

Student _____

MILLVILLE PUBLIC SCHOOL DISTRICT

**2015-16 REGISTRATION PACKET
CHILD FAMILY CENTER**

Please have the following to register your child:

- Original birth certificate
- Proof of residency
 - Property tax bill
 - Deed, lease, contract of sale, or mortgage
 - Letters from Landlords and other evidence of property ownership/tenancy/residency
 - Utility bill for the stated address in same person's name
 - Court documents or State Agency Placements
 - Voter Registration
- Parent/Guardian ID
- Physical (offered free at registration) or proof of appointment
- Immunization record
- Completed registration packet
- Food Stamp Number (if applicable)
- Custody/Guardianship papers (if applicable)

All information needs to be submitted before your child is placed in the program

FOR OFFICE USE:

Completed By: _____

Comments:

MILLVILLE PUBLIC SCHOOLS STUDENT ENROLLMENT FORM



Today's Date: _____

Student's Last Name _____ First Name _____ Middle _____
 Address _____ City _____ State _____ Zip _____ Phone [_____] _____
 PO BOX# _____ (if applicable) City _____ State _____ Zip _____ (use as mailing address? yes no)
 Birth Date ____/____/____ Sex Male Female Ethnicity/Race _____
 MM DD YY
 City of Birth _____ State _____ Country _____
 Date of US Entry ____/____/____ [Only applies to students NOT born in US]
 MM DD YY

Has student ever attended Millville Schools? Yes No [If YES, last grade completed _____]

Father/Guardian Last Name _____ First Name _____ Suffix _____
 Mother/Guardian Last Name _____ First Name _____
 Student resides with: Both parents Mother only Father only Guardian Custody/Restrictions

Father/Guardian cell phone [_____] _____ Mother/Guardian cell phone [_____] _____
 Father/Guardian work phone [_____] _____ Mother/Guardian work phone [_____] _____

Are parents federally employed? Yes No Federal ID# _____

Emergency Contacts (if we are unable to reach parent/guardian)

Contact #1 _____ Relationship to student _____ Phone [_____] _____
 Contact #2 _____ Relationship to student _____ Phone [_____] _____
 Contact #3 _____ Relationship to student _____ Phone [_____] _____

Last school attended _____ Phone [_____] _____
 School address _____ Fax [_____] _____
 City _____ State _____ Zip _____

Siblings Name _____ DOB ____/____/____ School attending _____ Grade _____
 Siblings Name _____ DOB ____/____/____ School attending _____ Grade _____
 Siblings Name _____ DOB ____/____/____ School attending _____ Grade _____

Check all that apply

- Classified Student
- Basic Skills Required
- Attended Alternative School
- 504 or Medical Alert
- Home Instruction
- Speech
- Requires Bilingual Language _____

.....
SCHOOL USE ONLY

School assigned to _____ Grade _____
 Start date _____ Student ID # _____
 Entered by _____ State ID # _____
 Transportation _____

- Health Record
 - Proof of Residency
 - BC
 - Transfer Card
 - MEETS REQUIREMENTS
- Emailed to _____ by _____



CHILD FAMILY CENTER
JoAnn D. Burns, Principal
1100 Coombs Road
Millville, N. J. 08332
Phone: (856) 293-2171
Fax: (856) 293-2174
Email: joann.burns@millvillenj.gov

THREE YEAR OLD PROGRAM

Child's Name _____ Birthdate _____
Parent's Name _____
Address _____
Phone Number _____

The following providers are available for you to choose to send your three year old child. Please visit and select which you would prefer to have your child attend. Number your first three choices 1, 2 and 3.

- | | | |
|--------------------------|---|--|
| <input type="checkbox"/> | Millville Day Care Center
911 Columbia Avenue
825-5345 -- Danielle Norcroff | Abbott Hours 8:30 AM – 2:30 PM
Wrap Hours 6:45 AM – 5:30 PM |
| <input type="checkbox"/> | Rieck Avenue Country Day School
250 Rieck Avenue
825-9067 -- Jennifer Ellis | Abbott Hours 9:00 AM – 3:00 PM
Wrap Hours 6:30 AM – 5:30 PM |
| <input type="checkbox"/> | Millville Head Start
532 N. High Street
327-1665 -- Amanda Sheets | Abbott Hours 9:00 AM – 3:00 PM |
| <input type="checkbox"/> | Child Family Center
1100 Coombs Road
293-2171 – Clara Beatty | Abbott Hours 8:00 AM – 2:00 PM
Wrap Hours 7:00 AM – 5:30 PM |

Please return this form with your selections and comments and all other registration information to me at the Child Family Center.

No child can be assigned a slot in a center until all registration requirements (birth certificate, proof of residency and health records) have been submitted to the Child Family Center.

Thank you,

JoAnn D. Burns
Principal



CHILD FAMILY CENTER

JoAnn D. Burns, Principal

1100 Coombs Road

Millville, N. J. 08332

Phone: (856) 293-2175

Fax: (856) 293-2174

Email: joann.burns@millvillenj.gov

Dear Parent/Guardian,

Thank you for your cooperation in setting up a preschool/kindergarten registration visit for your child. Please fill out the information below:

PK 3 Year Olds _____ PK 4 Year Olds _____ Kindergarten _____

Child's Name _____ Date of Birth ___/___/___

Address _____

Telephone No. _____

Parent/Guardian Name _____

Present School Attending _____

A physical is a requirement to attend school. We will have a nurse practitioner available during registration free of charge. Please check below if you are interested in an appointment for your child with the nurse practitioner. The County Health Department will be available for lead screening.

_____ yes, please set up an appointment _____ yes, I would like the lead screening
_____ no, I am not interested in an appointment _____ no, I am not interested in the lead screening

Our registration dates will be Tuesday, Wednesday and Thursday, May 19, 20 and 21, 2015. Please check the date that you prefer and we will make every attempt to schedule you on that date. You will be notified by mail of your appointment date and time.

_____ * Tuesday, May 19, 2015, 3:00 PM – 7:00 PM
_____ * Wednesday, May 20, 2015, 3:00 PM – 7:00 PM
_____ * Thursday, May 21, 2015, 9:00 AM – 1:00 PM

***PLEASE NOTE: IF YOU FAIL TO KEEP YOUR APPOINTMENT, YOU WILL FORFEIT YOUR SLOT IN THE PROGRAM.**

DO NOT WRITE BELOW THIS LINE
Preschool/Kindergarten Registration

Your appointment is:

Child's Name _____

Date _____ Time _____

Location: **Child Family Center**
1100 Coombs Road (Wheaton Village)
Millville, N. J. 08332

YOUR CHILD WILL NOT NEED TO ATTEND.

REQUIRED IMMUNIZATIONS

NEEDED FOR

PRE-SCHOOL 3 & 4 YEAR OLDS

DTaP - 4 DATES

POLIO - 3 DATES

MMR - 1 DATE AFTER 1ST BIRTHDAY

HIB - 1 DATE AFTER 1ST BIRTHDAY

PCV - 1 DATE AFTER 1ST BIRTHDAY

VARIVAX - 1 DATE AFTER 1ST BIRTHDAY

OR WRITTEN PROOF OF CHICKEN POX DISEASE

FLU BETWEEN 9/1 & 12/31 EACH YEAR

HEALTH HISTORY

PHYSICAL EXAM BY DOCTOR

OR NURSE PRACTITIONER

ALL RECORDS MUST BE SIGNED BY PHYSICIAN

RECOMMENDED IMMUNIZATIONS

HEPATITIS B SERIES

MILLVILLE PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

STUDENT NAME: _____, _____
Last First

Nickname: _____ Gender: F / M Birthdate: ___/___/___ Grade: _____
(circle one)

Language spoken in Home: _____ Name of Interpreter: _____

Does your child wear glasses? Yes No Contacts? Yes No Orthodontic appliance? Yes No

Does your child currently receive: Speech Therapy Yes No Physical Therapy Yes No Occupational Therapy Yes No

Doctor Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Does your child have an allergy to any foods, medications, insects, latex or other substances? Yes No

If Yes, please list in detail: _____

Please circle if allergy is **severe** **moderate** **mild** List symptoms: _____

What medication(s) or treatment is used to treat the allergy? _____

Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)? _____

Please check all that apply to your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies - seasonal | <input type="checkbox"/> Dyslexia/Learning disorder | <input type="checkbox"/> Muscular/Orthopedic Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Psychiatric/Psychological Disorder |
| <input type="checkbox"/> Chicken Pox- Date: _____ | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Serious Accident |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Other: _____ |

If yes to any of the above, describe and indicate any restrictions:

If your child is on medication, please list medication, dosage, frequency and reason for medication:

Please note any health concerns of which the school nurse needs to be aware:

Other information to be shared with the School Nurse:

Yes No I give the School Nurse permission to share health information with school personnel on a "need to know" basis in writing and/or verbally.

For Preschool Only (3yr & 4yr old students)

Yes No I give permission for my child to receive acetaminophen as ordered by the school physician and administered by the School Nurse for fever above 101 degrees if the parent/guardian cannot be reached.

Signature of Parent or Guardian: _____ Date: _____

Reviewed by Certified School Nurse: _____ Date: _____

BLOOD LEAD SCREENING FORM

To be completed by the Parents/Guardians

Child's Information:

Name: _____ Birth Date: _____

Address: _____

Telephone Number: (____) _____

Parent's/Guardian's Name: _____

Child Care Center Information:

Name: _____ Address: _____

Telephone Number: (____) _____

To be completed by the Child's Health Care Provider

Health Care Provider's Information:

Name: _____

Address: _____

Telephone Number: (____) _____

Blood Lead Screening(s)

Date	Age	Comments

Health Care Provider's Signature: _____ Date: _____

Parents/Guardians: Please return this completed form to your Child Care Center

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number	
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormalities Noted:			Weight (must be taken within 30 days for WIC)		
			Height (must be taken within 30 days for WIC)		
			Head Circumference (if <2 Years)		
			Blood Pressure (if >3 Years)		
IMMUNIZATIONS			<input type="checkbox"/> Immunization Record Attached		
			<input type="checkbox"/> Date Next Immunization Due:		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <i>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.</i>					
Name of Health Care Provider (Print)			Health Care Provider Stamp		
Signature/Date					