birth:**
Gender ☐ **Male** ☐ **Female**	**Ethnicity:** ☐ **Hispanic or Latino Origin** ☐ **Non Hispanic or Latino Origin** **Hispanic or Latino Origin** _____	**Race:** ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **Other PAC Islander** ☐ **White** ☐ **Other:**_____	**Primary Language:** _____ **Additional Languages Spoken in the Home:** _____
Home Address:	**Apt. #:**	**City:**	**State:**
Home Telephone Number	**Birth City and State:**	**Birth Country:**	**US Entry Date (if applicable):**
Health Insurance: Yes No	**Health Insurance Company:**	**Consent to Release Information to NJ Family Care: Yes No**	
1. Parent/ Guardian Information			
Last Name:	**First Name:**	**Relationship:**	**Home Address:**
Email Address:	**Mobile Telephone Number:**	**Employer Information:**	**Employer Number:**
2. Parent/ Guardian Information			
Last Name:	**First Name:**	**Relationship:**	**Home Address:**
Email Address:	**Mobile Telephone Number:**	**Employer Information:**	**Employer Number:**
3. Emergency Contact Information			
Last Name:	**First Name:**	**Relationship:**	**Telephone Number:**
Last Name:	**First Name:**	**Relationship:**	**Telephone Number:**

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2023-2024 Solicitud de Inscripción de Registro(Sp) ***(Por favor llene con tinta negra o azul)***

Información del Estudiante ☐ **Re registro** ☐ **Nuevo registro**			
Apellido del Estudiante	**Primer Nombre**	**Segundo Nombre:**	**Fecha de nacimiento:**
Género ☐ **Masculino** ☐ **Femenina**	**Etnia:** ☐ **Origen Hispano o Latino** ☐ **Non Hispanic or Latino Origin** **Origen Hispano o Latino:** _____	**Raza:** ☐ **Indio americano o nativo de Alaska** ☐ **Asiatico** ☐ **Negro o Afroamericano** ☐ **Hawaiano** ☐ **Otro isleño del Pacífico** ☐ **Blanco** ☐ **Otro:**_____	**Lenguaje primario** _____ **Idiomas adicionales** _____
Direccion:	**Apt. #:**	**Ciudad:**	**Estado:**
Numero de telefono:	**Ciudad y estado de nacimiento:**	**País de nacimiento:**	**Fecha de entrada en EE. UU. (si corresponde):**
Seguro Medico: Si No	**Compania de Seguro Médico:**	**Consentimiento para divulgar información a NJ Family Care Si No**	
1. Información del Padre/Tutor			
Apellido:	**Primer Nombre:**	**Relación:**	**Direccion:**
Correo electrónico:	**Numero de telefono:**	**Nombre de Empleo:**	**Numero de Empleo**
2. Información del Padre/Tutor			
Apellido	**Primer Nombre:**	**Relación:**	**Direccion:**
Correo electrónico:	**Numero de telefono:**	**Nombre de Empleo:**	**Numero de Empleo**
3. Información de Contacto en caso de Emergencia			
Apellido	**Primer Nombre**	**Relación:**	**Numero de telefono**
Apellido:	**Primer Nombre**	**Relación:**	**Numero de telefono**

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2023-2024 Aplikasyon Enskripsyon (Cre) ***(Tanpri enprime ak lank ble oswa nwa)***

Enformasyon sou Elèv ☐ **Re Enskripsyon** ☐ **Nouvo Enskripsyon**			
Siyati	**Premye Non:**	**Mwayen Non**	**Dat nesans**
Sèks ☐ **Gason** ☐ **Fi**	**Etnisite:** ☐ **Orijin Panyòl oswa Latino** ☐ **Orijin ki pa Panyòl oswa Latino** **Orijin Panyòl oswa Latino:** _____	**Ras:** ☐ **Endyen Ameriken oswa natif natal Alaska** ☐ **Azyatik** ☐ **Nwa oswa Afriken Ameriken** ☐ **Natifnatal Awayi** ☐ **Lòt moun zile PAC** ☐ **Blan** ☐ **Lòt:_____**	**Lang Prensipal** _____ **Lòt Lang yo Pale nan Kay la** _____
Adres:	**Bon #:**	**Vil la):**	**Eta:**
Nimewo telefòn:	**Vil nesans ak Eta:**	**Peyi nesans:**	**Dat Antre Etazini (si sa aplikab):**
Asirans Sante: Wi Non	**Konpayi Asirans Sante:**	**Konsantman pou Divilge Enfòmasyon nan NJ Family Care: Wi Non**	
1. Enfòmasyon Paran/Gadyen			
Siyati	**Premye Non:**	**Relasyon:**	**Adres:**
Imel:	**Nimewo telefòn:**	**Enfòmasyon patwon yo:**	**Nimewo patwon an:**
2. Enfòmasyon Paran/Gadyen			
Siyati	**Premye Non:**	**Relasyon:**	**Adres:**
Imel:	**Nimewo telefòn:**	**Enfòmasyon patwon yo:**	**Nimewo patwon an:**
Enfòmasyon pou Kontak Ijans			
Siyati	**Premye Non:**	**Relasyon:**	**Nimewo telefòn:**
Siyati	**Premye Non:**	**Relasyon:**	**Nimewo telefòn:**

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Home Language Survey/*Encuesta sobre el idioma del hogar/Sondaj Lang Lakay*

Question 1: **List all languages used in the student's home:** *Pregunta 1: Énumère todos los idiomas que se usan en el hogar del estudiante: Énumérez toutes les langues utilisées au domicile de l'élève :*

_____

Question 2: **Was the first language used by the student a language other than English**? *Pregunta 2: El primer idioma que usó el estudiante fue un idioma diferente al inglés? La première langue utilisée par l'élève était-elle une langue autre que l'anglais ?*

- ☐ No /Non
- ☐ Yes/Si/Oui

Question 3: **Does the student speak or understand a language other than English?** *Pregunta 3: El estudiante habla o entiende un idioma que no sea inglés? L'élève parle-t-il ou comprend-il une langue autre que l'anglais ?*

- ☐ No/Non
- ☐ Yes/Si/Oui

Question 4: **When interacting with others <u>at home</u> (example: parents, guardians, siblings), does the student understand or use a language other than English most of the time?** *Pregunta 4: Al interactuar con otras personas en el hogar (ejemplo: padres, tutores, hermanos), el estudiante entiende o usa un idioma que no es inglés la mayor parte del tiempo? Lorsqu'il interagit avec d'autres personnes à la maison (exemple : parents, tuteurs, frères et sœurs), l'élève comprend ou utilise une langue autre que l'anglais la plupart du temps ?*

- ☐ No/Non
- ☐ Yes/Si/Oui

Question 5: **When interacting with others <u>outside the home</u> (example: friends, caregivers), does the student understand or use a language other than English most of the time?** *Pregunta 5: Cuando interactúa con otras personas fuera del hogar (ejemplo: amigos, cuidadores), el estudiante entiende o usa un idioma que no es inglés la mayor parte del tiempo? Lorsqu'il interagit avec d'autres personnes à l'extérieur de la maison (exemple : amis, soignants), l'élève comprend ou utilise une langue autre que l'anglais la plupart du temps ?*

- ☐ No/Non
- ☐ Yes/Si/Oui

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Health History
Historia de Salud
Histoire De Le Sante

1.Does your child have or has your child had a health problem *(check all that apply):*
(Su hijo (a) tiene una de estas conficiones medica (marque todo que le applique)
(Votre enfant a-t-il ou a-t-il eu un problème de santé (cochez tout ce qui s'applique)

CONDITION	YES	NO	COMMENT
Allergies/Allergias			
Asthma/Asma/Asme			
Cancer			
Change in Eating Habits/Cambios en la comida			
Chicken Pox/Viruelas/Varicelle			
Chronic Fatigue/Tiredness/Fatiga/Cansancio			
Congenital Heart Disease/Problems del Corazon/Cardiopathie			
Diabetes/Diabetis/Diabete			
Earache or Ear Infections/Infeccion al Oido/Mald'orell			
Eczema			
Epilepsy or Convulsions/Convulsions o Epilepsia			
Eye or Vision problems/Problems de Vision			
Fractures or dislocation of Bones/Fracturas de Hueso			
Hearing problems/Problems de Escuchar			
Heart Murmur/Murmores del Corazon			
High Blood Pressure/Presion Alta			
HIV			
Kidney Disease/Problemas del rinon/Maladie du rein			
Lead Poisoning/Plomo/Empoisonnement au plomb			
Loss of Weight/Over Weight/Aumento O Perdida de Peso/Perte de poids/surpoids			
Mononucleosis/Mononucleosis/Mononucleose			
Mumps/Papera/Oreillons			
Nose Bleeds/Sangre por la Nariz/Saignements de nez			
Rheumatic Fever/Fiebre Reumatica/Rhumatisme articulaire			
Ringworm "Teetis"/Ronchas/Teigne			
Rubella/Rubeola/Rubeole			
Scarlet Fever/Fiebre Alta/Scarlatine			
Sickle Cell Anemia/Anemia/Anemie			
Toothache or problems/Dolor a los dientes o problemas/ma aux dents			
Tuberculosis (TB)/Tuberculose			
Ulcers or Stomach problems/Ulceras/Ukceres			

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1. **Does the child have any chronic medical problems, special needs, or handicapping conditions?** ¿*Tiene el niño algún problema médico crónico, necesidades especiales o condiciones de discapacidad? L'enfant a-t-il des problèmes médicaux chroniques, des besoins spéciaux ou des conditions de handicap ?* _____ *No* ____*Non* ____ Yes __ _____ Sí ___ _____ Oui_____
(Print Problem or Condition) (Problema o condición de impresión) (Problème ou condition d'impression)

_____

_____

_____

2. During the pregnancy with this child, did the mother smoke cigarettes? Yes ( ) or No ( ) Did the mother consume alcohol? Yes ( ) or No ( ) Consume any substance (Drugs or any medication other than vitamins or iron? Yes ( ) or No ( ) *Durante su embarazo fumaba? Consumía Bebidas Alcohólicas? Tomaba Medicinas Si ( ) o No ( ) Pendant la grossesse avec cet enfant, la mère a-t-elle fumé des cigarettes, consommé de l'alcool ou toute autre substance (Drogues ou tout autre médicament que des vitamines ou du fer) Oui ( ) ou Non ( )*

3. How long did the child remain in the hospital? *¿Cuánto tiempo estuvo en el Hospital? Combien de temps l'enfant est-il resté à l'hôpital ?*_____**Did the child leave the hospital with his/her mother/***Su hijo salio del hospital con sus madre L'enfant a-t-il quitté l'hôpital avec sam***Yes/Si/Oui ( ) or No/Non ( )**

4. What age did your child: *¿A qué edad su hijo: Quel âge votre enfant a-t-il:* _____ **Walk alone/***Que edad camino/Marcher tout seul*_____**Talk/***Hablar/Parler* **(2 words together)**_____**Become potty trained/***Fue al bano/ Devenir propre*
_____

5. Has the child been hospitalized for any reason since birth? *Su hijo(a) estado en el hospital? L'enfant a-t-il été hospitalisé pour une raison quelconque depuis sa naissance?* **Yes/Si/Oui ( ) or No/Non ( ) If yes, When/_Si sí, cuándo/Si oui quand**_____
_____**Why/Porque/Pourquoi**_____

6. Are there any problems in the home, which might affect your child's learning? *Hay algún problema en casa que afectar a su hijo(a) aprender? Y a-t-il des problèmes à la maison qui pourraient affecter l'apprentissage de votre enfant?* **Yes/Si/Oui ( ) or No/Non ( )**

Explain/Explique/Expliquer_____

_____

_____

7. Is there anything more about the child's health that you think is important for us to know? *Hay algo que debemos saber de su hijo(a) condición médica que usted crea ser importante? Y a-t-il quelque chose de plus sur la santé de l'enfant que vous pensez qu'il est important que nous sachions?* **Yes/Si/Oui ( ) or No/Non ( ) Explain/***Expliquer/Expliquer*

Explain/Explique/Expliquer_____

_____

_____

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Early Childhood Consent Forms/Formularios de consentimiento/Fòm Konsantman

Child's Name:/Nombre del niñ@:/Nom de l'enfant: _____

Health Records and Screenings/Registros de Salud y Exámenes/Dosye sante ak tès depistaj

I agree or permit that my child may participate in the following health activities:
Acepto o permito que mi hijo pueda participar en las siguientes actividades de salud:
Mwen dakò oswa pèmèt pitit mwen an ka patisipe nan aktivite sante sa yo:

- ☐ Height/Alutra/Wote
- ☐ Weight/Peso/Pwa
- ☐ Vision Screening/Examen Visual/Depistaj Vizyon
- ☐ Hearing Screening/Examen de Escuchar/Depistaj pou tande
- ☐ Dental Screening/Examen Dental/ Depistaj dantè

My signature indicates that I have the legal right to authorize the release of any medical information to process this application.
Mi firma indica que tengo el derecho legal de autorizar la divulgación de cualquier información médica para procesar esta solicitud.
Siyati mwen an endike ke mwen gen dwa legal pou otorize divilgasyon nenpòt enfòmasyon medikal pou trete aplikasyon sa a.

Parent Signature:/Firma de los padres:/Signature des parents:_____

Parent's Name:/Nombre de los padres:/Nom des parents:_____

Date:/Fecha:/Dat:_____

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Parent Signature:/Firma de los padres:/Signature des parents:_____

Parent's Name:/Nombre de los padres:/Nom des parents:_____

Date:/Fecha:/Dat:_____

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Medical Emergency Release/Treatment Form

Formulario De Autorización/Tratamiento De Emergencia Médica

Formulaire De Libération/Traitement D'urgence Médicale

MEDICAL INFORMATION:/*INFORMACIÓN MÉDICA:/INFORMATION MÉDICALE*:

Existing Medical Problems/*Problemas Médico:/Problèmes médicaux existants***:Yes/*Si/Oui*( )No/*Non*( )**

If yes please explain/*explicar/explique:*_____

Allergies to Food/Medicine etc/*Allergias a Comida o Medicina:/Allergies aux aliments/médicaments:*

Yes/*Si/Oui* ( ) No/*Non* ( ) If yes please explain/*explicar/ explique*_____

Does your child take Medication? *Su hijo(a) toma Medicina/Votre enfant prend-il des médicaments*

Yes/*Si/Oui* ( ) No/*Non* ( ) If yes please explain/*explicar/ explique*_____

Child's Doctor/Clinic Name_____Phone_____

Nombre del Doctor Clinica_____Telefono_____

Nom du médecin/clinique de l'enfant_ _____Telephoner_____

Choice of Hospital when possible/*Nombre de Hospital/Choix de l'hôpital si possible* _____

Phone:/*Telefono:/ Telephoner*_____

Date of child's last tetanus shot/*Ultima Vacuna contra el tétanos /vaccin contre le tétanos*_____

Medicaid #, If applicable/*N.º de Medicaid/Numéro d'assurance-maladie* _____

Medical Insurance Co./*Nombre de Seguro Médico/Compagnie d'assurance médicale* _____ **ID#**_____

Subscriber's Name/*Nombre de Subscridor/Nom de l'abonné* _____

It is understood that every effort will be made to notify me or _____ at_____ Before such action is taken, but if not possible to locate me or the above person, the uninsured expense of this service will be accepted by me. *Se entiende que se hará todo lo posible para notificar a mí o a _____ al _____ Nou konprann ke tout efò yo pral fè pou notifye mwen oswa _____ nan _____*

I authorize the child care provider to arrange transportation in case of emergency or acute illness and to arrange for possible medical and or surgical care at (1) the closest hospital available in case of dire emergency or (2) the hospital of my choice. *Autorizo al proveedor de cuidado infantil a organizar el transporte en caso de emergencia o enfermedad aguda y a coordinar la posible atención médica o quirúrgica en (1) el hospital más cercano disponible en caso de una emergencia extrema o (2) el hospital de mi elección. Mwen otorize founisè gadri a pou fè aranjman pou transpò nan ka ijans oswa maladi grav epi pou fè aranjman pou swen medikal ak oswa chirijikal posib nan (1) lopital ki pi pre ki disponib nan ka ijans grav oswa (2) lopital mwen chwazi a.*

Parent/Guardian Signature/*Firma Del Padre/Signature du parent/tuteur:*_____***Date:/Fecha:***_____

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.