Allamuchy Township School District Preschool Registration

Registration Form

DIRECTIONS TO PARENT/GUARDIAN: The questions on this form must be administered at the time of student enrollment. Some responses are optional to protect the privacy of student or family; however, the parent or guardian should understand that his/her responses to these questions will be of great help to the district and the state in planning a program that meets the unique needs of his/her child. If the parent or guardian declines to respond to a question, leave the item blank.

Office Use Only

Student ID#_____ Grade _____ Homeroom_____
Bus Route N/A CST Code_____ Entry Date _____

Parent Information:

Parent E-mail Address _____

Student Information:

1. Name of Child: Last_____First_____Middle_____
2. Gender of Child Male Female
3. Age of Child:_____Date of Birth:_____Proof of Age _____
4. Child's City of Birth:_____State:_____Country: _____
5. Permanent/Home address of student:
   Street:_____
   City:_____State:_____Zip: _____
6. Home Phone Number: _____
7. Family Status: _____
8. Student Resides with (Please check one)
   ☐ Father only ☐ Mother only ☐ Mother & Father
   ☐ Father & Stepmother ☐ Mother & Stepfather ☐ Guardian ☐ Other
9. Mother's (Guardian's) Information
   ☐ Custodial Parent ☐ Non-Custodial Parent **WITH** access to student records ☐ Non-Custodial Parent **NO** access to student records (Court Order must be provided)

   Mother's/Guardian's Name:_____Maiden Name _____
   Mother's Physical Address (if different than student)
   Street:_____
   City:_____State:_____Zip:_____
   Mother's/Guardian's Phone Number: _____
   Mother's Birthplace:_____Mother's Occupation: _____
   Mother's/Guardian's Employer & Address: _____

Mother's/Guardian's Work Phone Number:_____Cell:_____
Mother's Education:_____Cell Phone Carrier: _____
Email Address: _____

10. Father's (Guardian's) Information
    ☐ Custodial Parent ☐ Non-Custodial Parent **WITH** access to student records ☐ Non-Custodial Parent **NO** access to student records (Court Order must be provided)

    Father's /Guardian's Name:_____Maiden Name _____
    Father's Physical Address (if different than student)
    Street:_____
    City:_____State:_____Zip:_____
    Father's /Guardian's Phone Number: _____
    Father's Birthplace:_____Father's Occupation: _____
    Father's /Guardian's Employer & Address: _____
    Father's /Guardian's Work Phone Number:_____Cell:_____
    Father's Education:_____Cell Phone Carrier: _____
    Email Address: _____
11. Family Physician's Name: _____
    Address:_____
    Phone Number: _____
12. Brother's Older/Younger (Name and Birth Date): _____
    Sister's Older/Younger (Name and Birth Date): _____
13. Language of Child. The language or dialect first learned by an individual or first used by the Parent/Guardian with a child. This item is often referred to as the first language spoken. A representative sample of language in New Jersey is listed below. Place an "X" in the box to indicate the native language of the child.

☐ Arabic	☐ Fulfulde, Nigerian	☐ Pashto, Northern	☐ Sindhi
☐ Armenian	☐ German	☐ Polish	☐ Telugu
☐ Chamorro	☐ Haitian, Creole French	☐ Pashto, Southern	☐ Urdu
☐ Chinese, Cantonese	☐ Hindi	☐ Punjabi, Eastern	☐ Other
☐ Chinese, Mandarin	☐ Japanese	☐ Punjabi, Western	
☐ English	☐ Korean	☐ Singhalese	
☐ French	☐ Kurdish	☐ Somali	

14. Is English understood/spoken by parent/guardian/person enrolling student? Yes ☐ No ☐
15. Language most frequently spoken at home _____

The Allamuchy Preschool has a variety of options to fit your child's needs. Please select the program you wish for your child to be enrolled. (Please note that ages represent our recommendation but can be flexible with communication with the Preschool Director)

Program choices:

- ☐ FULL DAY – Monday-Friday 9:00 a.m. to 3:00 p.m. (3-4-5 yr. old) Allamuchy Residents: $639 monthly Non-Allamuchy Residents: $675 monthly
- ☐ HALF DAY – Monday-Friday 9:00 a.m. to 11:30 a.m. (3-4-5 yr. old) Allamuchy Residents: $419 monthly Non-Allamuchy Residents: $459 monthly
- ☐ FULL DAY – Mon.-Wed.-Fri. 9:00 a.m. to 3:00 p.m. (3-4-5 yr. old) Allamuchy Residents: $469 monthly Non-Allamuchy Residents: $506 monthly
- ☐ HALF DAY – Mon.-Wed.-Fri. 9:00 a.m. to 11:30 a.m. (3-4-5 yr. old) Allamuchy Residents: $285 monthly Non-Allamuchy Residents: $323 monthly
- ☐ FULL DAY – Tues.-Thurs. 9:00 a.m. to 3:00 p.m. (3 yr. old) Allamuchy Residents: $363 monthly Non-Allamuchy Residents: $405 monthly
- ☐ HALF DAY – Tues.-Thurs. 9:00 a.m. to 11:30 a.m. (3 yr. old) Allamuchy Residents: $190 monthly Non-Allamuchy Residents: $237 monthly

Optional Add-ons:
Before Care- 8:00 to 8:40 am
After Care- 3:00 to 3:30 pm

Before Care Selections	After Care Selection
☐ 5 days a week = $140 per month each ☐ 4 days a week = $115 per month each ☐ 3 days a week = $90 per month each ☐ 2 days a week = $60 per month each ☐ 1 day a week = $30 per month each	☐ 5 days a week = $140 per month each ☐ 4 days a week = $115 per month each ☐ 3 days a week = $90 per month each ☐ 2 days a week = $60 per month each ☐ 1 day a week = $30 per month each

New Student Health History

(To be completed by parent/guardian)

Thank you for taking the time to complete this comprehensive health history. The information provided Is confidential, and It will only be used by the school nurse and other school personnel you designate to ensure the health and safety of your child.

Name of person completing this form _____

Student Data Today's Date _____

Name:_____

Birth Date: _____

Address

Street:_____

City:_____State:_____Zip: _____

Phone Number: _____

Place of Birth (City/State) _____

Family Data

Student Lives with:

Name Relationship

_____

_____

_____

_____

_____

_____

_____

Family Health History

	Name	Age	Occupation	Level of Education
Mother				
Father				
Stepmother				
Stepfather				
Siblings				

General Health of Family Members

Mother _____

Father_____

Stepmother _____

Stepfather _____

Siblings _____

Describe any family health concerns the school nurse should be aware of (hereditary illness, chronically ill family members, contagious diseases in home, etc.)

_____

_____

Describe any economic concerns the nurse should be aware of (financial problems, poor housing, lack of clothing, problems affording medical or dental care, etc.)

_____

_____

Student Health Data

Please check and date all items that apply to the student's current health status, past and present.

☐	Normal Pregnancy	_____	☐	Serious Injury	_____
☐	Problem Pregnancy	_____	☐	Headaches	_____
☐	Vaginal Delivery	_____	☐	Seizures	_____
☐	Caesarian Delivery	_____	☐	Concussion/Head Injuries	_____
☐	Prematurity	_____	☐	Eyes (glasses/contacts)	_____
☐	Hospitalization	_____	☐	"Lazy Eye"	_____
☐	Surgery	_____	☐	Ears (infections, etc.)	_____
☐	Accidents	_____	☐	Tubes in ears	_____
☐	Broken Bones	_____	☐	Difficulty Hearing/Aids	_____
☐	German Measles/Rubella	_____	☐	Chicken Pox	_____
☐	Skin (rashes, eczema, etc.)	_____	☐	Impetigo	_____
☐	Head Lice	_____	☐	Hepatitis	_____
☐	Mononucleosis	_____	☐	Frequent Colds	_____
☐	Strep Throat	_____	☐	Asthma/Breathing Problems	_____
☐	Heart Problems	_____	☐	Anemia	_____
☐	Heart Murmur	_____	☐	Constipation/Diarrhea	_____
☐	Bedwetting	_____	☐	Daytime wetting/soiling	_____
☐	Frequent Stomach Aches	_____	☐	Excessive weight gain/loss	_____
☐	Pinworms/Parasites	_____	☐	Urinary Problems	_____
☐	Excessive Thirst	_____	☐	Muscle Problems	_____
☐	Diabetes	_____	☐	Mumps/Measles	_____
☐	Hernia	_____	☐	Thyroid/Hormone Problems	_____
☐	Neurological Problems	_____	☐	Scoliosis/Spine Problems	_____
☐	Immune Disorder	_____	☐	Lyme Disease	_____

If needed, use this space to further describe any of the critical items.

_____

_____

_____

Allergies

List any allergies the student has to medications, plants, insects, food, etc. Note if the allergy is severe or life threatening and describe the prescribed treatment for the allergic reaction.

_____

_____

_____

List all medications the student takes on a regular basis, both prescription and over the counter. Please include the dosage, time and reason for the medication.

_____

_____

_____

Please express any concerns you may have about the development, behavior or emotional heath of this student.

_____

_____

_____

Please describe any limitations or restriction on the student's activities during the school day.

_____

_____

_____

Student's Primary Cary Physician _____

Student's Special Care Physician _____

Health Insurance Carrier _____

Policy and ID Numbers _____

<u>Dental Health</u>

Name of Dentist _____

Does the student receive regular dental check-ups? _____

When was the last dental exam? _____

Detail any problems with teeth or gums _____

Please do not hesitate to contact me with any questions or concerns you may have about your child or the school health services program. (908) 852-1894 x303

MANDATORY HEALTH CARE DOCUMENT TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Name		Date of Birth	
Height		Blood Pressure	
Weight		Respiration	
Vision		Hearing	

Allergies _____

Medications _____

System	OK	Problem Found	If problem found, note action taken
General/Nutrition	☐	☐	
Skin/Hair/Nails	☐	☐	
Eyes/Ears	☐	☐	
Nose/Throat	☐	☐	
Teeth/Gums	☐	☐	
Lymphatic/Thyroid	☐	☐	
Chest/Breasts	☐	☐	
Respiratory	☐	☐	
Cardiac	☐	☐	
Gastrointestinal	☐	☐	
Urinary/Genital/Hernia	☐	☐	
Musculoskeletal/Spine	☐	☐	
Neurologic	☐	☐	
Emotional/Behavioral	☐	☐	

Recommendations _____

_____

Activity Restrictions _____

_____

IMMUNIZATIONS/TEST

Lead Level	_____					
DPT/DT/Tetanus DTAP/DPT Acell	_____	_____	_____	_____	_____	_____
	(Letter required from MD if exempt from pertussis vaccine. Scan and Attach)					
Polio	_____	_____	_____	_____	_____	_____
Measles/Mumps/ Rubella/MMR	_____	_____	_____			
Hepatitis B	_____	_____	_____			
Hib	_____	_____	_____	_____		
Varicella	_____	_____				
Mantoux	_____	RESULT	_____			
Tine	_____	RESULT	_____			
Influenza	_____	_____				
Pneumococcal	_____	_____	_____	_____		

Physician Name (Please Print) _____

Physician Signature or Stamp _____

Date of Exam _____

Date this form was completed _____

Please email completed forms to: pgardiner@aes.k12.nj.us

Or mail to:

Allamuchy Township School
20 Johnsonburg Rd.
Allamuchy NJ, 07820
Attn: Pat Gardiner

You may also call the office to set up an appointment to drop off your paperwork: 908 852 1894 x100