



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



2024-2025 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 72 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.

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

To register for the 2024-2025 Preschool Program, the child must be 3 or 4 years old on or before October 1st.

Para inscribirse en el programa preescolar de 2024-2025, el niño/a debe tener 3 o 4 años antes del 1 de octubre.

Pou enskri nan Pwogram Lekòl Matènèl 2024-2025 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*
- Tuberculosis (TB) : If Applicable** : Si es Aplicable Tuberculose (TB) : Le cas echeant
- Influenza Vaccine (Received on or after August 1st, 2024)** *Vacuna contra la influenza (recibida a partir del 1 de agosto de 2024) Vaksen kont Grip (Resevwa nan oswa apre 1ye Out 2024)*
- 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/a 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 Matènèl: 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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2024-2025 Registration Enrollment Application (English) *(please print in blue or black ink)*

Student Information <input type="checkbox"/> Re-Registration <input type="checkbox"/> New Registration			
Last Name:	First Name:	Middle Name:	Date of Birth:
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin Hispanic or Latino Origin _____	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other PAC Islander <input type="checkbox"/> White <input type="checkbox"/> 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 to Child:	Home Address:
Email Address:	Mobile Telephone Number:	Employer Information:	Employer Number:
2. Parent/ Guardian Information			
Last Name:	First Name:	Relationship to Child:	Home Address:
Email Address:	Mobile Telephone Number:	Employer Information:	Employer Number:
3. Emergency Contact Information			
Last Name:	First Name:	Relationship to Child:	Telephone Number:
Last Name:	First Name:	Relationship to Child:	Telephone Number:

Date Entered in Powerschool: _____
 Initials: _____

Irvington Public Schools
 Early Childhood Department
 2024-2025 Enrollment Application



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2024-2025 Solicitud de Inscripción de Registro(Esp) (Por favor llene con tinta negra o azul)

Información del Estudiante <input type="checkbox"/> Re registro <input type="checkbox"/> Nuevo registro			
Apellido del Estudiante	Primer Nombre	Segundo Nombre:	Fecha de nacimiento:
Género <input type="checkbox"/> Masculino <input type="checkbox"/> Femenina	Etnia: <input type="checkbox"/> Origen Hispano o Latino <input type="checkbox"/> Non Hispanic or Latino Origin Origen Hispano o Latino: _____ _____	Raza: <input type="checkbox"/> Indio americano o nativo de Alaska <input type="checkbox"/> Asiatico <input type="checkbox"/> Negro o Afroamericano <input type="checkbox"/> Hawaiano <input type="checkbox"/> Otro isleño del Pacífico <input type="checkbox"/> Blanco <input type="checkbox"/> Otro: _____	Lenguaje primario _____ Idiomas adicionales _____
Dirección:	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 al niñ@ :	Dirección:
Correo electrónico:	Numero de telefono:	Nombre de Empleo:	Numero de Empleo
2. Información del Padre/Tutor			
Apellido	Primer Nombre:	Relación al niñ@ :	Dirección:
Correo electrónico:	Numero de telefono:	Nombre de Empleo:	Numero de Empleo
3. Información de Contacto en caso de Emergencia			
Apellido	Primer Nombre	Relación al niñ@ :	Numero de telefono
Apellido:	Primer Nombre	Relación al niñ@ :	Numero de telefono

Date Entered in Powerschool: _____
 Initials: _____



2024-2025 Aplikasyon Enskripsyon (Cre) (Tanpri enprime ak lank ble oswa nwa)

Enformasyon sou Elèv <input type="checkbox"/> Re Enskripsyon <input type="checkbox"/> Nouvo Enskripsyon			
Siyati	Premye Non:	Mwayen Non	Dat nesans
Sèks <input type="checkbox"/> Gason <input type="checkbox"/> Fi	Etnisite: <input type="checkbox"/> Orijin Panyòl oswa Latino <input type="checkbox"/> Orijin ki pa Panyòl oswa Latino Orijin Panyòl oswa Latino: _____	Ras: <input type="checkbox"/> Endyen Ameriken oswa natif natal Alaska <input type="checkbox"/> Azyatik <input type="checkbox"/> Nwa oswa Afriken Ameriken <input type="checkbox"/> Natifnatal Awayi <input type="checkbox"/> Lòt moun zile PAC <input type="checkbox"/> Blan <input type="checkbox"/> 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 ak timeon:	Adres:
Imel:	Nimewo telefòn:	Enfòmasyon patwon yo:	Nimewo patwon an:
2. Enfòmasyon Paran/Gadyen			
Siyati	Premye Non:	Relasyon ak timeon:	Adres:
Imel:	Nimewo telefòn:	Enfòmasyon patwon yo:	Nimewo patwon an:
Enfòmasyon pou Kontak Ijans			
Siyati	Premye Non:	Relasyon ak timeon:	Nimewo telefòn:
Siyati	Premye Non:	Relasyon ak timeon:	Nimewo telefòn:

Date Entered in Powerschool: _____
 Initials: _____



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 at home (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 outside the home (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



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 hij@ tiene una de estas condiciones 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/chanjman nan abitid			
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			

Date Entered in Powerschool: _____
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1. Does the child have any chronic medical problems, special needs, or handicapping conditions? ¿Tiene su niñ@ 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. Is your child currently in Early Intervention? ¿Está su hij@ actualmente en Intervención Temprana? Èske pitit ou a nan Entèvansyon Bonè kounye a? **Yes/Si/Oui () or No/Non ()** If **yes, Si si, Si wi, Does your child have an I.E.P.?** ¿Su hij@ tiene un I.E.P.?Èske pitit ou a gen yon I.E.P.? **Yes/Si/Oui () or No/Non ()**.Or, O, Oswa, **Does your child have an I.F.S.P.?** ¿Su hij@ tiene un I.F.SP.?¿Su hijo tiene un I.F.S.P.? **Yes/Si/Oui () or No/Non ()**

3. 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 ()**

4. 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 hij@ salio del hospital con su madre L'enfant a-t-il quitté l'hôpital avec sam****Yes/Si/Oui () or No/Non ()**

5. What age did your child: ¿A qué edad su hij@: 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 baño/ Devenir propre** _____

6. Has the child been hospitalized for any reason since birth? Su hij@ 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** _____

7. Are there any problems in the home, which might affect your child's learning? Hay algún problema en casa que afectará a su hij@ 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 _____

8. 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 hij@ 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 _____



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 hij@ 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: _____

Recorded Voice and Image Release/Liberación De Voz e Imagen Grabadas/Anrejistre vwa ak imaj lage

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Moun ki anba siyen an bay Komisyon Edikasyon Irvington, Irvington, New Jersey, pèmision konplè pou anrejistre imaj oswa vwa moun ki nan lis la a pandan endividi sa a ap patisipe nan nenpòt aktivite ki gen rapò ak lekòl la oswa patwone. Mwen otorize distribisyon itilizasyon copyright san limitasyon anrejistreman sa yo ak dérivés yo pou itilize Komisyon Edikasyon Irvington.

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

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

Date:/Fecha:/Dat: _____

Medical Emergency Release/Treatment Form

Date Entered in Powerschool: _____
 Initials: _____



Tawana Moreland, Director

Lia Varsalona, Supervisor

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/Alergias 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 hij@ 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 _____ *Telefon* _____

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

Phone:/Telefono:/ Telefon _____

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** _____

(Emergency Contact Name)

(Phone Number)

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**

(Nombre del contacto de emergencia)

_____ *Nou konprann ke tout efò yo pral fè pou notifie mwen oswa* _____ *nan* _____

(Número de teléfono)

(Non kontak ijans)

(Nimewo telefòn)

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 aranjan pou transpò nan ka ijans oswa maladi grav epi pou fè aranjan 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/Dat:** _____

Date Entered in Powerschool: _____
 Initials: _____

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 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. <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 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 health 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.