BEDMINSTER TOWNSHIP PUBLIC SCHOOL DISTRICT
234 Somerville Road
Bedminster, NJ 07921
Telephone (908) 234-0768 Fax (908) 234-2318
www.bedminsterschool.org

Attached you will find the Bedminster School Registration Package. In addition to completing the attached package, in order to register your student, we will need the following documents presented:

PARENT / GUARDIAN ID:

- Passport
- Driver's License
- Military ID

ORIGINAL PROOF OF BIRTH (One of the following options):

- Passport
- Birth Certificate

ORIGINAL PROOF(S) OF RESIDENCY (One from each category):

Category A

- Real Estate Tax Bill
- Mortgage
- Lease

Category B

- Utility Bill
- Bank Statement

U.S. BASED PHYSICAL STAMPED BY A U.S. PHYSICIAN

UPDATED IMMUNIZATIONS FROM U.S. PHYSICIAN

Once the registrar has seen the originals, they will be copied and returned directly to you.

Please make an appointment to complete the registration process. To contact Karna Johnsen, School Registrar, via e-mail: kjohnsen@bedminsterschool.org. Or you may reach her by phone at 908-234-0768, Extension 202.

BEDMINSTER TOWNSHIP SCHOOL DISTRICT

STUDENT REGISTRATION FORM (Please print & complete ALL sections)

STUDENT INFORMATION:

Student Name: _____ **Date of Birth:** _____ **School Year / Grade:** _____
First *Middle* *Last*

City, State and Country of birth: _____
City *State* *Country*

If country of birth is NOT the United States: Date of Entry into the United States: _____

Date of First Entry into U.S. School: _____

Ethnicity (if multi-racial, please circle all that apply): *Hispanic* *African American* **Gender:** *Male*

White *Pacific Islander / Native Hawaiian* **(Please circle one)** *Female*

Asian *American Indian / Native Alaskan*

Primary language spoken at home: _____ **Native Language:** _____

Does student have health insurance? (*Please circle one*): NO YES **If yes, list insurance provider:** _____

Is student's parent/guardian on Active Military Duty, in the National Guard or the Reserve Component of the United States military services? NO YES

Student Home Phone Number: _____

Student Physical Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Student Mailing Address, City, State and Zip Code: _____
(If different from physical address) *Address* *City* *State / Zip Code*

PARENT / GUARDIAN INFORMATION:

Circle Resident Parent/Guardian: Mother Father Both

Is custody of this child limited by court order or legal agreement? NO YES

IF YES - THE ORIGINAL LEGAL DOCUMENT DECLARING RESIDENTIAL CUSTODY MUST BE PROVIDED TO THE SCHOOL UPON REGISTRATION

MOTHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

FATHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____
Street Address *City* *State / Zip Code*

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

(OVER)

EMERGENCY CONTACT & SIBLING INFORMATION:

Contact #1 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #2 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #3 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #4 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

SIBLING INFORMATION:

1) NAME: _____ AGE: _____

2) NAME: _____ AGE: _____

3) NAME: _____ AGE: _____

4) NAME: _____ AGE: _____

OFFSITE PERMISSION

_____ **YES** - My child has permission to go off school grounds on walking field trips throughout the school year. Students may go off school grounds throughout the year to practice school security drills and/or for curricular related activities such as nature walks, field day, etc.

SPECIAL PROGRAMS:

Has your child ever been in a Special Needs Program? NO YES **Is your child currently in a Special Needs Program?** NO YES

Does your child have a 504 Plan? NO YES

If yes to either of the above questions, please list which program: _____

Is your child receiving Speech Services? NO YES

Has your child ever been in or are they currently in a Limited English Proficiency/English as a Second Language (ESL) Program? NO YES

PLEASE BE SURE TO SIGN AND DATE

PARENT / GUARDIAN SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

Proof Of Residency: Lease (if so, expiration date) _____ Mortgage or Deed Real Estate Tax Bill

Utility Bill (indicate which utility) _____

Proof of Birth: Passport BC **Grade:** _____ **First Day:** _____

Homeroom: _____ **Student ID:** _____

Revised: 2/14/17

MCKINNEY-VENTO QUESTIONNAIRE FORM
(OPTIONAL & CONFIDENTIAL)
Bedminster Township School

Student Name: _____ Date of Birth: _____

School Name: _____ Grade: _____

Your child may be eligible for additional educational services through the McKinney-Vento Homeless Assistance Act. Eligibility can be determined by completing this questionnaire. **THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.** If eligible, students are to be immediately enrolled in accordance with the McKinney-Vento Assistance Act.

1. **Do you/your student live in any of these following situations?**
   - ☐ In emergency or transitional shelter or program
   - ☐ Sharing the housing of other persons due to:
     - ☐ Loss of housing, economic hardship or a similar reason (i.e. evicted)
     - ☐ Long term, cooperative living arrangement
     - ☐ Other (please specify): _____
   - ☐ In a vehicle of any kind, park, public space, abandoned building, substandard housing, bus or train station or similar setting
   - ☐ In a motel, hotel, campground or similar setting due to: (select one)
     - ☐ Lack of alternative adequate accommodations
     - ☐ A convenient living arrangement (i.e. waiting for apartment/home to be ready)
     - ☐ Other (please specify): _____
   - ☐ None of the above

2. **What is your/your student's living situation?** Please check one box.
   - ☐ Living with your legal parent guardian
   - ☐ Living alone
   - ☐ Living with an adult that is not a legal parent or guardian

---

The undersigned certifies that the information provided is accurate:

PRINT NAME OF PERSON COMPLETING FORM: _____

SIGNATURE: _____

DATE: _____

ADDRESS OF CURRENT RESIDENCE: _____

_____

PHONE NUMBER OR MESSAGE NUMBER: _____

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HOME LANGUAGE SURVEY FORM

Child's Name: _____ Birth Date: _____
Address: _____ Grade: _____
Home Phone: _____
Cell Phone: _____
Parent(s)/Guardian(s) Name: _____

1. What language do you use most often when speaking to your child? _____
2. What language did your child first use for communication? _____
3. What language does your child use most often when talking to brothers, sisters and other children at home? _____
4. What language does your child most often use when speaking with you or other adults in the home? _____
5. What language does your child use most often when speaking with friends or neighbors? _____
6. Has your child received ESL (English as a Second Language) services in a previous school district? What grade levels and where? _____
   _____

Please indicate other family members living in the home with you.

Other Adult Members of Family:	English	Other Language Spoken
_____	Yes__No__	_____
_____	Yes__No__	_____
_____	Yes__No__	_____

Other Children in the Home:

_____	Yes__No__	_____
_____	Yes__No__	_____

In which language do you wish to receive written communication? _____

_____ _____
Parent/Guardian Signature Date

Revised: 9/2018

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.

Bedminster Township School
Health History

Child's Full Name:

_____

(Last) (First) (Middle) (Nickname)

_____ _____ Grade_____

(Date of Birth) (Country of Birth)

Please complete the following health history. **Give dates**, if possible.
Has your child ever had the following? **If yes, please explain**:

1. Accident(s) _____
2. Allergic Reactions (Include bee stings, food or medications, etc.)

Yes_____ No_____ **If yes, explain** _____

_____

Has your child ever needed medication or medical attention in the past for a reaction to a bee sting or food allergy? Yes_____ No_____ **If yes, please provide details:** _____

_____

3. Asthma Attack: Yes_____ No_____ Other Respiratory Infections: Yes_____ No_____

Explain _____

4. Bone or Joint Disease or Injury: Yes_____ No_____ **If yes, explain** _____

_____

5. Communicable Diseases (Specify): _____
6. Convulsion or Seizures: Yes_____ No _____ **If yes, explain** _____

_____

7. Diabetes: _____
8. Dental Problems: Yes____ No_____ Explain_____
9. Ear Infections: Yes _____ No _____ Ear Tubes: Yes _____ No _____ Date _____

Does your child have a hearing problem? Yes _____ No _____
Does your child wear a hearing aide? Yes _____ No _____
Does your child have a speech/language problem? Yes _____ No _____

10. Frequent throat infections: Yes _____ No _____
11. Frequent headaches: Yes _____ No _____
12. Kidney or Urinary Tract Problems: Yes_____ No _____**Explain if yes** _____

_____

13. Heart Problems/Murmurs/Rheumatic Fever: Yes _____ No _____ **Explain** _____

_____

14. Does your child have any vision problems: Yes _____ No _____
15. Does your child wear glasses? Yes_____(when) _____No_____

16. Does your child have any neuromuscular problems or limitations? Yes_____ No _____
Explain if yes _____
17. Does your child have any developmental delays or been diagnosed with any syndromes? Yes_____ No_____ **Explain if yes** _____
18. Has your child ever been hospitalized? Yes _____ No _____ **If yes, state when and reason:** _____
19. What medicine, if any, does your child take? _____
_____
20. Does your child have any present physical limitations that may require program modifications or restrictions? _____
_____
21. Please add any other problems or comments you would like to bring to the attention of the school nurse: _____
_____

Note: **No Medication can be given at school without a completed medication administration form signed by the parent and the prescribing physician. All medication must be in the original container with the pharmacy label intact. Medications should be hand delivered to the school nurse by the parent or guardian. Please see the school nurse or the school website for medication administration forms.**

Parent's Signature _____ Date_____
Mother's Full Name _____ Employer _____
Home Address _____ Work Address _____
_____ _____
Home Phone_____ Work Phone _____
Cell Phone _____
Father's Full Name _____ Employer _____
Home Address _____ Work Address _____
_____ _____
Home Phone _____ Work Phone _____
Cell Phone _____

Home Situation:

_____ Parents reside together
_____ Parents separated
_____ Parents divorced
_____ Guardian cares for child
_____ Single parent home
_____ Father remarried
_____ Mother remarried
_____ Other _____

If parents are divorced or separated, who has legal (official) custody? _____

**Legal custody papers should be supplied to the Main Office and stored in child's Permanent Record Folder.

Child's Name: _____
Name and age of sibling(s): _____
_____

Last school attended_____address:_____
Describe child's last school experience:
_____
_____
Was child absent frequently? If so, explain _____
_____

Personality and Emotional Development
Please check all that apply to your child:

_____Happy	_____Moody	_____Withdrawn
_____Sad	_____Easily upset	_____ Overactive
_____Friendly	_____Quiet	

Problems when separated from family? Yes _____ No _____ Explain: _____
_____
Loss of family member? Yes _____ No _____ Explain: _____
_____

Social Interactions
(Please check where appropriate)

Peers	Adults
_____Good	_____ Good
_____Fair	_____ Fair
_____Poor	_____ Poor

Traumatic events? If so, please explain: Yes _____ No _____ explain: _____
_____
_____

Please list any concerns, questions or problems that the school personnel should know about
_____
_____

Please sign below if you would like **this page** shared with your child's teacher (if needed).
Parent's Signature _____

Bedminster Township School Emergency Medical Information (For Nurse)

ID# _____ (Office use)

Students Name _____ Sex ____ Date of Birth ___/___/___ Grade _____
Print (last) (first) (middle initial)

Home Address _____ Home Phone _____ E-Mail _____

Mother's/Guardian's Name (First, Last): _____ Father's/Guardian's Name (First, Last) _____

Where can she be reached between 9AM-4:30PM?

Address _____

_____

Home Phone ( ) _____

Cell Phone ( ) _____

Work ( ) _____

Where can he be reached between 9AM-4:30PM?

Address _____

_____

Home Phone ( ) _____

Cell Phone ( ) _____

Work ( ) _____

Name and phone number(s) of emergency contact person(s) if parent cannot be reached. Please inform this/these person(s)

Name _____ Relationship _____ Phone ( ) _____

Name _____ Relationship _____ Phone ( ) _____

Name _____ Relationship _____ Phone ( ) _____

List ALL medications that are currently being taken _____

Has your child been prescribed an: 1) Epinephrine Auto-Injector ☐Yes ☐ No 2) Inhaler ☐ Yes ☐ No

Physical disorders, considerations, or limitations: _____

Please complete all information accurately and update the school nurse with any changes. Reliable information is necessary should a sudden accident or illness occur while your child is at school. We will attempt to contact you if any type of medical attention is needed; however, in the event that treatment is necessary and we are unable to contact you, your signature below will authorize the school authorities, doctor, or hospital to use their best judgment in the interest of your child's health.

EMERGENCY TREATMENT PERMISSION

TO ANY DOCTOR OR HOSPITAL
Authorization is given to perform necessary emergency treatment of my child whose medical history is listed above.

_____ _____
(Signature of legal parent/ guardian) (Date)

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that medical information may be shared, when necessary, with appropriate professional staff involved in the care of my child. My consent is valid for the current school year and is intended to allow the staff to better serve the individual needs of my child.

_____ _____
(Signature of legal parent/guardian) (Date)

COMPLETE REVERSE SIDE

Please list other children attending New Jersey Public Schools (Name, School)

Does child have Health Insurance?

Yes ___ If Yes, name of insurance company _____ Policy Number: _____

No ___ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.
For more information call 800-701-0710 or visit www.njfamilycare.org to apply online
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)

List any medical/surgical care your child has received during the past year:

_____

Dental Exam	_____ date	_____ braces
Eye Exam	_____ date	_____ contacts _____ glasses
Allergy	_____ kind	_____ medications
Allergic Reaction	_____ date	_____ medications
Immunizations/Tetanus	_____ date	_____ type
Restrictions	_____ type	

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Hospital _____ Telephone _____

I, the undersigned, do hereby authorize officials of New Jersey Public schools to contact directly the persons 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 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 district financially responsible for the emergency care and/or transportation for said child.

_____

Signature of Parent(s)/Guardian(s) **Date**