



**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: \_\_\_\_\_

**SPECIAL PROGRAMS**

Has your child ever been in a Special Needs Program? NO YES I & RS IEP NO YES  
Please circle all types of programs that apply: 504

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:** \_\_\_\_\_



**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: \_\_\_\_\_

## 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.doc](http://www.nj.gov/health/forms/ch-15.doc) or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5865.

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 stroke 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](http://www.pacnj.org) or by phone at 808-687-9340.

f. Special Diet - 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.

# 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) <span style="float: right;">(Fks)</span>		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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION II - TO BE COMPLETED BY THE 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)			
<b>IMMUNIZATIONS</b>		<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 signs/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					

**Bedminster Township School  
Health History**

Child's Full Name:

\_\_\_\_\_  
(Last) (First) (Middle) (Nickname)  
\_\_\_\_\_  
(Date of Birth) (Country of Birth) Grade \_\_\_\_\_

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	_____ Single parent home
_____ Parents separated	_____ Father remarried
_____ Parents divorced	_____ Mother remarried
_____ Guardian cares for child	_____ 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)

<u>Peers</u>	<u>Adults</u>
_____ 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 DISTRICT**

234 Somerville Road  
Bedminster, NJ 07921  
Telephone (908) 234-0768 Fax (908) 234-2318  
[www.bedminsterschool.org](http://www.bedminsterschool.org)

### **Preschool Integrated Program - Full Day Tuition Agreement**

#### **Tuition**

The tuition fee for the Half-Day Preschool Integrated Program for the 2025-2026 school year is \$7500.00 annually. Tuition is payable in monthly installments and there is no prorating. A deposit of \$750.00 is due upon execution of this agreement and holds a spot for your child in the program. The deposit is non-refundable and will be applied to the June 2025 installment. Tuition for September 2025 is due no later than September 1, 2025. Thereafter, each payment of \$750.00 is due on or before the first of each month from October through May. Failure to pay the tuition fee in a timely manner will result in your child being disenrolled from the program. Tuition is non-refundable.

If you withdraw your child from the program at any time during the year, you must send written notice of your decision to the attention of the Supervisor of Student Services, Kelly Gutierrez and the School Secretary, Karna Johnsen. By doing so your child's spot will be given to the next child on the waiting list.

Please note that transportation will not be provided by the school and continued enrollment is contingent on compliance with all school policies and procedures. The school reserves the right to terminate attendance for non-compliance or any other reason it deems to warrant disenrollment.

#### **School Calendar**

A copy of the 2025-2026 school year calendar can be obtained on our website at [www.bedminsterschool.org](http://www.bedminsterschool.org)

The school calendar takes into consideration the holidays that school is not in session. Your monthly tuition payment is based upon the average number of school days per month and does not change based on actual school days per month. Please note that there will still be preschool on early dismissal or delayed opening days, however, they will be run on an abbreviated schedule. Monthly payments are the same whether or not there is a school holiday, abbreviated schedules, or weather-related closings that month. The District will only cancel school due to an extreme weather condition or other emergency situations. You will be notified by the SchoolMessenger system if school is canceled. You can also check the school website for school cancellations. You can also register on the school website for email alerts as well as the Friday Folder.

**BEDMINSTER TOWNSHIP SCHOOL DISTRICT**

234 Somerville Road  
Bedminster, NJ 07921  
Telephone (908) 234-0768 Fax (908) 234-2318  
www.bedminsterschool.org

**Student Absence**

Costs remain the same throughout the school year, therefore tuition cannot be redacted if your family takes a vacation or if you choose to keep your child home.

Please sign and return this agreement along with the deposit to:

Bedminster Township School  
Attn: Kelly Gutierrez  
234 Somerville Road  
Bedminster, NJ 07921

\*Checks should be made payable to: Bedminster Board of Education

I have read and accepted the terms of this agreement.

Student's name: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_