

**CHILD FAMILY CENTER
MILLVILLE PUBLIC SCHOOLS**

**2014-15
REGISTRATION INFORMATION**

Please have the following to register your child:

- Birth Certificate**
- Immunization Record**
- Physical**
- Proof of Residency**
- Parent/Guardian ID**
- Completed Enrollment Form**
- Food Stamp Number (if applies)**

Your child will not be placed until each of these has been submitted.



Steve Price
Supervisor of Administrative Services
Millville Public Schools
PO Box 5010
Millville, NJ 08332
(856) 327-6033

December 12, 2011

Re: Proof of Residence

Here is a list of what we are currently accepting as proof of residency. It has changed slightly from our last list of acceptable documents. If you have any questions regarding the lists, please our office.

Acceptable Proof of Residency:

- Property Tax Bills
- Deed, Lease, Contract of Sale or Mortgage
- Letters from Landlords and other evidence of property ownership/tenancy/residency
- Utility Bills for the stated address in same person's name
- Delivery Receipts and/or evidence of personal attachment to a location(secondary proof may be required)
- Court Documents or State Agency Placements
- Voter Registration

Please remember that we can ask for multiple forms of proof if we feel there is any question about the residency. Also, drivers' licenses are not proof of residency. If you, or a parent, have any questions please call me.

MILLVILLE PUBLIC SCHOOLS
STUDENT ENROLLMENT FORM

Today's Date: _____

Student's Last Name _____ First Name _____ Middle _____
Address _____ City _____ State _____ Zip _____ Phone [____] _____
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 cell phone [____] _____ Mother cell phone [____] _____
Father work phone [____] _____ Mother work phone [____] _____

Are parents federally employed? Yes No Federal ID# _____

Non-Household Emergency Contacts

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 Requires Bilingual Another Language Spoken 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 Faxed to _____ by _____



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 20, 21 and 22, 2014. 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 20, 2014, 3:00 PM – 7:00 PM

_____ * Wednesday, May 21, 2014, 3:00 PM – 7:00 PM

_____ * Thursday, May 22, 2014, 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.



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"/> | Corson Park Day Care
4 North 12 th Street
825-5540 – Jill Miller | Abbott Hours
Wrap Hours | 9:00 AM – 3:00 PM
6:30 AM – 5:30 PM |
| <input type="checkbox"/> | Millville Day Care Center
911 Columbia Avenue
825-5345 -- Danielle Schmidt | Abbott Hours
Wrap Hours | 8:30 AM – 2:30 PM
6:45 AM – 5:30 PM |
| <input type="checkbox"/> | Rieck Avenue Country Day School
250 Rieck Avenue
825-9067 -- Ellen Dayton/Jennifer Ellis | Abbott Hours
Wrap Hours | 9:00 AM – 3:00 PM
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
Wrap Hours | 8:00 AM – 2:00 PM
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

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

NJISS FORM

**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: _____

CHILD FAMILY CENTER
Nurse Health Registration Form

Dear Parent Guardian:

The school nurse's office is open from 8:00 am to 5:00 pm daily. The health services provided for all students are: Height, Weight, Dental, Hearing, Vision and Blood Pressure Screenings.

The non-prescription medications which are available to all students with approval of the school physician are: Chloraseptic throat spray, Anbesol, Vaseline, Sting Kit, 0.5% hydrocortisone ointment, eye wash, sterile saline, Polysporin ointment and burn gel.

If your child requires prescription or non-prescription medication on a regular basis, you must obtain a written order from your child's physician on the school medication administration form and you will need to supply the medication and sign the form giving the school nurse permission to give the medication.

Please complete the questionnaire on the back and return it to the school nurse so we can update your child's health records. This information will be shared with your child's teacher, administration, and other staff on a need to know basis unless a written note is received from you requesting it be kept confidential.

If you have any questions regarding the health services provided, please call us at 856-293-2178.2177. We look forward to this school year and hope we can be of help to you and your child.

Sincerely,

Karen Chamenko, RN, BA, CSN
Jeanne Reed, RN, BSN

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

- Immunization Record Attached
 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		

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 _____