TRENTON BOARD OF EDUCATION
Office of Early Childhood – Preschool Program
929 Parkside Avenue
Trenton, New Jersey 08618
Phone (609) 656-4900 Ext. 5667 Fax (609) 393-0158

Student ID: _____
PowerSchool Entry: _____
Home School: _____
Home Language: _____

STUDENT REGISTRATION –REENROLLMENT
CHECKLIST VERIFICATION

Name of Student: _____

Date of Birth: _____ Age by September 30, 2022 _____ 3 years _____ 4 years

School/Provider Name: _____

New Enroll: ☐ Re-Enroll: ☐

- Original Birth Certificate of Student _____ (name of student)
- Custodial Parent/Guardian Documentation (if Applicable)
- Student Immunization Record
- Physical Exams
- Proofs of Address ***Refer to Checklist***
- Home Language Survey is completed and signed by parent/guardian
- Registration Packet is completed and signed by parent/guardian
- Special Services Pupil Placement/Transfer Sheet (IEP – Copy of Cover Page, if applicable)

Residency Documentation: Registration must include the following for each column to be accepted as proof of residency. Provide one piece of evidence from **Column A and column B**. A ***Notarized letter*** will be required along with **two (2) poof of address** in the name of the person who has agreed to provide alternate/temporary living arrangements for families from **Column A** as well as **one (1) proof** in parent/guardian's name from **Column B**. Any document provided must be correctly dated in a manner appropriate for the document (i.e. utility bills no older than thirty (30) days, Lease signed and dated with valid terms).

Column A	Column B
☐ Current Household Utility Bill	☐ Current Household Lease
☐ Original Deed/Contract of Sale	☐ Current Paystub w/ another utility bill
☐ Current Lease Expiration Date: _____	☐ Monthly Benefits Statement
☐ Current Mortgage Statement	☐ Monthly Insurance Documents
☐ Current Property Tax Bill	☐ Document mailed from state or federal agency
☐ Notarized Letter in the name of the person who has agreed to provide alternative/temporary living arrangements	{DO NOT WRITE - - EARLY CHILDHOOD OFFICE USE ONLY}

Checked By: _____ Date: _____

Checked By: _____ Date: _____

EC OFFICE USE ONLY

1st Appointment ☐ Reschedule (Original Date: _____) ☐ Notarized Letter ☐ Flagged ☐ Approved Shelter

TRENTON BOARD OF EDUCATION

"Children Come First, Los niños son primero"

Alfonso Q. Llano
Interim Superintendent of Schools

Monica Carmichael
Director
Early Childhood Department
609.656.4960 • 609.393.0289 fax

ELIGIBILITY FOR PRESCHOOL REGISTRATION

Public schools are required to provide a free education to all persons over age 5 and under age 20 who are domiciled in the district. Domiciled means that the student is living with a parent or guardian whose permanent home is located within the boundaries of the district.

- A home is permanent when the person intends to return to it when absent and has no present plan to move from it, even though he/she has existence of homes or residences elsewhere.

- Residency requires bodily presence as an occupant in a given district.

If at any time, you or your child changes domicile or residence, you must report this information immediately to the school building secretary.

IT IS THE POLICY OF THE BOARD THAT SHOULD THE DISTRICT DISCOVER THAT A CHILD IS NOT A LEGAL RESIDENT OF THE DISTRICT AND IS ILLEGALLY ATTENDING TRENTON PUBLIC SCHOOLS, THE DISTRICT WILL ASSESS THE PARENTS THE FULL COSTS OF THE TUITION FOR SUCH ATTENDANCE. ANY ADDITIONAL COSTS FOR SPECIAL EDUCATION SERVICES WILL BE ADDED TO THE REGULAR EDUCATION COSTS.

Parent/Guardian of: _____ School: _____ Grade: _____

By my signature, I am indicating that I have read the information above, understand it, and affirm that my child(ren) and I are legal residents of and are domiciled in the Trenton Public School District.

Signed: _____ Date: _____

PLEASE RETURN THIS FORM TO THE SCHOOL FAMILY WORKER.

THIS COPY IS TO BE MAINTAINED IN THE STUDENT'S CUMULATIVE FOLDER.

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ELEGIBILIDAD PARA INSCRIPCIÓN PREESCOLAR

Las escuelas públicas tienen la obligación de proveer educación gratuita a todas las personas mayores de 5 años y menores de 20 años cuyo domicilio está dentro del distrito. Domicilio significa que el estudiante está residiendo con su padre o tutor cuyo hogar permanente está situado dentro de los límites del distrito.

- Un hogar es permanente cuando la intención de la persona es de regresar ahí cuando no está a presente y no tiene ningún plan de mudarse de ahí en la actualidad, a pesar de que él/ella tienen otras casas o residencias en otro lugar.

- Residencia requiere la presencia corporal de un ocupante en un distrito dado.

Si en algún memento, usted o su hijo(a) cambia de domicilio o residencia, usted tiene que reportar esta información a la secretaria de la escuela inmediatamente.

ES LA NORMA DE LA JUNTA QUE SI EL DISTRITO DESCUBRE QUE UN NIÑO(A) EST A ASISTIENDO A LAS ESCUELAS PUBILICAS DE TRENTON ILEGALMENTE, EL DISTRITO LE COBRARA A LOS PADRES EL COSTE COMPLETE DE LA CUOTA DE ASISTENCIA. QUALQUIER COSTE ADICIONAL POR SERVICIOS DE EDUCACIÓN ESPECIAL SE LE AUMENTARA AL COSTE REGULAR DE LA EDUCACIÓN.

Padre/Tutor de: _____ Escuela: _____ Grado: _____

Con mi firma, estoy indicando que he leído la información anterior, la entiendo y afirmo que mi hijo (s) y yo somos residentes legales y estamos domiciliados en el Distrito de Escuelas Públicas de Trenton.

Firmado: _____ Fecha: _____

POR FAVOR, DEVUELVA ESTE FORMULARIO SECRETARIO DE LA ESCUELA.
ESTA COPIA DEBE MANTENERSE EN EL ARCHIVO CUMULATIVO DEL ESTUDIANTE

Trenton Board of Education

"Children come first, Los Nino's son primero"

Addendum to Registration Packet

Disclaimer: Trenton Public School district is collecting this information in an effort to ensure that all medical and health information is documented in a timely manner for new students entering district schools.

Name of Child (First and Last) _____

1. Did your child recently arrive in the United States? Circle one: Yes No
2. If YES, on what date did your child arrive? Month _____ Day _____ Year _____
3. Have you traveled from Sierra Leone in the last twenty-one (21) days? Circle one: Yes No
4. Have you traveled from Liberia in the last twenty-one (21) days? Circle one: Yes No
5. Have you traveled from Guinea in the last twenty-one (21) days? Circle one: Yes No

If you answered YES to questions three (3), four (4), or five (5), please proceed to question six (6). If you answered NO, proceed to the signature and date section.

6. Are you registering other children in any other school in district? Circle one: Yes No
7. If YES, list the names of each child and school you are registering them at below.

Name of Child (First and Last)	Name of school child will be or is registered at

I hereby authorize the district to release the responses to questions one (1) through five (5) to school-based staff (classroom teachers, paraprofessionals, nurse, and/or principal) who will interact with my child, _____.

_____

Signature of person completing this form Relationship to Child

_____

Name of person completing this form (Please Print) Date

Trenton Public School District Staff ONLY Registrar Initials: _____ Date" _____
Registrar Instructions: Contact nurse when YES is indicated for questions three (3), four (4), or five (5)

- ☐ Copy with registration packet
- ☐ Copy to nurse
- ☐ Copy to principal for affirmative responses ONLY when YES is indicated for questions three (3), four (4), or five (5)

Trenton Board of Education

"Children come first, Los Nino's son primero"

Anexo al paquete de inscripcion

Descargo de responsabilidad: El distrito escolar publico de Trenton solicita la informacion a fin de asegurar de que todo los datos medicos de los alumnus nuevos que ingresan al distrito escolar se documenten en forma oportuna.

Nombre del menor (primero y apellido) _____

1. El menor ingreso recientemente a los Estafos Unidos? Marcar con un ciculo solo una: Si No
2. Si respondio? En que fecha llego el menor? Mes _____ Dia _____ Ano _____
3. Ha regresado de Sierra Leona en los ultimos veinte y uno (21) dias? Marcar con un ciculo solo una: Si No
4. Ha regresado de Liberia en los ultimos veinte y uno (21) dias? Marcar con un ciculo solo una: Si No
5. Ha regresado de Guinea en los ultimos veinte y uno (21) dias? Marcar con un ciculo solo una: Si No

Si contest Si a las preguntas tres (3), cuatro (4), o cinco (5), continue con la pregunta seis (6). Si contest NO, pas a la seccion donde debe firmar su nombre y la fecha de esta declaracion.

6. Ha inscrito a otros menores en otras escuelas del distrito? Marcar con un ciculo solo una: Si No
7. Si contest Si, indique a continuacion el nombre de cada uno de los menores y de las escuelas donde los Inscribio.

Nombre del menor (primero y apellido)	Nombre de la escuela donde lo inscribio o inscribira

Por la presente autorizo al distrito a entregar mis respuestas a las preguntas uno (1), a cinco (5) al personal de las escuela (profesores, profesionales, enfermera, director) que interactuaran con el menor, _____.

_____

Firma de la persona que complete este formulario Relacion con el menor

_____

Nombre (en-letra de imprenta) Fecha

SOLO para el personal del distrito de escuelas publicas de Trenton Iniciales del secretario de admisiones: _____ Fecha: _____
Instrucciones al secretario de admisiones: Comuniquese con la enfermera si se respondio Si a las preguntas tres (3), cuatro (4), o cinco (5)

- ☐ Copia al paquete de inscripcion
- ☐ Copia a la enfermera
- ☐ Copia al director solo en caso de respuestas afirmativas (respuesta Si a las preguntas tres (3), cuatro (4), o cinco (5)

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

HOME LANGUAGE SURVEY

PART A: HOME INSTRUCTION

Student's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Address: _____
(City/State/Zip)

Place of Birth: _____ School: _____

Teacher: _____ Grade: _____

PART B: LANGUAGE INFORMATION

1. What language did your child speak first?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

2. What language do you speak most often to your child at home?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

3. What language does your child most often speak when speaking at you home?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

4. What language does your child use when speaking to: brothers/sisters?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

5. What language does your child speak most often with other family members?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

PART C: LANGUAGE SELECTION

What language do you prefer the school to send you communications? (Please indicate language below)

_____ _____ _____

Indicate Language Parent/Guardian Signature Date

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

ENCUESTA SOBRE EL IDIOMA DEL HOGAR

PARTE A: **INFORMACION DE HOGAR**

Nombre del Estudiante: _____ Fecha de Nacimientto: _____

Nombre de los Padres o Guardian Legal: _____

Direccion: _____

(Ciudad/Estado/Codigo Postal)

Lugar de Nacimiento: _____ Escuela: _____

Maestro/a: _____ Grado Academico: _____

PARTE B: **INFORMACION SOBRE EL IDIOMA**

1. Que idioma hablo su nino/a primero?
   ☐ Ingles ☐ Espanol ☐ Otro _____
   (Idioma)

2. Que idioma le habla usted a su nino/a corrientemente ensu casa?
   ☐ Ingles ☐ Espanol ☐ Otro _____
   (Idioma)

3. Que idioma usa su nino/a corrientemente cuando le habla a usted en el hogar?
   ☐ Ingles ☐ Espanol ☐ Otro _____
   (Idioma)

4. Que idioma usa su nino/a mas corrientemente cuando le habia a sus hermanos/as?
   ☐ Ingles ☐ Espanol ☐ Otro _____
   (Idioma)

5. Que idioma usa su nino/a mas corrientemente con otros miembros de la familia?
   ☐ Ingles ☐ Espanol ☐ Otro _____
   (Idioma)

PARTE C: **SELECCION DE IDIOMA**

En que idioma usted desea recibir comunicaciones de la escuela? (Favor de indicar el idioma a continuacion)

_____ _____ _____

Indique el idioma Firma de Padre o Guardian Fecha

TRENTON BOARD OF EDUCATION
OFFICE OF EARLY CHILDHOOD
929 Parkside Avenue
Trenton, NJ 08618
Phone (609) 656-4900 ext. 5667 Fax (609) 393-0809

Is the child Spanish, Hispanic or Latino? Mark one or mor group to indicate the child's Spanish/Hispanic/Latino origin.
Es el nino Espanol, Hispano o Latino? Marque uno o mas grupos para indicar el origen Espanol, Hispano o Latino del nino.

	No, not Spanish/Hispanic/Latino	No, No es Espano/Hispano/Latino
	Yes, Mexican, Mexican American, Chicano	Si, Mejicano, Mejicano-Americano, Chicano
	Yes, Puerto Rican	Si, Puerotriqueno
	Yes, Cuban	Si, Cubano
	Yes, other Spanish/Hispanic/Latino (Print group)	Si, Espano/Hispano/Latino de otro grupo (indique en letra de imprenta el grupo)

What language does the child speak most at home? Mark one box.
Que lenguaje habla su hijo a habla en la casa? Marque una respuesta.

	English	Ingles
	Spanish	Espanol
	Arabic	Arabe
	Chinese	Chino
	Creole (Hatian)	Creole (Haitiano)
	Gujarati	Gujarati
	Korean	Coreano
	Polish	Polaco
	Portugese	Portugues
	Russian	Ruso
	Urdu	Urdu
	Some other Language (Print Language)	Otro Lenguaje (Indique el lenguaje)

Does the child have any chronic medical problems, special needs, or handicapping conditions? Mark one box
Padece el nino de algun problema medico cronico, de necesidades especiales o algun tipo de incapacidad. Marque una respuesta

	No	No
	Yes (Pint problem or condition)	Si (Indique en letra de imprenta el problema o condicion.)

Will the child be enrolling for the entire school day?
Su hijo/a sera matriculado para el dia entero escolar?

	Yes, enrolling for the entire school day	Si, sera matriculado el dia entero
	No, enrolling for half day	No, sera matriculado medio dia

What kind of health insurance does the child have?
Que clase de seguro medico tiene el nino?

	Private or employment-based health insurance	Seguro de salud privado o basado en el empleo
	Medicaid	Medicaid
	New Jersey Family Care	New Jersey Family Care
	Some other health insurance	Otro tipo de seguro medico
	Uninsured	No tiene seguro

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

EC-5

DENTAL EXAMINATION/TREATMENT FORM

Section A: **To be completed by parent/guardian**

Pupil's Name: _____ Birthdate: _____

Address: _____

School/Grade: _____

Section B: **To be completed by child's dentist**

REPORT OF EXAMINATION

Please circle tooth (teeth) being treated

Tooth Chart																		
RIGHT																		LEFT
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		UPPER
					A	B	C	D	E	F	G	H	I	J				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		LOWER
					T	S	R	Q	P	O	N	M	L	K				

Comments: Please check all that apply

____ fluoride treatment ____ cavities treated

____ sealants ____ further treatment necessary

____ cleaning ____ treatment completed

____ x-rays _____ date of next appointment

_____ _____
Printed Name of Dental/Examiner Signature of Dental/Examiner

_____ _____
Date Phone Number

Please return this form to your child's school once it is completed by the dentist.

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 2

PUPIL HEALTH HISTORY

Pupil's Name: _____ School: _____ Grade: _____
Birthdate: _____ Sex: _____
Address: _____ Telephone: _____
Parent/Guardian's Name: _____ Telephone (Work): _____
Usual Care Provider: (check) Private Physician ____ HMO ____ H.J. Austin Health Center ____ Clinic ____
Doctor's Name: _____ Telephone number: _____

Health History and Development:

1. Length of pregnancy _____ months Delivery (circle one) Normal, Caesarian, Premature
   Birth weight _____lbs _____oz
   Problems at birth or delay sending newborn home. If yes, explain _____
2. Birth sequence of above child 1st ____ 2nd ____ 3rd ____ 4th ____ Other ____
3. What age did your child walk _____ talk _____ toilet-train _____
4. Does your child have any of the following problems?
   Vision _____ Hearing _____ Speech _____
5. Does your child take medications? Yes _____ No _____ If yes, explain _____
   _____
6. Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes _____ No _____
   If yes, explain _____
7. Has your child had a serious injury? Yes _____ Year _____ No _____
   If yes, explain _____
8. Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization?
   Yes _____ Year _____ No _____
   If yes, explain _____
9. Has your child been tested for lead poisoning? Yes _____ No _____ Results _____

Disease History (Age)

Measles _____
Scarlet Fever _____
Pneumonia _____
Convulsions _____
Polio _____
Heart Disease _____
Anemia _____
Frequent headaches _____
Frequent nosebleeds ____
German Measles _____
Whooping Cough _____
Ear Infections _____
Tubes in ears _____
Sickle Cell _____
Fractures _____
Liver Disease _____
Lyme Disease _____
Mumps _____
Asthma _____
Tuberculosis _____
Chicken Pox _____
Epilepsy _____
Frequent Sore throats ___
Diabetes _____
Tonsillitis _____

Any restrictions or limitations to physical activity? _____
Is there anything about your child's health not mentioned above that we should know?
_____

Date _____ Signature of Parent/Guardian _____

CONFIDNETIAL INFORMATION

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 2

HISTORIAL DE SALUD

Nombre del estudiante: _____ Escuela: _____ Grado: _____
Fecha de nacimiento: _____ Sexo: _____
Direccion: _____ Telefono: _____
Nombre del padre o encargado: _____ Numero de trabajo: _____
Cuidado medico: (check) Doctor privado ____ HMO ____ Centro de Salud ____
Nombre del doctor: _____ Telefono: _____

Historial de Salud y de Desarrollo:

1. Meses de embarazo _____ months Parto (circule uno) Normal, Caesarian, Prematuro
   Birth weight _____lbs _____oz
   Problemas al nacer o estadia en el hospital. No _____ Si _____
   Explicacion _____
2. Total de embaraso_____ Estudiante es el numero_____
3. A que edad el nino(a) camino? _____ Hablo? _____ uso el isodoro? _____
4. Tiene su hijo (a) problema con lo siguiente??
   Vision _____ Oir _____ Hablar _____
5. Tomas u hijo (a) aigm medicamento? Si _____ No _____
6. Tiene su hijo alguna alergia a alguma comida, plantas, animals, insectos u otro? Si _____ No _____
   Explique _____
7. Ha tenido au hijo (a) alguns lesion o golpe aerio? Si _____ Year _____ No _____
   Cuando? Explique_____
8. Tiene el nino (a) alguna operacion o procedimiento medico que haya requerido hospitalizacion o servicios de paciente exterpo? Si _____ No _____
9. Le ban hocho is pruba del plomo a su nino (a)? Si _____ No _____ Resultado _____

Historia de la enfermedad (Anos)

Sarampion _____ Sarampion aleman _____ Paperas _____
Fiebre eacariato _____ Tosferina _____ Asma _____
Pulmonia _____ Infecciones del oido _____ Tuberculosis _____
Convulsiones _____ Tubos en los oidos _____ Varicelas _____
Polio _____ Sickle Cell _____ Epilepaia _____
Corazon _____ Fracturad _____ Dolor de gargania _____
Anemia _____ Higado _____ Diabetes _____
Frecuente dolor de cabeza _____ Lyme Disease _____ Amigdalitis _____
Frecuente sangra por la nuriz _____

Hay alguna restriccion o limitacion para la actividal fiaics? _____
Tiene alguma informacion acerca de la salud de su hijo que no se la mencionado?
_____

Fecha _____ Firma del padre _____

CONFIDNETIAL INFORMATION

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 1

HEALTH ENROLLMENT CONSENT/NOTIFICATION FORM

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

SIGNING IS CONSENT FOR MANDATED HEALTH SERVICES:

MEDICAL EXAMINATION

A medical examination is REQUIRED at time of entry to school:

- Students new to this district, and students in pre-school or Kindergarten

State mandate specifies that this medical exam be done by the student's own health care provider, with a full report sent to the school.

Please have your health care provider complete the UNIVERSAL CHILD HEALTH RECORD and return it to the school.

If your child does not have a private physician or health care provider, please understand that he/she will be scheduled for a new entry school medical examination.

THIS ALSO SERVES AS NOTICE OF THE OTHER MANDATED PROGRAMS:

TUBERCULOSIS (MANTOUX) TEST

A skin test for tuberculosis is done on all students entering from another country or an area designated by the NJ Department of Health and Human Services.

SCOLIOSIS SCREENING

A strip to the waist examination is done by the school nurse, and/or the school physician to determine whether your child's spine is developing straight. This screening is done every other year from 10 to 18 years of age.

HEALTH SCREENINGS

Screenings by the school nurse, as required by the State of New Jersey, include: height, weight, dental, vision, hearing, and blood pressure. You will be notified, by a referral form, if your child needs to have an examination by a health professional following these screenings.

_____ _____

Parent/Guardian Signature Date

ESCUELAS PUBLICAS DE TRENTON
OFICINA DE SERVICIOS DE SALUD ESCOLAR
Trenton, New Jersey

SH 1-S

CONSENTIMIENTO DE MATRICULA PARA SALUD/HOJA DE NOTIFICACION

Nombre del estudiante: _____ Fecha de nacimiento: _____

Escuela: _____ Grado: _____

SU FIRMA ES EL CONSENTIMIENTO PARA LOS SERVICIOS DE SALUD MANDATORIOS:

EXAMEN MEDICO

Un examen medico es **REQUERIDO** al entrar a la escuela:

- Estudiantes nuevos al distrito, y estudiantes en PRE-escolar o Kindergarten

El estado require que dicho examen sea realizado por el proveedor de cuidado de salud del estudiante, con un reporte complete enviado a la escuela.

Por favor, haga que su proveedor de cuidado de salud complete la forma de CUIDADO DE SALUD UNIVERSAL DEL NINO/A (UNIVERSAL CHILD HEALTH RECORD).

Si su hijo/a no tiene un medico privado o proveedor de cuidado de salud privado, favor de entender que su hijo/a sera enlistado para un examen medico en la escuela para entrada inicial.

ESTA FORMA TAMBIEN SIRVE DE NOTIFICACION PARA OTROS PROGRAMS MANDATORIOS:

PRUEBA DE TUBERCULOSIS (MANTOUX)

La prueba en la piel para la tuberculosis es realizada a todos los estudiantes que entran a la escuela de otros paises o areas designadas pore d Departamento de Salud y Servicios Humanos de NJ.

ESCOLIOSIS

Un desnudo de la cintura hacia arriba es realizado por la enfermera escolar, y/o el medico escolar pan determiner si la columna vertebral de sus hijo/a se esta desarrollando derecho. Este examen se realiza cada otro ano de 10 a 18 anos de edad.

PRUEBAS DE SALUD

Como requisite del Estado de New Jersey, la enfermera de la escuela llevara a acabo examines que incluyen: medir, pesar, dental, vision, audicion, y presion arterial. Le notificaremos si su hijo/a necesita seguimiento por un profesional de la salud luego de las pruebas realizadas en la escuela.

_____ _____

Frima del padre o guardian Fecha

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. **Your child will continue to receive services at no cost to you under this new system**. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

Please fill the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVIES

Child's Name: _____
(First) (MI) (Last)

Child's Date of Birth: _____
(Month) (Day) (Year)

As a parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature: _____ **Date**: _____

Please return this form to:

_____
_____
_____
_____

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

Nuestro distrito escolar esta participando en un programa por el cual el gobierno federal le pagara a distritos escolares con dolares del "Medicaid" parte de los gastos de salud relacionados con la educaton especial a estudiantes elegibles para el "Medicaid". **Bajo este programa, su nino continuara recibiendo estos servicios sin costo alguno a Usted**. Este program simplente nos ayudara a aumentar los fondos federales que apoyan la education. La information que Usted proveera en esta autorizacion sera empleda solo para este proposito.

Por favor, escribe la informacion requerida, firme el formulario, y devuelvalo a la direccion indicada.

AUTORIZACION PARA REVELER INFORMACION PARA OBTENER PAGO DEL MEDICAID PARA SERVICIOS DE SALUD

Nombre del Estudiante: _____
(Nombre) (Segundo Nombre) (Apellido)

Fecha de Nacimiento del Estudiante: _____
(Mes) (Dia) (Ano)

Como padre/turto del estudiante aqui nombrado, doy mi permiso para reveler la informacion de los archivos escolares de mi hijo/a los representates de agencias locales, estatales, y federales con el proposito unico de obtener pago de Medicaid para los servicios de salud del Programa de Educacion Individualizado (IEP) de mi hijo/a.

Firma: _____ **Date**: _____
(Nombre y apellido de padre/tutor del estudiante) (Mes/Dia/Ano)

Por favor devuelva este formulario a:

_____
_____
_____
_____

TRENTON PUBLIC SCHOOL
Trenton, New Jersey
Office of School Health Services

MH-02

MECICAL HOME INFORMATION FORM

Dear Parent/Guardian

In order to determine how many students, have a medical home, it is necessary for you to complete the Medical Home Information Form. Please return the form to the school nurse.

Name of Student: _____ School: _____

Address: _____ Grade: _____
_____
_____

Phone Number: _____

Name of Health Care Provider: _____
(Doctor's Name or Clinic)

Address: _____
_____
_____

Phone Number: _____

Does your child have health insurance? Yes_____ No _____

If yes, name of insurance company: _____

NJ Family Care Provides FREE or low cost health insurance for uninsured children, low income parents. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Print Name: _____

Signature: _____ Date: _____

ESCUELAS PUBLICAS DE TRENTON
Trenton, New Jersey
Servicion de Salud Escolar

MH-02

FORMA DE INFORMACION DE HOGAR MEDICO

Estimados Padres/Encargados:

Para poder determiner cuantos estudiantes tienen medicos primaries, es necesario que usted complete la Forma de Informacion de Hogar medico. For de regresar la forma a la enfermera escolar.

Nombre del Estudiante: _____ Escuela: _____

Direccion: _____ Grado: _____

_____

_____

Numero de Telefono: _____

Nombre del Proveedor de Cuidado de Salud: _____
(Doctor o Clinica)

_____

_____

_____

Numero de Telefono: _____

Tiene su hijo(a) seguro medico? Si_____ No _____

De ser cierto, nombre de la compania de seguro: _____

(NJ Family Care ofrece seguro de salud GRADUTITO o de bajo costo para ninos sin seguro, padres de bajos ingresos. Puede divulger mi nombre y direccion al Programa NJ Family Care para contactarme sobre el seguro de salud.)

Nombre Impreso: _____

Firma: _____ Fecha: _____

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 dietary specifications:	☐ 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

PREVENTATIVE HEALTH SCREENINGS

Type of Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Led: ☐ 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)
Signature/Date
Health Care Provider Stamp:

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 sign 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.)
    a. 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.
    b. 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.
    c. Head Circumference – Only enter if the child is less than 2 years
    d. 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.
    a. The Immunization record must be attached for the form to be valid
    b. "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 car plan should be completed and attached for any of the medical issues 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 form 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 an 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. Not, any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
    d. Special Equipment – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
    e. Allergies/Sensitivities – Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
    f. Special Diets – Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
    g. Behavioral/Mental Health issues – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding. Or ADHD.
    h. Emergency Plans – May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. ***Screening*** – This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date the test was performed. Not if the test was abnormal or plan n "N" if it was normal.
    a. For lead screening state if the blood sample was capillary or venous and the value of the test performed.
    b. For PPD enter millimeters of induration, and the date listed should be the date read. If the chest x-ray was done, record results.
    c. Scoliosis screening 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)
    a. Print the health care provider's name.
    b. Stamp with health care site's name, address and phone number.

Trenton Pubic School District, Office of Early Childhood
Preschool Family Survey

The Office of Early Childhood has developed the following survey in effort to benefit preschool family needs. Input from this survey will help us design parent involvement programs that best fit the needs of our families. The survey information will be kept confidential. We realize your time is very limited and we thank you for completing this survey. Please contact Sheree Dublin, Community & Parent Involvement Specialist at (609) 656-4900 ext. 5669.

Please complete the survey below.

1. What is your relationship to the enrolled preschool student?
   a. ____ Mother ____ Father
   b. ____ Legal Guardian (Individual Raising child)
   Language(s) spoken at home: _____

2. Which of the following topics would you like to learn more about during this school year? (check all that apply)
   ____ Discipline/Behavior
   ____ Nutrition
   ____ Health and Safety
   ____ Bedtime Strategies
   ____ Supporting Math Skills at Home
   ____ Preparing for Kindergarten
   ____ Stages of Child Development
   ____ Preschool Curriculum
   ____ Sibling Rivalry
   ____ Ways to Raise a Reader
   ____ College Saving Plans
   ____ Science can be Fun
   ____ Other: _____

3. What is the best time for you to participate in workshops or activities?
   a. ____ Morning (between 8:30am and 12 noon)
   b. ____ Afternoon (between 12 noon and 4pm)
   c. ____ Evening (between 4pm and 7pm)

4. How did you find out about the Preschool program? (Please check all that apply)
   ____ Flyer sent home
   ____ Childcare
   ____ Newspaper
   ____ Flyer or poster in a business or agency
   ____ Heard it from friend or relative
   ____ District local channel
   ____ Other: _____

5. What is the most effective way to inform you of workshops/activities/meetings?
   ____ Flyer
   ____ Email
   ____ Phone Calls
   ____ Staff
   ____ Other: _____

6. Do you have internet access at home? (Please check all that apply)
   ____ Phone
   ____ Computer at home
   ____ Computer at Work
   ____ Other: _____

7. Would you be interested in obtaining information about any of the following services? If yes, please provide your contact information.
   Name: _____ Child's Name: _____
   Phone number: _____ Center Location: _____
   ____ Parenting Classes
   ____ Social Services
   ____ Legal Services
   ____ Adult Education Classes
   ____ Parent Support Groups
   ____ Job Training Opportunities
   ____ English Language Classes
   ____ Money Management Classes
   ____ Health Insurance/NJ Family Care
   ____ WIC Nutrition Program
   ____ Other: _____

8. Does your family have any special talents that you would be willing to share with our preschool students? (i.e. Musical talents, cooking talents, artistic talents, etc.) If so, please explain and provide contact information.

_____

_____

Name: _____Phone Number: _____

9. What do you think is the best way schools and families can work together to support students?

_____

_____

_____

Distrito de las Escuelas Publicas de Trenton, Oficina de la Primera Infancia
Encuesta de Familias Pre-escolars

La Oficina de la Primera Infancia ha desarrollado la siguiente encuesta en un esfuerzo para beneficiar las necesidades de las familias pre-escolar. La información recibida de esta encuesta nos ayudara a desinar programas de involucración para las familias que puedan llenar las necesidades que tengan. La información de la encuesta será mantenida confidencial. Reconocemos que su tiempo es limitado y le agradecemos por completar esta encuesta. Por favor comuníquese con Sheree Dublin, Especialista en la Involucración de Familias y la Comunidad al (609) 656-4900 ext. 5669.

Por favor complete la siguiente encuesta

1. ¿Cuál es su relación al estudiante pre-escolar matriculado?
   ____ Madre ____ Padre
   ____ Guardián Legal (Individual criando a un niño)

2. ¿Cuál de los siguientes temas le gustaría saber más en este ano? (Marque todos los que aplica)
   ____ Disciplina/Comportamiento ____ Etapas del Desarrollo de Niños
   ____ Nutrición ____ Currículo Pre-escolar
   ____ Salud y Seguridad ____ Rivalidad entre Hermanos
   ____ Estrategias para la hora de dormir ____ Maneras de criar a un Lector
   ____ Apoyando habilidades de matemática en el hogar
   ____ Plan de Ahorros para el Colegio ____ Preparando para Kindergarten
   ____ La Ciencia puede ser divertido
   ____ Otro: _____

3. ¿Cuál es el horario mejor para usted participar en talleres o actividades?
   ____ Mañanas (entre 8:30am y 12 de la tarde)
   ____ Tardes (entre 12 de la tarde y 4pm)
   ____ Anochecer (entre 4pm y 7pm)

4. ¿Cómo se enteró del Programa Pre-escolar? (Marque todos los que le aplican)
   ____ Boletín enviado a su hogar ____ Boletín en una escuela o negocio
   ____ Cuidado Infantil ____ De un amigo o familiar
   ____ Periódico ____ Canal local del Distrito
   ____ Otro: _____

5. Cuál es la manera más efectiva en informarle de talleres/actividades/reuniones?
   ____ Boletín ____ Llamadas Telefónicas
   ____ Correo electrónico ____ Por medio de Empleados
   ____ Otro: _____

6. ¿Tienes acceso a internet en casa? (Por favor marque todos los que apliquen)
   ____ Teléfono ____ Computadora en casa
   ____ Computadora en el trabajo
   ____ Otro: _____

7. ¿Estaría interesado en obtener información sobre alguno de los siguientes servicios? Si su repuesta es si, por favor escribe su información de contacto:
   Nombre: _____ Nombre del Estudiante: _____
   Número de Teléfono: _____
   ____ Clases de Crianza
   ____ Oportunidades para Entrenamiento de Trabajo
   ____ Servicios Sociales ____ Clases de Ingles
   ____ Servicios Legales ____ Clases de manejo de dinero
   ____ Clases de Educación para Adultos ____ Seguro Médico/NJ Familia Care
   ____ Grupos de Apoyo para Padres ____ Programa de Nutrición de WIC
   ____ Otro: _____

8. ¿Tiene su familia algún talento especial que usted podría compartir con nuestros estudiantes pre-escolares? (ej.: talentos musicales, talentos de concina, talentos artísticos, etc.)

_____
_____

Nombre: _____ Número de Teléfono: _____

9. ¿Qué piensa usted que es la mejor manera para que las escuelas y familias trabajen juntos para apoyar a los estudiantes?

_____
_____
_____