**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

Phone: (609) 716-5000
Fax: (609) 716-5555
Web Site: www.ww-p.org

**2020-2021 School Year**

Dear Preschool Parents/Guardians:

Let me take this opportunity to welcome you to the West Windsor-Plainsboro Regional School District. We are extremely proud of the accomplishments of students, teachers, and staff. When you have a moment, please visit the district web site for detailed information about us: www.ww-p.org.

Our registration process is easy to follow, and will enable us to provide the best experience for your child. To begin, please collect the following items, which are necessary to start the registration procedure:

- **Proof of Residency.** A copy of your mortgage agreement, H.U.D. settlement statement, affidavit of title, lease, deed, tax bill, or contract of sale (until closure of home) with your name on it will be accepted.
- **Health and Immunization Records.** Current records can be obtained from your previous school or pediatrician. These must be current with dates and translated into English. ***Please note that the physical examination forms must be dated no more than one year (365 days) prior to the entry into WW-P schools.*** All the forms are enclosed in this registration packet.
- **Proof of Age.** Birth certificate or passport in its original form or with seal; no photocopies are accepted.
- **Previous School Records.** School records should include report cards, IEPs (if applicable), and recent state test results.

Please complete these forms and bring them to Community Education, which is located in the district offices at 321 Village Road East, West Windsor NJ 08550. We are open from 8:30 a.m. to 4:00 p.m. If you have any questions, please call us at 609-716-5000. Your child does not need to come with you for registration. *Please check the web site for any additional registration forms that are not included in this packet.*

It is my hope that you will have a wonderful experience in our district and that our mission statement will become a reality for your child: "Building upon our tradition of excellence, the mission of the West Windsor-Plainsboro Regional School District is to empower all learners to thoughtfully contribute to a diverse and changing world with confidence, strength of character, and love of learning."

Sincerely,

David Aderhold, EdD
Superintendent of Schools

# WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT
# REGISTRATION DATA SHEET

SCHOOL: _____ DATE: _____ STUDENT ID#: _____

| Student Name - Last Name | First Name | MI | Date of Birth | Gender | Grade Registering for |
|---|---|---|---|---|---|
| | | | | | |

| Current Address | City | Zip Code |
|---|---|---|
| | | |

| Phone Number | Development Name | Former Address (include zip code) |
|---|---|---|
| | | |

| Birth City | Birth State |
|---|---|
| | |

If the student was born outside the United States, what date did the student first enter a US School? _____

Which of the following ethnic groups best describes you? (Optional)

☐ White ☐ Black/African American ☐ Hispanic
☐ Asian ☐ American Indian/Alaskan Native ☐ Pacific Islander

Primary language spoken at home: _____

| Relationship to Student _____ Legal Guardian (Y/N) _____ | | Title: Mr/Mrs/Ms/Dr _____ |
|---|---|---|
| First name: | | Last Name: |
| Address if different from student: | | E-mail Address (s) |
| Business Phone: | Ext # | Cell Phone: |

| Relationship to Student _____ Legal Guardian (Y/N) _____ | | Title: Mr/Mrs/Ms/Dr _____ |
|---|---|---|
| First name: | | Last Name: |
| Address if different from student: | | E-mail Address (s) |
| Business Phone: | Ext # | Cell Phone: |

Does the child have Health Insurance? (Y/N) _____ If "yes" name of Insurance Provider _____

**Sibling Information:**

Name: _____ Relation: _____ Date of Birth: _____
Name: _____ Relation: _____ Date of Birth: _____
Name: _____ Relation: _____ Date of Birth: _____

**Emergency Contact Information:** *(Please list one local contact other than yourself)*

| First Contact Name: | Relationship: | Daytime Phone Number: | Cell Phone: |
|---|---|---|---|
| Second Contact Name: | | | |

| Previous School (s) - Most Recent First - (List Pre-School if Applicable) | | | | | |
|---|---|---|---|---|---|
| Grades Attended | Dates Enrolled | Date Left | School - Address | Public? Yes or No | Location |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

☐ *Transfer of Records Request sent.* Date: _____

*I hereby affirm that the information entered is true and correct to the best of my knowledge.*

Parent/Guardian Signature: _____ Date: _____

## Required Registration Forms

- ☐ Health/Immunization Records received. Date/Initial: _____/_____
- ☐ Proof of Residency received. Date/Initial: _____/_____
- ☐ Birth Certificate received. Date/Initial: _____/_____
- ☐ District Guardian form received - if applicable. (if student is not living with parents) Date/Initial: _____/_____

**Please list any special Transportation requirements on the line below:**

**For Transportation Department Use Only**

Route # (s): _____ Pick up time: _____

Bus Stop: _____

Driver (s): _____ Effective Date: _____

## *FOR OFFICE USE ONLY*

### Related Services Forms

- ☐ ESL Services Eligible. Foreign Language Survey received. Date/Initial: _____/_____
- ☐ Consent to Release Personally Identifiable Information received. Date/Initial: _____/_____
- ☐ Meets "Future Resident" conditions and application has been received. Date/Initial: _____/_____
- ☐ Child has been previously referred or tested as a Special Education Student. Date/Initial: _____/_____
- ☐ Child has been classified as a Special Education Student. Date/Initial: _____/_____
- ☐ Child Study Team Release and Questionnaire received. Date/Initial: _____/_____
- ☐ Child has received services under a 504 Plan. Previous 504 plan has been received. Date/Initial: _____/_____
- ☐ Child is currently receiving Speech and Language Services. Date/Initial: _____/_____

### High School Forms

- ☐ Varsity Athlete? Transfer Waiver form completed if applicable. Date/Initial: _____/_____
- ☐ Has taken the High School Proficiency Assessment at a previous NJ High School. Date/Initial: _____/_____

# Native Language Survey

Today's Date _____

Student's Name _____ _____ _____
FIRST MIDDLE LAST

Student's Date of Birth _____ Gender: M ____ F ____

Grade _____ Home School _____

Mother's Name _____ _____ Cell Phone # _____
FIRST LAST Work Phone # _____

Email _____

Father's Name _____ _____ Cell Phone # _____
FIRST LAST Work Phone # _____

Address _____ Email _____

_____ Home Phone # _____

1.In what country was your child born? _____

2.What is the language that your child first acquired? _____

3.What is the primary language used in your home, regardless of the language spoken by your child?

_____

4.What is the language most often spoken by your child? _____

5.How well does your child speak English? _____ not at all _____ somewhat _____ very well

6.How well does your child understand English? ____ not at all ____ somewhat ____ very well

7.Has your child ever been in an "English As A Second Language" or "English Language Learner" or "Bilingual" program? _____ yes _____ no

8.If yes, what dates? From _____ To _____

If yes, did your child test out of this program? _____ yes _____ no

***Please list the schools your child has attended. Start with the most recent:***

| **Name and Location (including country) of School** | **Dates Attended** | | **Was English taught as a subject?** | | **Was all instruction delivered in English every day?** | |
|---|---|---|---|---|---|---|
| *School* | *From* | *To* | *Yes* | *No* | *Yes* | *No* |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

Phone: (609) 716-5000
Fax: (609) 716-5555

# TRANSFER OF STUDENT RECORDS

Date: _____

To Whom It May Concern:

Re: _____

Date of Birth: _____

Grade: _____

The student named above has recently enrolled in our district. Would you kindly forward all school, discipline, and medical records to us at your earliest convenience? Please include results of standardized group and individual tests, and any other information that will assist us in proper placement.

Sincerely,

Sujata Ray
Registrar

Previous School and Address:

_____
_____
_____

West Windsor-Plainsboro School:

_____
(add name of school)

Parent Authorization for Release:

_____
Signature

***Please send records to the attention of <u>Guidance Department</u> at the appropriate school(s). See next page for addresses. Thank you.***

# West Windsor-Plainsboro District Schools

Dutch Neck Elementary School
392 Village Road East
West Windsor, NJ 08550

Maurice Hawk Elementary School
303-305 Clarksville Road
West Windsor, NJ 08550

Town Center Elementary School
700 Wyndhurst Drive
Plainsboro, NJ 08536

J.V.B. Wicoff Elementary School
Plainsboro Road
Plainsboro, NJ 08536

Millstone River School
75 Grovers Mill Road
Plainsboro, NJ 08536

Village School
601 New Village Road
West Windsor, NJ 08550

Community Middle School
55 Grovers Mill Road
Plainsboro, NJ 08536

Grover Middle School
10 Southfield Road
West Windsor, NJ 08550

High School North
90 Grovers Mill Road
Plainsboro, NJ 08536

High School South
346 Clarksville Road
West Windsor, NJ 08550

**West Windsor-Plainsboro Regional School District**

Phone: (609) 716-5000
Fax: (609) 716-5012

# CHILD STUDY TEAM REQUEST FOR RECORDS

Has your child ever been referred to and/or tested by a Child Study Team?

Yes _____ No _____

Has your child ever been classified as a Special Education Student?

Yes _____ No _____

If either answer is yes, complete the information below.

---

To Whom It May Concern: School _____

I hereby give permission to release any medical, psychological, educational, and/or social information to the West Windsor-Plainsboro Child Study Team concerning my child.

_____ _____
Student's Name Date of Birth

_____
Address

_____ _____
Parent/Guardian Signature Date

*This information will be treated with the utmost confidentiality and will be used only by professional people for the purpose of arriving at the best educational plan for your child.*

**West Windsor-Plainsboro Regional School District**

Phone: (609) 716-5000
Fax: (609) 716-5555

# PARENT'S STATEMENT OF RESIDENCY

I am the _____ of _____.
(Mother or Father) (Child's Name)

I currently live and reside at _____
(Street Address) (Apt. No.)

_____. This postal address is in West Windsor/Plainsboro Township.
(Town) (Zip) (Circle one)

My child resides with me at that address. I submit the following proof of my residence:

_____Copy of Executed Deed _____Copy of Executed Lease

_____ Signed Settlement Statement _____ Affidavit of Title

_____Other _____H.U.D. Settlement

(See cover page for additional information)

I do / do not maintain any other residence.
(Circle one)

If you do, give address of other residence and state why you are residing here instead.
_____
_____
_____
_____

In the event an investigation should disclose that my child is not entitled by law to attend the West Windsor-Plainsboro Regional School District free of charge, I understand that the child will be dis-enrolled, and that I will be held responsible for the costs of tuition to the district for any periods of unlawful attendance. Such tuition will be based upon the per pupil costs of education for the portion of the year in which the child was unlawfully enrolled.

I certify that the foregoing statements made by me are true. I am aware that if any of these statements are false, I will be subject to legal action.

DATE:_____ PARENT'S SIGNATURE:_____

**West Windsor-Plainsboro Regional School District**

Phone: (609) 716-5000
Fax: (609) 716-5012

# QUESTIONNAIRE FOR PRESCHOOL PARENTS

Dear Parents/Guardians:

We want to get to know your child as quickly as possible. Your input to this questionnaire is of great value to us. Please complete this form. Thank you.

Child's Name: _____ _____ _____
(First) (Last) (Name to be used at school)

Date of Birth: _____ Age in September _____ (years) _____(months) Gender _____

**School _____**

1. Please list the names and ages of your child's brothers and sisters.

| Name | Age |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

2. What languages are spoken in your home?

_____ _____ _____ _____

3. List all your child's school experiences:

| Name of School | Years Attended |
|---|---|
| _____ | _____ |
| _____ | _____ |

4. At what age did your child begin talking? _____

5. Has your child ever received speech or language therapy? Yes _____ No _____
6. Has your child ever received occupational therapy? Yes _____ No _____
7. Has your child ever received a learning evaluation? Yes _____ No _____
8. Does your child have any health problems or allergies? Yes _____ No _____

   If so, please explain _____

_____

9. Is there some event that has occurred in your family structure (i.e. birth of a child, loss of a family member) of which you feel the teacher should be aware? Please explain.

_____

_____

10. Is your child right or left handed? Right handed _____ Left handed _____

11. Is your child able to

dress himself _____ button _____ snap _____ zip _____

12. Do you read to your child regularly? Yes _____ No _____

13. What would you consider to be your child's area of strength?

_____

_____

_____

14. What else do you want us to know about your child?

_____

_____

_____

**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

## Provisional Admittance

According to the N.J. State Sanitary Code, Chapter 14, provisional admittance to school is based on medical verification indicating that at least one dose of each of the following vaccines has been administered and that full compliance is in process. The vaccines are Diptheria-Pertussis-Tetanus (DPT), Oral Polio Vaccine (OPV), Measles, Mumps and Rubella (MMR), Hepatitis B and Varicella (Chicken Pox). Please see the enclosed Immunization Requirement form for further explanation of required immunizations. Upon enrollment into school;

i. Each school district shall require parents to provide examination documentation of each student within 30 days upon enrolling into school.

ii. When a student is transferring to another school, each school district shall ensure that student documentation of entry examination is forwarded to the transfer school district pursuant to N.J.A.C. 6A:16-2.4(d).

iii. Students transferring into a New Jersey school from out-of-State or out-of-country may be allowed a 30-day period in order to obtain entry examination documentation.

STUDENT'S NAME _____ GRADE____ MALE___ FEMALE___

TRANSFERRED FROM:

SCHOOL: _____

ADDRESS: _____

I request that my child be provisionally admitted to school pending completion of deficiencies according to New Jersey State requirements. Upon evaluation of my child's record by the school nurse, deficient immunizations/physical exam will be met or in the process of compliance by _____.

| _____ | _____ | _____ |
|---|---|---|
| DATE | SIGNATURE PARENT/GUARDIAN | PHONE |

For Office Use Only
Imm. _____
Physical _____
Tb. Date _____

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

TO THE EXAMINING HEALTHCARE PROVIDER:

**In order to insure that the health office has a completed and updated health record for your patient/student and for communication purposes if the school nurse has a question, please complete the information below and STAMP in the space provided.**

**Thank you very much for your cooperation.**

**PHYSICIAN'S/PROVIDER'S STAMP**

## HISTORY REVIEWED AND STUDENT EXAMINED BY:

☐ Primary Care Provider

☐ School Physician Provider

☐ License Type: ☐ MD/DO
☐ APN
☐ PA

**PHYSICIAN'S PROVIDER'S SIGNATURE:**

_____

**Today's Date:** _____ **Date of Exam:** _____

***PLEASE NOTE THE DATE OF THE PHYSICAL IS ALSO REQUIRED ON THE TOP OF PAGE 1 OF THE HEALTH HISTORY AND THE PHYSICIAN'S SIGNATURE IS ALSO REQUIRED AGAIN ON PAGE 3 (PHYSICAL EXAM) OF THE PACKET.**

# PREPARTICIPATION PHYSICAL EVALUATION
# HISTORY FORM

***(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)***

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete _____ Signature of parent/guardian _____ Date _____



HE0503 9-2361/0410

*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# PREPARTICIPATION PHYSICAL EVALUATION
# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

| | | |
|---|---|---|
| 1. Type of disability | | |
| 2. Date of disability | | |
| 3. Classification (if available) | | |
| 4. Cause of disability (birth, disease, accident/trauma, other) | | |
| 5. List the sports you are interested in playing | | |
| | Yes | No |
| 6. Do you regularly use a brace, assistive device, or prosthetic? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | | |
| 9. Do you have a hearing loss? Do you use a hearing aid? | | |
| 10. Do you have a visual impairment? | | |
| 11. Do you use any special devices for bowel or bladder function? | | |
| 12. Do you have burning or discomfort when urinating? | | |
| 13. Have you had autonomic dysreflexia? | | |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | | |
| 15. Do you have muscle spasticity? | | |
| 16. Do you have frequent seizures that cannot be controlled by medication? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

**Please indicate if you have ever had any of the following.**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete _____ Signature of parent/guardian _____ Date _____



*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# PREPARTICIPATION PHYSICAL EVALUATION
# PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION | | |
|---|---|---|
| Height _____ Weight _____ ☐ Male ☐ Female | | |
| BP _____ / _____ ( _____ / _____ ) Pulse _____ Vision R 20/ _____ L 20/ _____ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____



HE0503 9-2661/3410
*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# PREPARTICIPATION PHYSICAL EVALUATION
# CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

_____

_____

_____

_____

**EMERGENCY INFORMATION**

Allergies _____

_____

_____

_____

_____

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Other information _____

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**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

**Completed Cardiac Assessment Professional Development Module**

Date _____ Signature _____



*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
## N.J.A.C. 8:57-4: Immunization of Pupils in School

| DISEASE(S) | MEETS IMMUNIZATION REQUIREMENTS | COMMENTS |
|---|---|---|
| **DTaP** | (AGE 1-6 YEARS): 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses.<br>(AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses. | Any child entering pre-school, pre-Kindergarten, or Kindergarten needs a minimum of four doses. Pupils after the seventh birthday should receive adult type Td. DTP/Hib vaccine and DTaP also valid DTP doses.<br>Laboratory evidence of immunity is also acceptable. |
| **Tdap** | GRADE 6 *(or comparable age level for special education programs)*: 1 dose | For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97.<br>A child does not need a Tdap dose until FIVE years after the last DTP/DTaP or Td dose. |
| **POLIO** | (AGE 1-6 YEARS): 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses.<br>(AGE 7 or OLDER): Any 3 doses. | Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable.<br>Polio vaccine is not required of pupils 18 years of age or older.<br>Laboratory evidence of immunity is also acceptable. |
| **MEASLES** | If born before 1-1-90, 1 dose of a live Measles-containing vaccine on or after the first birthday.<br>If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday.<br>If entering a college or university after 9-1-95 and previously unvaccinated, 2 doses of a live Measles-containing vaccine on or after the first birthday. | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine.<br>Any child entering Kindergarten needs 2 doses.<br>Previously unvaccinated students entering college after 9-1-95 need 2 doses of measles-containing vaccine or any combination containing live measles virus administered after 1968. Documentation of 2 prior doses is acceptable.<br>Laboratory evidence of immunity is also acceptable.<br>Intervals between first and second measles/MMR/MR doses cannot be less than 1 month. |
| **RUBELLA and MUMPS** | 1 dose of live Mumps-containing vaccine on or after the first birthday.<br>1 dose of live Rubella-containing vaccine on or after the first birthday. | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine.<br>Any child entering Kindergarten needs 1 dose each.<br>Each student entering college for the first time after 9-1-95 needs 1 dose of rubella and mumps vaccine or any combination containing live rubella and mumps virus administered after 1968.<br>Laboratory evidence of immunity is also acceptable. |
| **VARICELLA** | 1 dose on or after the first birthday. | All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering a school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine.<br>Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is also acceptable. |
| **HAEMOPHILUS INFLUENZAE B (Hib)** | (AGE 2-11 MONTHS)[1]: 2 doses<br>(AGE 12-59 MONTHS)[2]: 1 dose | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten.<br>[1] Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months.<br>[2] Minimum of 1 dose of Hib vaccine is needed after the first birthday.<br>DTP/Hib and Hib/Hep B also valid Hib doses. |
| **HEPATITIS B** | (K-GRADE 12): 3 doses or 2 doses [1] | [1] If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.<br>Laboratory evidence of immunity is also acceptable. |
| **PNEUMO-COCCAL** | (AGE 2-11 MONTHS)[1]: 2 doses<br>(AGE 12-59 MONTHS)[2]: 1 dose | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten.<br>[1] Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months.<br>[2] Minimum of 1 dose of Pneumococcal vaccine is needed after the first birthday. |
| **MENINGO-COCCAL** | (Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose [1]<br>(Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose [2] | [1] For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97.<br>[2] Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable. |
| **INFLUENZA** | (AGES 6-59 MONTHS): 1 dose ANNUALLY | For children enrolled in child care, pre-school or pre-Kindergarten on or after 9-1-08.<br>1 dose to be given between September 1 and December 31 of each year. |

## AGE APPROPRIATE VACCINATIONS (FOR LICENSED CHILD CARE CENTERS/PRE-SCHOOLS)

| CHILD'S AGE | NUMBER OF DOSES CHILD SHOULD HAVE (BY AGE): |
|---|---|
| 2-3 Months | 1 dose DTaP, 1 dose Polio, 1 dose Hib, 1 dose PCV7 |
| 4-5 Months | 2 doses DTaP, 2 doses Polio, 2 doses Hib, 2 doses PCV7 |
| 6-7 Months | 3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza |
| 8-11 Months | 3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza |
| 12-14 Months | 3 doses DTaP, 2 doses Polio, 1 dose Hib, 2-3 doses PCV7, 1 dose Influenza |
| 15-17 Months | 3 doses DTaP, 2 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose PCV7, 1 dose Influenza |
| 18 Months-4 Years | 4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, 1 dose PCV7, 1 dose Influenza |

## PROVISIONAL ADMISSION:

Provisional admission allows a child to enter/attend school but must have a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. If a pupil is <5 years of age, they have 17 months to complete the immunization requirements. If a pupil is 5 years of age and older, they have 12 months to complete the immunization requirements.

## GRACE PERIODS:

- 4-day grace period: All vaccines doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

# Vaccine Administration Record for Children and Teens

Patient name: _____

Birthdate: _____

Chart number: _____

| Vaccine | Type of Vaccine[1] (generic abbreviation) | Date given (mo/day/yr) | Source (F,S,P)[2] | Site[3] | Vaccine | | Vaccine Information Statement | | Signature/ initials of vaccinator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Lot # | Mfr. | Date on VIS[4] | Date given[4] | |
| **Hepatitis B**[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Diphtheria, Tetanus, Pertussis**[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM. | | | | | | | | | |
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| | | | | | | | | | |
| | | | | | | | | | |
| ***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Polio**[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Pneumococcal** (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Rotavirus** (Rv) Give oral (po). | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Measles, Mumps, Rubella**[5] (e.g., MMR, MMRV) Give SC. | | | | | | | | | |
| | | | | | | | | | |
| **Varicella**[5] (e.g., Var, MMRV) Give SC. | | | | | | | | | |
| | | | | | | | | | |
| **Hepatitis A** (HepA) Give IM. | | | | | | | | | |
| | | | | | | | | | |
| **Meningococcal** (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC. | | | | | | | | | |
| | | | | | | | | | |
| **Human papillomavirus** (e.g., HPV) Give IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Influenza**[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Other** | | | | | | | | | |

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

Technical content reviewed by the Centers for Disease Control and Prevention, Nov. 2006.

www.immunize.org/catg.d/p2022b.pdf • Item #P2022 (11/06)

# Vaccine Administration Record for Children and Teens

Patient name: Shawn Abler

Birthdate: February 3, 2006

Chart number: SA-4837

| Vaccine | Type of Vaccine[1] (generic abbreviation) | Date given (mo/day/yr) | Source (F,S,P)[2] | Site[3] | Vaccine | | Vaccine Information Statement | | Signature/ initials of vaccinator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Lot # | Mfr. | Date on VIS[4] | Date given[4] | |
| **Hepatitis B**[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. | HepB | 2/03/06 | S | RT | 0651M | MRK | 7/11/01 | 2/03/06 | JTA |
| | Hib-HepB | 4/03/06 | S | RT | 1051M | MRK | 7/11/01 | 4/03/06 | DCP |
| | Hib-HepB | 6/05/06 | S | RT | 1051M | MRK | 7/11/01 | 6/05/06 | DCP |
| **Diphtheria, Tetanus, Pertussis**[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM. | DTaP | 4/03/06 | S | RT | 647A2 | GSK | 7/30/01 | 4/03/06 | DCP |
| | DTaP | 6/05/06 | S | RT | 647A2 | GSK | 7/30/01 | 6/05/06 | DCP |
| ***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM. | Hib-HepB | 4/03/06 | S | RT | 1051M | MRK | 12/16/98 | 4/03/06 | DCP |
| | Hib-HepB | 6/05/06 | S | RT | 1051M | MRK | 12/16/98 | 6/05/06 | DCP |
| **Polio**[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM. | IPV | 4/03/06 | S | LT | U4569-8 | SPI | 1/01/00 | 4/03/06 | DCP |
| | IPV | 6/05/06 | S | LT | U4569-8 | SPI | 1/01/00 | 6/05/06 | DCP |
| **Pneumococcal** (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM. | PCV | 4/03/06 | S | LT | 489-835 | WYE | 9/30/02 | 4/03/06 | DCP |
| | PCV | 6/05/06 | S | RT | 489-835 | WYE | 9/30/02 | 6/05/06 | DCP |
| **Rotavirus** (Rv) Give oral (po). | Rv | 4/03/06 | P | Oral | 0857M | MRK | | | DCP |
| | Rv | 6/05/06 | P | Oral | 0857M | MRK | 4/12/06 | 6/05/06 | DCP |
| **Measles, Mumps, Rubella**[5] (e.g., MMR, MMRV) Give SC. | | | | | | | | | |
| **Varicella**[5] (e.g., Var, MMRV) Give SC. | | | | | | | | | |
| **Hepatitis A** (HepA) Give IM. | | | | | | | | | |
| **Meningococcal** (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC. | | | | | | | | | |
| **Human papillomavirus** (e.g., HPV) Give IM. | | | | | | | | | |
| **Influenza**[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN. | | | | | | | | | |
| **Other** | | | | | | | | | |

Hib-HepB (Comvax)

1 shot, 2 different VIS dates

How to record Hib-HepB combination vaccine

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

# Vaccine Administration Record for Children and Teens

Patient name: Renee Schmidt

Birthdate: December 2, 2004

Chart number: 2345678

| Vaccine | Type of Vaccine[1] (generic abbreviation) | Date given (mo/day/yr) | Source (F,S,P)[2] | Site[3] | Vaccine | | Vaccine Information Statement | | Signature/ initials of vaccinator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Lot # | Mfr. | Date on VIS[4] | Date given[4] | |
| **Hepatitis B**[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. | HepB | 12/02/04 | F | RT | 0651M | MRK | 7/11/01 | 12/02/04 | JTA |
| | DTaP-HepB-IPV | 2/02/05 | F | RT | 635A2 | GSK | 7/11/01 | 2/02/05 | DCP |
| | DTaP-HepB-IPV | 4/02/05 | F | RT | 712A2 | GSK | 7/11/01 | 4/02/05 | DCP |
| | DTaP-HepB-IPV | 6/02/05 | F | RT | 712A2 | GSK | 7/11/01 | 06/02/05 | DLW |
| **Diphtheria, Tetanus, Pertussis**[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM. | DTaP-HepB-IPV | 2/02/05 | F | RT | 635A2 | GSK | 7/30/01 | 2/02/05 | DCP |
| | DTaP-HepB-IPV | 4/02/05 | F | RT | 712A2 | GSK | 7/30/01 | 4/02/05 | DCP |
| | DTaP-HepB-IPV | 6/02/05 | F | RT | 712A2 | GSK | 7/30/01 | 6/02/05 | DLW |
| | DTaP-Hib | 3/02/06 | F | RA | P0897AA | SPI | 7/30/01 | 3/02/06 | RLV |
| **Haemophilus influenzae type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM. | Hib | 2/02/05 | F | LT | UA744AA | SPI | 12/16/98 | 2/02/05 | DCP |
| | Hib | 4/02/05 | F | LT | UA744AA | SPI | 12/16/98 | 4/02/05 | DCP |
| | Hib | 6/02/05 | F | LT | UA744AA | SPI | 12/16/98 | 6/02/05 | DLW |
| | DTaP-Hib | 3/02/05 | F | RA | 7172AA | SPI | 12/16/98 | 3/02/05 | RLV |
| **Polio**[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM. | DTaP-HepB-IPV | 2/02/05 | F | RT | 635A2 | GSK | 1/01/00 | 2/02/05 | DCP |
| | DTaP-HepB-IPV | 4/02/05 | F | RT | 712A2 | GSK | 1/01/00 | 4/02/05 | DCP |
| | DTaP-HepB-IPV | 6/02/05 | F | RT | 712A2 | GSK | 1/01/00 | 6/02/05 | DLW |
| **Pneumococcal** (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM. | PCV | 2/02/05 | F | LT | 489-835 | WYE | 9/30/02 | 2/02/05 | DCP |
| | PCV | 4/02/05 | F | RT | 489-835 | WYE | 9/30/02 | 4/02/05 | DCP |
| | PCV | 6/02/05 | F | LT | 489-835 | WYE | 9/30/02 | 6/02/05 | DLW |
| | PCV | 3/02/06 | F | LA | 501-245 | WYE | 9/30/02 | 3/02/06 | RLV |
| **Rotavirus** (Rv) Give oral (po). | | | | | | | | | |
| **Measles, Mumps, Rubella**[5] (e.g., MMR, MMRV) Give SC. | MMRV | 12/02/05 | P | RA | 0857M | MRK | 1/15/03 | 12/02/05 | DLW |
| **Varicella**[5] (e.g., Var, MMRV) Give SC. | MMRV | 12/02/05 | P | LA | 0857M | MRK | 12/16/98 | 12/02/05 | DLW |
| **Hepatitis A** (HepA) Give IM. | HepA | 12/02/05 | F | LA | 0524L | MRK | 8/04/04 | 12/02/05 | MAT |
| | HepA | 6/02/06 | F | LA | 0634K | MRK | 3/21/06 | 6/02/06 | MAT |
| **Meningococcal** (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC. | | | | | | | | | |
| **Human papillomavirus** (e.g., HPV) Give IM. | | | | | | | | | |
| **Influenza**[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN. | TIV | 10/05/05 | RA | F | U097543 | SPI | 7/18/06 | 10/05/05 | JTA |
| | TIV | 11/05/05 | RA | F | U097543 | SPI | 10/20/05 | 11/05/05 | DCP |
| **Other** | | | | | | | | | |

DTaP-HepB-IPV (Pediarix)

DTaP-Hib (Trihibit)

1 shot, 2 lot #s

1 shot, 3 different VIS dates

How to record DTaP-HepB-IPV, MMRV, and DTaP-Hib combination vaccines

MMRV (ProQuad)

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

# Vaccine Administration Record for Children and Teens

Patient name: Jane Stamper

Birthdate: October 15, 1989

Chart number: 3456789

| Vaccine | Type of Vaccine[1] (generic abbreviation) | Date given (mo/day/yr) | Source (F,S,P)[2] | Site[3] | Vaccine Lot # | Vaccine Mfr. | Vaccine Information Statement Date on VIS[4] | Vaccine Information Statement Date given[4] | Signature/ initials of vaccinator |
|---|---|---|---|---|---|---|---|---|---|
| **Hepatitis B**[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. | ~~HepB (1.0 ml)~~ | ~~6/02/02~~ | ~~P~~ | ~~RA~~ | ~~0651M~~ | ~~MRK~~ | ~~7/11/01~~ | ~~6/02/02~~ | ~~TAA~~ |
| | HepB (1.0 ml) | 1/02/03 | P | RA | 0651M | MRK | 7/11/01 | 1/02/03 | TAA |
| | | | | | | | | | |
| | | | | | | | | | |
| **Diphtheria, Tetanus, Pertussis**[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM. | DTP | 12/15/89 | P | RT | 326-912 | LED | 1/01/88 | 12/15/89 | DCP |
| | DTP | 2/15/90 | P | RT | 326-912 | LED | 1/01/88 | 2/15/90 | DCP |
| | DTP | 4/15/90 | P | RT | 326-912 | LED | 1/01/88 | 4/15/90 | DLW |
| | DTP | 4/15/91 | P | RA | 326-912 | LED | 1/01/88 | 4/15/91 | RLV |
| | DTP | 4/15/94 | P | RA | 326-912 | LED | 10/15/91 | 4/15/94 | JTA |
| | Td | 10/15/01 | P | RA | 467-854 | WAL | 6/10/04 | 10/15/01 | PWS |
| ***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM. | Hib | 12/15/89 | P | LT | 1492L | MRK | 6/01/89 | 12/15/89 | DCP |
| | Hib | 2/15/90 | P | LT | 1492L | MRK | 6/01/89 | 2/15/90 | DCP |
| | Hib | 10/15/90 | P | LT | 1492L | MRK | 6/01/89 | 10/15/90 | DLW |
| | | | | | | | | | |
| **Polio**[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM. | OPV | 12/15/89 | P | Oral | 0678A | LED | 3/01/83 | 12/15/89 | DCP |
| | OPV | 2/15/90 | P | Oral | 0678A | LED | 3/01/83 | 2/15/90 | DCP |
| | OPV | 4/15/91 | P | Oral | 0896A | LED | 3/01/83 | 4/15/91 | RLV |
| | OPV | 4/15/94 | P | Oral | 0987A | LED | 10/15/91 | 4/15/94 | JTA |
| **Pneumococcal** (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM. | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Rotavirus** (Rv) Give oral (po). | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Measles, Mumps, Rubella**[5] (e.g., MMR, MMRV) Give SC. | MMR | 1/15/91 | P | RA | 0857M | MRK | 1/01/88 | 1/15/91 | DLW |
| | MMR | 10/15/01 | P | LA | 0946M | MRK | 1/01/88 | 10/15/01 | PWS |
| **Varicella**[5] (e.g., Var, MMRV) Give SC. | Var | 10/15/01 | P | LA | 0799M | MRK | 12/16/98 | 10/15/01 | PWS |
| | | | | | | | | | |
| **Hepatitis A** (HepA) Give IM. | | | | | | | | | |
| | | | | | | | | | |
| **Meningococcal** (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC. | MCV4 | 8/19/05 | P | LA | U1766AA | SPI | 4/4/05 | 8/19/05 | DCP |
| | | | | | | | | | |
| **Human papillomavirus** (e.g., HPV) Give IM. | HPV | 9/12/06 | P | RA | 0637F | MRK | 9/6/06 | 9/12/06 | MAT |
| | HPV | 11/14/06 | P | RA | 0637F | MRK | 9/5/06 | 11/14/06 | MAT |
| | | | | | | | | | |
| **Influenza**[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN. | | | | | | | | | |
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| | | | | | | | | | |
| **Other** | Tdap | 7/9/06 | P | LA | C2454AA | SPI | 9/22/05 | 7/9/06 | MAT |

2-dose adult HepB for adolescents

How to record adult HepB vaccine given to 11-15 year olds

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV). *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

Phone: (609) 716-5000
Fax: (609) 716-5555

Parents/Guardians of New Students:

The Health Office staff welcomes you to the West Windsor-Plainsboro Regional School District.

We require all new students to supply the school nurse with health information. Enclosed are all the necessary forms that must be completed: health history questionnaire, immunization requirement form, and private physical form. An emergency information card will be given to your child at school.

New students are required to undergo a physical examination, but a new examination is not necessary if a student has received a physical examination within 365 days of the day the student begins school. All the forms are enclosed in this registration packet.

During the school year, new students will be screened for height, weight, blood pressure, vision, and hearing. A Mantoux tuberculin test will be given, if necessary.

If there are any questions or concerns regarding your child's health, please feel free to contact the nurse's office at your child's school.

| | |
|---|---|
| Wicoff Elementary School | (609)716-5450 |
| Town Center Elementary School | (609)716-8330 |
| Dutch Neck Elementary School | (609)716-5400 |
| Maurice Hawk Elementary School | (609)716-5425 |
| Millstone River School | (609)716-5500 |
| Village School | (609)716-5200 |
| Community Middle School | (609)716-5300 |
| Grover Middle School | (609)716-5250 |
| High School North | (609)716-5100 |
| High School South | (609)716-5050 |

**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

Phone: (609) 716-5000
Fax: (609) 716-5555

# HEALTH OFFICE INFORMATION AND PROCEDURES

The nurses of the West Windsor-Plainsboro Regional School District would like you to be aware of procedures that are to be followed in helping to safeguard your child's health.

## ACCIDENTS

The school attempts to provide an environment in which the student will be safe from accidents. If any accident or sudden illness occurs, first aid will be administered and the student's parents notified. No care beyond first aid will be given by the school physician or nurse.

## GUIDELINES FOR KEEPING A CHILD HOME

DO NOT SEND A STUDENT TO SCHOOL WHO IS COMPLAINING OF FEELING ILL, OR WHO HAS HAD A FEVER THE NIGHT BEFORE SCHOOL. Children must be fever-free (WITHOUT TYLENOL) for 24 hours before they return to school. Children who feel unwell before school invariably feel ill in class and must be sent home. It is unfair to the other children in the class, as well as the teacher, to be exposed to a student with a possible contagious illness.

## TEL-SAFE

When a student will be out of school, notify Tel-Safe. For a prolonged illness of three or more days, a note is required for admittance into class. Please dial 716-5000 and then the extension below:

| | | | |
|---|---|---|---|
| Dutch Neck | 5410 | Community Middle School | 5310 |
| Maurice Hawk | 5430 | Grover Middle School | 5260 |
| Village | 5210 | High School South | 5063 |
| Wicoff | 5460 | High School North | 5110 |
| Millstone River | 5510 | Town Center | 6510 |

## MEDICATION

Administration of medication during school hours is not encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, **the medication will be given by the school nurse only.** No medications other then those deemed necessary for life threatening illness/conditions (as defined in the WW-P Board's Medication Policy), shall be administered on field trips.

The following procedures must be followed if any medication (including inhalers) is to be administered during school hours.

- A prescription form, found in the nurse's office, is required to be completed and signed by the student's physician and signed by the parent.
- The form and container with the pharmacist's label designating patient's name, instructions, name of drug and name of physician must be given to the **nurse by the parent.**

When specific guidelines are followed, certain students may self-administer medication.

*Grades K-5* – No student will be permitted to self-administer medication without the assistance of the nurse other than those deemed necessary for life threatening illness/conditions (as defined in the WW-P Board's Medication Policy)

*Grades 4-5* – A student will be permitted to use inhalers for asthma without nurse's assistance on **field trips only. A student will be permitted to self administer insulin on field trips and in school if directed by physician.**

*Grades 6-12* – A student may self-administer medication for life threatening illnesses/conditions (as defined in the WW-P Board's Medication Policy) *Specific guidelines are in place for overnight field trips.

## PHYSICAL EDUCATION

If a student cannot take physical education classes due to illness or injury, a note stating the reason for the excuse must be sent by the parents to the nurse. If a prolonged physical education absence is necessary, a note from a physician is required.

## IMMUNIZATIONS

In order to attend school, state law states that each student's immunization requirements must be fulfilled. These requirements are stated on the school calendar and in the school registration packets.

Further information regarding school health services is provided in registration packets and school calendar. If you have any questions regarding the above information, please call the school nurse. The main thrust of our efforts is the well being of your child in a healthy school environment. Only through parent-school cooperation can this be accomplished.

**Screenings:** All students are screened for vision, hearing, blood pressure, height, weight, and pediculosis. Screenings occur throughout the year. Referrals are sent home to the parents if there is a problem.

____HSS ____HSN ____Grover MS ____Community MS

____Millstone River ____Village ____ Hawk ____DN

____Wicoff ____ Town Center

*Please check one*

# Prescription Form for Administration of Medication in School

**Student's Name**_____ **D.O.B.**_____ **Grade**_____

**Diagnosis** _____

**Name of Medication** _____ **Dosage**_____

**Time and Circumstances of Administration**_____

**Possible side effects:**_____

**Length of time the prescription is valid** _____**(May not exceed the school year)**

When specific guidelines are followed, a student may self-administer medication. Self-administration of a prescribed medication is permitted only in exceptional circumstances when a life threatening condition exists. For purposes of the Board policy life threatening illness is defined as, "*...an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthmatic attack or the use of an adrenaline injection to treat a potential anaphylactic reaction.*"

**When self-administration of medication is applicable for a life threatening condition and in accordance with West Windsor-Plainsboro School District policy guidelines are as follows:**

Grades **K-3** – No student will be allowed to self-administer medication without the assistance of a nurse.

Grades **4-5** – A student will be allowed to use inhalers without nurse assistance on field trips **only**.

Grades **6-12** – A student may self-administer medication for life threatening illnesses.

_____ is capable and has been instructed in the proper method of
**Student's name**

self administration of _____as directed.
**Medication**

**When an auto-injector is prescribed, please provide the following information:**

Is there a documented history of anaphylaxis? Yes_____ No_____

If yes, please provide the signs/symptoms of this child's anaphylactic episode(s)_____

_____ _____ _____

**SIGNATURE OF PHYSICIAN/DENTIST** **DATE** **PHONE**

_____

**PHYSICIAN/DENTIST NAME (PRINT/TYPE/STAMP)**

## WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

### Parent Permission for Administration of Medication in School

**Student's Name**_____**D.O.B.**_____ **Grade**_____

Administration of medication during school hours **is not** encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer _____ as
**Name of Medication**

Directed by my physician. I will supply the medication in its original container and personally deliver it to the school nurse.

**Medication Information /Adjustments**

If this medication is to be given on a regular basis, please indicate what needs to be done if the student is on a class trip or on early closing days. ***Teaching staff can not administer.***

**Check One:**

_____Student will not be taking the medication when going on a class trip.

_____Administer the medication when the student returns from the class trip.

_____Parent will administer the medication when accompanying student on the trip.

**Circle One: Administer/Do Not Administer** the medication on early closing days.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

_____ _____

**Signature of Parent/Guardian** **Date**

_____

Parent/Guardian Name (Print/Type/Stamp)

**WEST WINDSOR PLAINSBORO REGIONAL SCHOOL DISTRICT**
Transportation Department
505 Village Rd West
West Windsor, NJ 08550
Phone: 609-716-5570 FAX: 609-716-5169

## ALTERNATE TRANSPORTATION REQUEST FORM

**This form must be completed each time you want to make a change to your child's transportation Once the form has been received and approved by Transportation, you will be able to print a revised bus pass directly from Genesis. Processing normally takes three days. Check Genesis for the revision. All alternates must be for five days a week, no exceptions.**
**PLEASE NOTE: If there are changes the week before school begins, and/or two weeks after school starts, these changes will take approximately 10 to 14 days longer than normal to process. This is due to the volume of changes at the last minute. Please submit your forms, in a timely manner, directly to the Transportation Dept. NOTE: REQUESTS DO NOT ROLL OVER YEAR TO YEAR!**

Date:_____
Student Name: _____Grade:_____
Home Address:_____
Home Phone: _____
School you child attends: _____

**ALTERNATE LOCATION REQUESTED-PLEASE FILL IN AND COMPLETE INFORMATION BELOW:**

**ALL TRANSPORTATION MUST BE 5 DAYS PER WEEK**
Will your child ride bus to school, from home? Yes _____ No_____
If no, please completely fill out the area below: (Incomplete information will delay the processing)
Name of daycare/sitter: _____
Complete address of daycare/sitter: _____
Contact number for the daycare or sitter: _____
**********
Will your child ride bus from school, to home? Yes _____ No_____
Name of daycare/sitter: _____
Complete address of daycare/sitter: _____
Contact number for the daycare or sitter: _____
***NOTE:*** *If you request and are granted a change in session for your kindergarten student, parents will be responsible for transporting their child. If West Windsor-Plainsboro schools are closed, for any reason, there will not be transportation to or from the daycare location.*

_____ _____
Effective Date of Change (3 days later) Parent/Guardian Signature (form must be signed)

**PLEASE NOTE:** *There must be room on the alternate bus you are requesting, to accommodate* requests.

Revised: 12/10/18

**WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT**

(609) 716-5570
FAX 609-716-5169

## TRANSPORTATION PROCEDURES

1. Students will be allowed to ride one bus to school from home or child care and another bus to home or child care facility after school. This must be for five days a week each way.
2. Parents requesting a transportation change for childcare arrangements must complete the **Alternate Transportation Form** five school days in advance of the effective change date. No forms will be processed between the dates of August 25 and September 15 due to the start of school.
3. Parents requesting a transportation change due to a change in address must submit to the district registrar a new proof of residency. The registrar will contact the Transportation Department regarding the change of address.
4. Students may not switch buses to go home with another student for school projects, music lessons, playing, or other personal matters.
5. Visiting out-of-district children may not ride district buses. The parents who are hosting the children must provide transportation.
6. Students may not use a different stop before contacting The Transportation Department and requesting the change. The Transportation Department will need to verify the request before granting or denying the request.
7. Students should be at their bus locations ten minutes before the scheduled pick-up times. Parents are responsible for transporting children who have missed their bus.
8. Parents are not permitted to ride or board school buses to or from school. Younger siblings are not permitted to ride the school buses to or from school or accompany parents or coaches on field/athletic trips.
9. Telephone requests for changes will only be accepted in emergencies.

EDUCATIONAL SERVICES®

The West Windsor-Plainsboro Regional School District uses Genesis as its student information system. Genesis is filled with all the important information you need: attendance, school course schedules, grades, teacher contact information, emergency information, bus routes, and more.

Information about Genesis can be found on the district web site: http://www.west-windsor-plainsboro.k12.nj.us/parents___s_t_u_d_e_n_t_s/genesis.

**After completing the registration process, all parents will been given an account in this new system. Your account is linked to your e-mail account, so please keep us updated if your e-mail address changes.**

The new student information system can be used from your smartphone, tablet, laptop, or desktop. The Genesis Parent Module will allow you to view class schedules, assignments, emergency contacts, grades, bus routes, attendance, athletic information, and more. You will be able to sign forms and write directly to teachers and administrators.

For more information on Genesis:

**http://www.west-windsor-plainsboro.k12.nj.us/parents___s_t_u_d_e_n_t_s/genesis/**