Thank you for your interest in
The Barnegat Township School District
Preschool Program

Important Notifications:

Our registration process is on a first come, first serve basis. There may be a preschool waitlist once this program is filled to capacity.

Please note, we will only accept preschool registration applications that are fully completed and accompanied by all required medical documents.

This is a full-day, week-long, preschool program. Regular attendance is required and monitored in order to remain in the program.

Thank you for your understanding.

Barnegat Township School District

Pre-K Registration Checklist

Student's Name: ______________________________

Parent's/Guardian's Name: ______________________________

Contact Phone Number: ______________________________

All forms noted below must be turned in to the proper school official by the date listed below to ensure that your child is registered for school.

In order for your child's Pre-K registration to be complete, the following documentation is needed: (checked items have been received).

To be completed by Main Office:

- ORIGINAL BIRTH CERTIFICATE WITH RAISED SEAL
  The birth certificate for the above named student indicates that he/she will be 3 years of age on or before October 1st of the current school year.

  School Official's Signature: ______________________________ Date: ____________
- Proof of Residence (2)
- Parent/Guardian Identification

To be completed by Nurse's Office:

- Diphtheria, tetanus, & acellular pertussis (DTaP): 4 doses by 18 months old.
- Inactivated Poliovirus (Polio): 3 doses by 18 months old.
- Haemophilus influenza type b (Hib): 3-4 doses by 18 months old.
- Pnemococcal conjugate (PVC 13): 3-4 doses by 18 months old.
- Measles, mumps, rubella (MMR): 1 dose after 1st birthday.
- Varicella (VAR): 1 dose after 1st birthday.
- Influenza (IIV; LAIV): one dose due annually between ages 6-59 months of age
- School Entrance Physical (dated prior to or within 1 year of school entrance)
- Attended Other Pre-K Program
  - YES
    Where: ______________________________
    Years: ______________________________
- Other (specify)

____

Note(s) to Parent/Guardian:

____

____

Barnegat Township School District

Barnegat Township Preschool Program, 550 Barnegat Blvd., Barnegat, NJ 08005
609-698-5832 Ext. 5005

****

Required Documents Received (for office use only):

Birth Certificate: ☐	Proof of Residency: (1) ☐ (2) ☐	Custody Papers: ☐	Immunization Records: ☐	Physical Form ☐	Flu Vaccine: ☐

Student's Name: ______________________________ **Gender:** ___ M ___ F

Last First Middle

Home Address: ______________________________ **Phone:** ____________

Date of Birth: ____________ **City/State of Birth:** ____________ **Country of Birth:** ____________

Please check the appropriate number:

(1.) __ White/Non-Hispanic (2.) __ Hispanic (3.) __ Black/Non-Hispanic

(4.) __ American Indian/Alaskan Native (5.) __ Asian (6.) __ Pacific Islander

Updated 10/31/19

Barnegat Township Preschool Program

Special Education

Question			
Has your child been in Early Intervention?		☐ Yes	☐ No
If so, which related services did they receive?	☐ Speech Therapy	☐ Occupational Therapy	☐ ABA
	☐ Physical Therapy	☐ Developmental Intervention	☐ Other ________
What type of setting was the related service received in?	☐ Home	☐ Daycare	☐ Other ________
What were the locations the related Service(s) were received in?	Location: ________ Location: ________ Location: ________ Location: ________ Location: ________		
What were the dates or period related service(s) were received?			
Did you child test out or age out of early intervention?		☐ Tested out	☐ Aged out
Does your child have an IEP?		☐ Yes	☐ No
If so, have they received one or more related service?		☐ Yes	☐ No

Please list any additional relevant information pertaining to your child and special education:

____

____

____

____

Family History

Is there a ***family history*** of the following:	***Biological family*** member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc.)
☐ Learning Difficulties (reading, math, writing, spelling)	
☐ Speech or language problems (articulation, stuttering, etc.)	
☐ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
☐ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
☐ Intellectual Disability	
☐ School Failure (failing grades, dropout, etc.)	
☐ Drug or Alcohol Addiction	

Barnegat Township School District

PERMANENT RECORD DEVELOPMENTAL HISTORY

PRESCHOOL

Student's Last Name:			Student's First Name:
BIRTH HISTORY			
	Check One		**Comments:**
Was your pregnancy full term?	Yes ☐	No ☐	
Did you have any illnesses during pregnancy?	Yes ☐	No ☐	
Were there any birth complications?	Yes ☐	No ☐	
What was the birth weight?	___ Lbs. ___ Oz.		
Other:			
Did your child ever attend another preschool program?	Yes ☐	No ☐	
If yes, please clarify:			

Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

Barnegat Township Preschool Program

Preschool Questionnaire

Emotional Maturity: Does your child:	Yes	No	Sometimes
1. Have a positive self-concept? Does he/she feel good about the things he/she can do?	☐	☐	☐
COMMENTS:			
2. Make needs known to others? (Example: Requests help when needed)	☐	☐	☐
COMMENTS:			
3. Shows a sense of confidence when doing most tasks?	☐	☐	☐
COMMENTS:			
4. Have the ability to separate from Parent (Mom/Dad) for two to three hours?	☐	☐	☐
COMMENTS:			
5. Accept change in an established routine? (Example: Change in schedule)	☐	☐	☐
COMMENTS:			
6. Initiate activities?	☐	☐	☐
COMMENTS:			
7. Try new activities?	☐	☐	☐
COMMENTS:			
Social Maturity: Does your child:	Yes	No	Sometimes
8. Interact well with other children?	☐	☐	☐
COMMENTS:			
9. Enjoy being with other children?	☐	☐	☐
COMMENTS:			

Barnegat Township Preschool Program

Preschool Questionnaire (continued)

Social Maturity: Does your child:	**Yes**	**No**	**Sometimes**
10. Prefer same-age or older playmates as opposed to younger children?	☐	☐	☐
COMMENTS:			
Physical Maturity: Does your child:	**Yes**	**No**	**Sometimes**
11. Can your child sit still and listen to a story for 3 to 5 minute period?	☐	☐	☐
COMMENTS:			
12. Can your child sit and concentrate on a TV show of his/her choice?	☐	☐	☐
COMMENTS:			
13. Is your child physically coordinated? (e.g., walks, runs without tripping)	☐	☐	☐
COMMENTS:			
14. Are small muscle skills developed? (e.g. holds a pencil with index and middle finger low on the point; handles scissors well)	☐	☐	☐
COMMENTS:			
Intellectual Maturity: Does your child:	Yes	No	Sometimes
15. Have an interest in printed words?	☐	☐	☐
COMMENTS:			
16. Remember past events?	☐	☐	☐
COMMENTS:			

Barnegat Township Preschool Program
Preschool Questionnaire (continued)

Intellectual Maturity: Does your child:	Yes	No	Sometimes
17. Recall words to songs and rhymes?	☐	☐	☐
COMMENTS:			
18. Recall name, address, and telephone #?	☐	☐	☐
COMMENTS:			
19. Speak clearly?	☐	☐	☐
COMMENTS:			
20. Speak clearly so that others can understand?	☐	☐	☐
COMMENTS:			
21. Follow simple directions when asked? (e.g. "Go to the sink and get soap?")	☐	☐	☐
COMMENTS:			

The Barnegat Township School District would like to clarify our process for the placement of students into schools within our district. Although students are placed at schools by certain catchment areas, our boundaries remain fluid in our efforts to equalize class sizes and school resources and remain compliant with program standards.

Barnegat Township School District

PERMANENT RECORD BASIC DATA SHEET

PLEASE PRINT ALL INFORMATION

Has this child ever attended Barnegat Township Schools?
Y/N ___ Year(s) ___

STUDENT'S NAME	Last: First: MI:	GRADE	
HOME ADDRESS			
HOME PHONE		GENDER *(Circle one)*	M / F / X Non-binary
RACE/ETHNICITY *(Must choose both a race and ethnicity)*	___White ___Black/African American ___American Indian/Alaska Native ___Native Hawaiian or Pacific Island ___Asian ___Other	ETHNICITY (*Check one*)	_ Hispanic _ Non-Hispanic
DATE OF BIRTH	BIRTH CITY & STATE	DATE OF U.S. ENTRY (if applicable) ___	

STUDENT RESIDES WITH: *(CUSTODIAL PARENT)* Father ___ Mother ___ Step-Father ___ Step-Mother ___ Guardian ___

CUSTODY *(must choose one)* The Barnegat Township School District requires the following documentation when appropriate: **(Please provide documentation with registration information.)**

o No Custody Issue o Joint Custody Documentation o Restraining Orders o Student Name Change

CHECK ALL THAT APPLY						
	Parents Separated		Father Remarried		Mother Remarried	
	Parents Divorced		Father Deceased		Mother Deceased	

MOTHER'S NAME	Last: First:	OCCUPATION	
MOTHER'S ADDRESS		CITY/STATE/ZIP	
MOTHER'S EMAIL		CELL NUMBER	
MOTHER'S BIRTH PLACE		WORK NUMBER	
FATHER'S NAME	Last: First:	OCCUPATION:	
FATHER'S ADDRESS		CITY/STATE/ZIP	
FATHER'S EMAIL		CELL NUMBER	
FATHER'S BIRTH PLACE		WORK NUMBER	
NAME OF GUARDIAN *(IF NOT MOM OR DAD)*	Last: First:	OCCUPATION	
GUARDIAN'S ADDRESS		CITY/STATE/ZIP	
GUARDIAN'S EMAIL		CELL NUMBER	
GUARDIAN'S BIRTH PLACE		WORK NUMBER	
STEP-FATHER'S NAME		STEP-MOTHER'S NAME	

LIST NAME AND AGE OF OTHER CHILDREN IN THE FAMILY	

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

PARENT/GUARDIAN SIGNATURE		DATE	

Barnegat Township School District

PERMANENT RECORD **SPECIAL SERVICES** DATA SHEET

I. Basic Student Information

Student's Name: ______________________ Grade: ______________

Student's Address: ______________________ Home Phone: ______________

Birth Date: ______________________ Male _____ Female _____

Parent Name: ______________________ Cell Phone # ______________

II. Basic Education Information

Does this child have a disability? **If YES, please include a copy of your child's current Individualized Educational Plan (IEP).**	☐ YES ☐ NO
Has this child ever attended school in Barnegat? ☐ YES ☐ NO	If YES, what school(s): When:
Name of last school/district:	
Address of last school:	
Phone number of last school:	
Fax number of last school:	
Has this child ever received any special education/basic skills? (Please check <u>all</u> that apply.)	☐ 504 Plan ☐ Basic Skills/Supplemental Instruction ☐ Occupational Therapy ☐ Out-of-District Placement ☐ Physical Therapy ☐ Resource Room ☐ Self-Contained Classroom ☐ Speech Therapy ☐ Other ______________
Has this student ever been retained? ☐ YES ☐ NO	If YES, which grade(s):
Does this child speak a language other than English at home? ☐ YES ☐ NO	If YES, which one(s):
Has this child ever attended school and lived outside of the USA? ☐ YES ☐ NO	If YES, where:

Parent/Guardian's Name: ______________________

Parent/Guardian's Signature: ______________________

Barnegat Township School District
PERMANENT RECORD DEVELOPMENTAL HISTORY
PRESCHOOL

Student's Last Name:					Student's First Name:
BIRTH HISTORY					
	Check One				Comments
Was your pregnancy full term:	Yes		No		
Did you have any illnesses during pregnancy?	Yes		No		
Were there any birth complications	Yes		No		
What was the birth weight?		lbs.		oz.	

DEVELOPMENTAL HISTORY

Indicate at what age your child:	Walked		Talked		Toilet Trained	

	Check one				Comments
Does your child get along well with other children their age?	Yes		No		
Has your child attended nursery school?	Yes		No		
Can your child identify colors?	Yes		No		
Can your child fasten or unfasten buttons?	Yes		No		
Can your child count fingers up to 5?	Yes		No		
Can your child bounce a ball?	Yes		No		
Did your child have an early interest in clocks and calendars and the ability to understand their function?	Yes		No		
Does your child know the relationships among and between the various coin denominations? (4 quarters equals $1.00)	Yes		No		
Did your child learn to read early with little or no formal teaching?	Yes		No		

Check all that apply to your child:	Nail Biting		Cries Easily		Bed Wetting		Thumb Sucking	
	Nightmares		Temper Tantrums		Jealousy		Stubbornness	

Other:

DID YOUR CHILD EVER ATTEND ANOTHER KINDERGARTEN OR PRE-SCHOOL PROGRAM?

IF YES, PLEASE CLARIFY:

Barnegat Township School District
PERMANENT RECORD HEALTH HISTORY
PRESCHOOL

Student's Last Name:				Student's First Name:			
HEALTH HISTORY – ILLNESSES AND DISEASES (List Dates)							
German Measles		Strep Infection		Measles		Poliomyelitis	
Asthma		Mumps		Rheumatic Fever		Diabetes	
Otitis Media		Whooping Cough		Convulsive Disorders		Chicken Pox	
Allergies (List Type)				Emotional (List Type)			
Other:							
Operations or Injuries (List Dates):							

Check all that apply to your child	Vision Problems		Hearing Problems		Speech Problems	
	Glasses Prescribed		Hearing Aid		Other Prosthesis (Indicate type)	

Is your child taking any medications?	Yes		No		If yes, identify:

The Portion Below This Line Will Be Completed by School Nurse

PLEASE BRING IMMUNIZATION RECORD FROM THE DOCTOR'S OFFICE TO THE SCHOOL NURSE WHO WILL COMPLETE THIS SECTION										
STUDENT'S NAME:	Last:			First:		MI:		DATE OF BIRTH:		
IMMUNIZATIONS AND TESTS										
D.P.T.	1st		2nd		3rd		4th		Booster (on or after 4th Birthday)	
OPV POLIO Virus Vaccine	1st		2nd		3rd		4th		Booster (on or after 4th Birthday)	
MEASLES (RUBELLA)	On or after the 1st birthday								One before entering Kindergarten	
GERMAN MEASLES (RUBELLA)	On or after the 1st birthday					MUMPS IMMUNIZATION			On or after the 1st birthday	
M.M.R	On or after the 1st birthday								One before entering Kindergarten	
HEPATITIS B	1st		2nd				3rd			
MANTOUX TEST (recommended By State)	Date:		Reading:						MM	
VARICELLA	On or after the 1st birthday									

State NJ Smart ID#

Barnegat Township School District

PERMANENT RECORD HEALTH HISTORY

SCHOOL YEAR
20___ / 20___

Last Name	First Name	MI	School	Grade/Teacher
Address			Birth Date	Gender

Parent/Guardian/Emergency Contacts	Relationship	Phone Numbers	
Mother/Guardian Name:		Home: Work:	Cell: Email:
Father/Guardian Name:		Home: Work:	Cell: Email:
Call 3rd:		Home: Work:	Cell:
Call 4th:		Home: Work:	Cell:
Call 5th:		Home: Work:	Cell:

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

___YES If yes, name of insurance company ___________

___NO NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: ___________ Printed Name: ___________ Date: ___________

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

Student's doctor/healthcare provider: ___________ Phone: ___________

Student's dentist: ___________ Phone: ___________

INDICATE IF A STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

HEALTH CONDITION	YES	NO	EXPLANATION IF "YES"	
Medication Allergies			List:	
Food Allergies			Food(s):	EpiPen required?
Allergy to Bee Stings				EpiPen required?
Allergies (other)			List:	
Asthma			Medication required at school?	
Diabetes			Type 1 (Insulin dependent) _____ Type 2 _____	Medication:
Seizure Disorder			Type of seizure:	
Neurological Disorder			Specify:	
Heart Condition			Specify:	
Blood Disorder			Specify:	
Cancer			Specify:	
Bowel/Bladder Issues			Specify:	
Migraine Headaches			Specify:	
Bone/Muscle Problems			Specify:	Prosthesis/Brace?
ADD/ADHD			Medication:	
Mental Health / Behavioral Issues			Specify: Medication:	
Wears Glasses/Contacts			Glasses _____ Contacts _____	Distance _____ Reading _____
Hearing Loss			Right Ear _____ Left Ear _____	Hearing Aid(s):
Serious Injury			Specify:	Date(s):
Surgery			Specify:	Date(s):
Other Serious Illness			Specify:	Date of onset:
Medication Taken at Home			List:	

I, the undersigned, do hereby authorize officials of New Jersey Public schools to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

___________ Parent/Guardian Signature ___________ Print Parent/Guardian Name ___________ 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 <u>that is being used to complete the form</u>. 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 <u>www.nj.gov/health/forms/ch-15.dot</u> 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 <u>should</u> 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.

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

BARNEGAT TOWNSHIP SCHOOL DISTRICT

Home Language Survey Form: Step 1

Introduction

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL).

Instructions

Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the instructions. When you arrive at a decision ("Proceed to Records Review Process" or "Do not proceed to Records Review Process"), the Home-Language Survey is complete.

Student Information

Student name: Student birth date:

Street Address:

City: State: Zip Code:

Phone number:

Survey Questions

Question 1

What was the first language used by the student?

A language other than English. Proceed to question 2a.

English. Proceed to question 2b.

Question 2a

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question 7.

No. Proceed to question 4.

Question 2b

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question 4.

No. Proceed to question 3.

Question 3

Does the student understand a language other than English?

Yes. Proceed to question 4.

No. Proceed to 9.

Question 4
When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

Yes. Proceed to question 7.

No. Proceed to question 5.

Question 5
When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

Yes. Proceed to 8.

No. Proceed to question 6.

Question 6
Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

Yes. Proceed to 8.

No. Proceed to 9.

Question 7
What are the home languages spoken? List below and proceed to 8.

8. Proceed to Step 2: Records Review Process (To be completed by NJ Certified Staff only – Reference <u>ESSA ELL Entry and Exit Guidance</u>, p. 4).
Home Language Survey is complete.

9. Do not proceed to Step 2: Records Review Process.
Home Language Survey is complete. Student is not an English-Language Learner (ELL).

Barnegat Township School District

Custody Alert

I. BASIC INFORMATION (PLEASE PRINT)

Name of Residential Custodian (s): ______________________________

Student's Name: ______________________________

Student's School: ______________________________ Student's Grade Level: __________

Is there joint custody? Yes _____ No _____

Is there a custody issue? Yes _____ No _____

II. REQUIRED DOCUMENTATION
(Must be provided with registration information for the school to be able to enforce.)

The Barnegat Township School district requires the following documentation when appropriate:

- Joint Custody Documentation
- Restraining Orders
- Student Name Change
- Court Orders Regarding Custody/Guardianship

III. PERMISSION REQUIRED FOR ACCESS TO CHILD
(Written documentation required.)

The following people **MAY NOT** have legal access to the child without written custodian permission:

	Name	Relationship to Student	Address	Phone #
1.				
2.				

THE SCHOOL MUST BE NOTIFIED IMMEDIATELY OF ANY CHANGES TO THIS FORM.

______________________________ Signature of Legal Custodian

______________ Date

PARENT PORTAL ACCESS FORM
BARNEGAT TWP. SCHOOL DISTRICT

NEW ACCOUNT/NEW STUDENT(S) ONLY

Please complete one form for all students that will be listed under your account & return it to any of their attending schools for processing.

Parent/Guardian Information

(Please print clearly)

Parent/Guardian First Name: ____________________ Last Name________________________

Daytime Telephone: (______) ______-_____________________

Valid e-mail address: ____

Student(s) Information

Student's Name: ______________________________ School: _________________ Grade:________

Student's Name: ______________________________ School: _________________ Grade:________

Student's Name: ______________________________ School: _________________ Grade:________

Student's Name: ______________________________ School: _________________ Grade:________

Student's Name: ______________________________ School: _________________ Grade:________

Thank you for completing this Parent Portal Access Form.

For new accounts, you will receive an e-mail with your username & password information.

If you have any questions, please contact the web desk at (609) 698-5832 ext. 5148.

THANK YOU & HAVE A GREAT SCHOOL YEAR !

BARNEGAT TOWNSHIP SCHOOL DISTRICT

PHOTO / MEDIA PERMISSION

This parental permission form is to inform you and to request permission for your child's photo/image and other personal identifiers to be published on the district's public internet sites, district-approved publications, and/or the local media.

As a learning community, we want to celebrate all of our students and their work. However, by law, we are required to ask for your consent to post or publish personally identifying information about your child. As you know, there are potential dangers – dangers that have always existed – associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information that Barnegat Township Schools would use can include student names and a photo or image.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

☐ **I GRANT** permission for this student's photo/image and name to be published on the school and/or district's public Internet site, school publications and/or local media.

☐ **I <u>DO NOT</u> GRANT** permission for a photo/image that includes this student to be published on the school and/or district's public Internet site, school publications and/or local media.

(Check one)

INTERNET USE GUIDELINES / PERMISSION

1. All students must have a signed permission slip from their parents that authorizes them supervised access to the Internet, including electronic mail.
2. Respect for the equipment of the school and its network is a condition for use of the computers.
3. Students are to notify the teacher/media specialist immediately of any disturbing material they may encounter on the web or in e-mail.
4. Students are to never give anyone their password to any of their accounts or allow another student to use their account to access the Internet or school network.
5. Students must gain clearance from the teacher/media specialist before downloading any programs from the Internet.
6. Students are permitted to utilize their own personal device, such as tablets, iPads, or cell phones (with permission from the teacher) for instructional purposes and in conjunction with Policy # 2363 – Pupil Use of Privately Owned Technology. The school district shall assume no responsibility for the security of or damage to any privately owned technology brought to school by a student.

☐ **I GRANT** permission for my child to have supervised access.

☐ **I <u>DO NOT</u> GRANT** permission for my child to have supervised access.

(Check one)

Student's Name: ______________________ Student's Grade: __________

Print Name of Parent/Guardian: ______________________

Signature of Parent/Guardian: ______________________

Relation to Student: ______________________ Date: __________

Sample Medicaid Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you? No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits? The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared? In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information? Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind? You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services? No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions? Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) ____Mailed to parent(s) ____Emailed to parent(s) ____IEP meeting ____ Hand Delivered

Barnegat Township School District

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI) PARENT CONSENT FORM

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act,34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: ______________________________

Child's Date of Birth: ________/________/__________

Parent: ____ Date:______/______/______

I give consent to bill for SEMI: Yes

No

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Form 22A 20160314