OXFORD TOWNSHIP SCHOOL DISTRICT

PRE-K
REGISTRATION PACKET

FORM A
(Pupil Information)

FORM B
(Home Language Survey)

FORM C
(Student History)

FORM D
(Emergency Contact)

FORM E
(Proof of Residency)

Bring original of governmental birth certificate (county, city, etc. not hospital certificate)

Oxford Central School Health Office
Barbara Svercauski, RN, BSN, CSN
17 Kent Street
Oxford, NJ 07863
Ph: 908-453-4101 Ext. 2106
Fax: 908-453-0022

Required Information for Pre-school and Prekindergarten Registration

The following must be provided to register for pre-school and pre-kindergarten:

- ***Updated official immunization record from the doctor. This must show evidence of immunizations for diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hepatitis B and varicella.***
- ***Original Birth Certificate***
- ***Proof of residency (2 documents)***
- ***Recent picture of your child***

State of New Jersey Vaccine Requirements for Pre-school/ Prekindergarten Entry:

DTP/DTaP Series--- 4 doses
Hib Vaccine----------1 dose
Hepatitis B------------3 doses
MMR Series ---------1 dose
Polio Series ----------3 doses
Varicella --------------1 dose
Influenza Vaccine----1 dose
PCV--------------------1 dose

Please provide the school with an official copy of your child's immunization record.

The State of New Jersey also requires that your child have a physical performed and documented by your physician before entrance into school. This may have been completed up to one calendar year prior to your child's entrance into pre-school/ prekindergarten at Oxford Central School. The required form can be found in this packet.

It is also suggested that your child have a dental evaluation.

Please feel free to contact me with any questions you may have.

Thank you,
Barbara Svercauski RN
School Nurse

PARENT TO COMPLETE

Oxford Central School
17 Kent Street
Oxford, NJ 07863

Registration Health Inventory

Please complete the following information and return to the school nurse at registration. Please use the back of the form if necessary.

STUDENT: ______________________________ DOB:______________________
Mother's name______________________________ Cell #______________________
Father's name______________________________ Cell#______________________
Home phone #____
Child's Physician______________________________ Phone #____________________
Specialist Name ______________________________ Phone #____________________
Please list names of child's siblings and birthdates of each:

____
____
____

1. Please indicate any problems that occurred with either pregnancy or birth of this child. (i.e. premature or full term, c- section, diabetes (mom), hypertension (mom), etc.)____
____
____
____

2. **DEVELOPMENTAL ISSUES:**
   Age at walking: ________________ Age began talking: ______________
   Age at toilet training: ____
   Describe present eating and sleeping habits:
   ____
   Any difficulty with: bed wetting ________________;
   bowel habits _______________; speech ______________________;
   other ____

3. **HEALTH HISTORY:** Has your child had any of the following? **(Please circle any that apply)** **<u>If yes, explain on other side.</u>**

Hospitalizations	Constipation (frequent)
Operations	Diarrhea (frequent)
Frequent colds	Joint pain, swelling or limping
Frequent sore throats	Frequent earaches
Hearing loss	Tubes placed in ears
Vision problems	Wears glasses
Dental issues	Headaches
Urinary issues	Bronchitis

Speech problems
Skin issues
Heart disease
Coordination problems
Pneumonia
Lyme disease

Asthma or Reactive airway disease diagnosed by doctor
Allergic reaction to foods, medications, other____________________
Seizure disorder; if yes on meds______________________________
ADHD or other behavior issue________________________________
List any medication prescribed by doctor taken by child____
____

Any comments: ____
____

List any recent significant injuries:
____
____

List any recent medical tests:
____
____

Date of last physical by doctor: ______________________________

4. **EMOTIONAL/BEHAVIOR HISTORY**:
Describe relationship with parents:
____
____
____

Describe relationship with any siblings:
____
____
____

Does your child exhibit any of the following? **(Please circle any that apply)** **If yes, explain on other side.**
Excessive shyness
Temper tantrums
Difficulty interacting with other children
Persistent crying
Nail biting

5. **OTHER**
Please list any significant medical, social or behavioral history in child's immediate family:
____
____
____

Please provide any further information that you feel would help provide a more healthful environment for your child:
____
____
____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ *I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.*

Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	

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

OXFORD TOWNSHIP SCHOOL DISTRICT
ENGLISH LANGUAGE SERVICES
HOME LANGUAGE SURVEY

FORM B

Please print

Student Name ______________________ **Grade** __________

Address ______________________________________

Date of Birth ______________ **Telephone #** ______________

Parent/Guardian ______________________________________

1. What language did the child first speak? ______________________

2. What language(s) does the family speak at home? ______________________

3. What language do you most often use when speaking to your child? __________

4. What language does the child use in speaking to:
   a. older relatives? (grandparents, aunts, uncles) ______________
   b. brothers and sisters? ______________________
   c. friends and other relatives? ______________________

5. In which language do you prefer to receive communication from school? ________

______________________ ______________

Parent/Guardian Signature **Date**

FORM C

OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, N.J. 07863

Student History

Child's Name ____

1. Has there been any family incidents (i.e. death, separation, family financial concerns, etc.) recently that may have upset the child? Yes _____ No _____

   If checked yes, please describe below

   ____

   ____

2. Family:

   How many children are in your family? __________

   Any foster children? ______ Adopted? _______

   Any others living at home other than parents? ______________________

   Relationship? ______________________

   Who has legal custody of the child? ______________________

   Do both parents work? ______________________

   Who cares for the child? ______________________

   Foreign language spoken at home? ______________________

   How does the child react to situations when one or both parents leave home?

   ______ Cries _____ Accepts it well ______ Temper Tantrum ______ Adjusts quickly to situation

   Has the child traveled much? _________ Where? ______________________

3. Development:

   Did you have any difficulties ___ Before ___ During ___ After the birth of your child?

   Please explain ______________________

   ____

4. At what age (approximately) did the child learn to:

   Crawl __________ Walk __________ Toilet Trained __________

   Can dress him/herself __________ Tie shoe laces __________

   Button __________ Zip __________

Student History

Has the child had formal pre-school experience? __________

Where? ____ How long? __________________________

How clear and well-formed was the child's speech and how is it now?

____

Does the child have children his/her age to play with in his/her neighborhood?

____

Did the child have difficulty learning to ride a bicycle ____, skip rope ______, learn to throw or catch? _____

Handedness _________________________________ (left, right, or both)

What the child's favorite activities? ____

Does the child know his full name ? ______ Address? ______ Telephone number? __________

Does the child know nursery rhymes? _____ Songs? _____ Stories? _____ ABC's ______

Does your child listen to instructions when he is called, directed, etc.? ______________________________

Does your child have any fears? ______________________ Please explain: __________________________

____

____

Does your child take a nap? ____

Is there any other condition or experiences you would wish to mention that could affect the learning situation of your child? ____

____

____

______________________________________ ______________________
Signature of Parent/Guardian Date

FORM D

OXFORD CENTRAL SCHOOL
17 Kent Street, Oxford, N.J. 07863

EMERGENCY CONTACT

1. **Student Information**

Name ______________________________

Address ______________________________

Home Telephone # ____________ Date of Birth ____________

Grade ________ Teacher ______________ School Year ______

2. **Parent/Guardian Information**

Father/Guardian's name ______________ Home Tel. # ____________

Work tel. # (w. ext) ______________ Cell Tel. # ____________

E-mail ______________

Mother's/Guardian's name ______________ Home tel. # ____________

Work tel. # (w. ext.) ______________ Cell tel. # ____________

E-mail ______________

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated. Notify the school immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the school with a copy of the order.

3. **Child Care Provider Information**

Those designated below are authorized to pick up my child from school in an emergency:

Child care provider's name ______________________

Tel. # ______________ Cell tel. # ______________

Child care provider's name ______________________

Tel. # ______________ Cell tel. # ______________

4. **Local Contact Information (Designate 1 parent in our school)**

1. Local contact's name ______________ Relationship to child ________

Home tel. # ______________ Work tel. # (w. ext.) ______________

Cell tel. # ______________

2. Local contact's name ______________ Relationship to child ________

Home tel. # ______________ Work tel. # (w. ext.) ______________

Cell tel. # ______________

5. **Out of Town Contact Information**

Name ______________________ Relationship to child ________

Home tel. # ______________ Work tel. # (w. ext.) ______________

Cell tel. # ______________

6. **Medical/Physician Information**

List student's known allergies or medical conditions ______________________

____

____

Doctor's name ______________ Tel. # ______________

Hospital preference ______________________

Insurance company ______________________

Dentist's name ______________________

In a medical emergency, we hereby authorize the school district to seek emergency medical assistance for our child if we cannot be reached.

7. Does child have Health Insurance? **YOU MUST COMPLETE THIS SECTION FULLY**

Yes _____ If Yes, name of insurance company ___________________________________

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

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature __________________ Printed Name _________________ Date ________

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

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

____

Dental Exam	Date:	Braces
Eye Exam	Date:	Contacts Glasses
Allergy	Kind:	Medications
Allergic Reaction	Date:	Medications
Immunizations/Tetanus	Date:	Type:
Restrictions	Type:	

Doctor ____ Telephone ______________

Dentist ____ Telephone ______________

Hospital ____ Telephone ______________

Address ____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

____

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

Please keep a copy of this form for your records.
Important: Please update your school immediately if any information changes.

FORM E

1OXFORD BOROUGH SCHOOLS
17 Kent Street
Oxford, New Jersey 07863

Proof of Residency Certification

Registration Date: ______________________

I / We ___________________________, parent/guardian of ________________________
(Print Parent's Name) (Print Student's Name)

affirm that I / We reside in the town of Oxford at the property located at:

____, Oxford, N.J. 07863
(Property Address)

____
(Signature of Parent/Guardian)

Two of the following documents have been provided and copies attached as proof of residency:

(Note: If unable to provide documentation at time of registration, proof of residency information must be provided within thirty (30) days of the date of registration.)

________ Current driver's license
________ Current property deed, lease agreement or property tax bill
________ Current utility bill
________ Other - Please describe (other acceptable items may include pay stub form from current employer showing property address, post office mail box number showing property address, automobile registration, or voter registration card).

____

____

____

□□

Office Use Only:

I ____________________________________ have reviewed the material(s) presented on
(Administrator's Signature)

____________________________________ and **approve** / **deny** (circle one) the above
(Date)

named student's admittance to the Oxford Central School.

OXFORD TOWNSHIP SCHOOL DISTRICT
Oxford, N.J. 07863

Especially for Moms, Dads, and Guardians

We very much look forward to welcoming your child to Oxford Central School in September. The teachers have done a marvelous job of preparing their classrooms for your child.

Here are a few items that require your help . . .

1. **HELP US WITH CHILD SAFETY**:
   DO NOT park your car in the bus loading area. Please park in the lot directly across the street or in front of the school if space is available. Parking is also available in the municipal lot across the bridge.

2. **WALK IN DESIGNATED AREA**:
   Use the front crosswalk. DO NOT BLOCK THE SIDEWALK.
   Pre-School students are picked up by their teacher at the front entrance and/or cafeteria in inclement weather.

3. **FOLLOW SIGN-IN PROCEDURES**:
   Whenever visiting the school, you must first go to the main office, sign-in, and if permission is granted, then visit the desired location.