LACEY TOWNSHIP HIGH SCHOOL
A Tradition Of Pride · A Tradition Of Excellence

JASON KING
PRINCIPAL

Welcome to Lacey Township High School

Educating Students in Grades 9 – 12

- **All new students** must pre-register on the Lacey Township School District website prior to making an in-person registration appointment in Lacey Township High School.
- Pre-registration is located on our website at www.laceyschools.org
- Once the on-line registration is completed, contact the Lacey Township High School Main Office located at 73 Haines St. (609) 971-2020.
- Please bring all required documents and completed forms to your in-person registration appointment.
- School hours are as follows: 6:55 am – 1:55 pm

73 Haines Street · Lanoka Harbor, NJ 08734 · Phone: (609) 971-2020 · Fax: (609) 242-0873
www.laceyschools.org

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REGISTRATION DAY CHECKLIST

Please bring these items with you to your registration appointment. Students are not considered fully registered until all items are submitted.

(√) Check off each item

A	Original Birth Certificate with the raised seal. A copy will be made at your registration appointment.	
B	Four (4) forms of Proof of Residency to include any of the following items: Property tax bill, deed, contract of sale, lease agreement, mortgage voter registration, vehicle registration, license, permit, bank statements, utility bill, credit card bills, phone bill, and cancelled checks with your current Lacey address at the time of your registration meeting.	
C	Must bring appropriate completed Residency Form. This form is available on the Online Pre-Registration Page – Step 5: Residency Forms.	
D	Student Release of Records (completed by parent).	
E	Pre-Participation Physical Evaluation History Form – Physical and Immunizations (completed by Physician; submit along with current immunizations records) *See Required Medical Documents Letter.	
F	Student Medical Concerns Form & Medication Procedure Form (completed by parent, if applicable).	
G	Guardianship/Custody papers if applicable	
H	Application for Free and Reduced Price School Meals (if applicable) This is available on LTSD Website – Department & Programs ~ Food Service (Print, Fill out and Bring to Childs School)	
*	Transfer Card/Release Paperwork from previous school	
*	Service Copies; IEP, 504 for placement purposes	

*For students transferring from a school outside of Lacey Township School district.

Please make every effort to have your paperwork completed for your scheduled appointment time.

LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES
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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Required Medical Documents

In accordance to NJ State laws, the Lacey Township Board of Education requires that all registrants submit a completed physical examination form and an immunization record before the start of the school year. The physical form must be dated within 365 days from the start of the school year.

Universal Child Health Record Form

1. Physical Examination – completed by physician
   - A current physical should be submitted upon registration
   - If physical was not performed within 365 days from the start of the school year, a new one must be submitted immediately upon completion.
2. Immunization Form – completed by physician
   - A current immunization record must be submitted at registration, regardless of physical exam date.
   - Any subsequent immunization data should also be submitted immediately upon completion

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LACEY TOWNSHIP HIGH SCHOOL
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JASON KING
PRINCIPAL

Request for Student Records

Dear School Administrator:

The following student has been registered in school as of: _____

STUDENT NAME: _____ GRADE: _____

Please forward the following information to us as soon as possible so that we may properly place this student in our school:

Scholastic Records	Transfer Cards
Health Records	Birth Certificate
Test Results	Basic Skills Records
Report Cards	Discipline Records
Grade in Progress	Special Education Records
NJ SMART ID #	Attendance Record
IEP	504

Thank you for your prompt attention to this matter:

I hereby authorize the release of all available information and reports to:

Lacey Township High School
73 Haines St.
Lanoka Harbor, NJ 08734

Parent's Name: _____
(please print)

Parent's Signature: _____ Date: _____

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JASON KING
PRINCIPAL

Physical Examination Form

☐ Will receive a medical examination from home (family Physician)

☐ Do not have a home (family Physician), will require a medical examination from the school physician

Parent's Signature: _____ Date: _____

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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Prescribed and/or Over the Counter Medication Procedure

(Including Aspirin, Tylenol, and Ibuprofen)

For any medication your child will take in the school, please observe the following procedure:

1. Prior to any medication being administered by the school nurse, a written document must be received. Physician's document must state:
    a. the diagnosis
    b. name of medication
    c. dosage, frequency, and time medication is to be administered
    d. physician's documentation can be faxed to the school nurse
2. Parental permission for nurse to administer the medication as directed by the physician
3. Medication prescribed 3 times a day should be taken before school, after school, and at bedtime.
4. All medication must be brought to the school nurse in the original pharmaceutical container with the student's name on it.
5. Medications must be stored in a locked cabinet with the nurse's office; students are not to carry medications on their person or keep them in their lockers.

Please notify the school nurse of any existing medical problems. Thank you for your cooperation in this matter.

Authorization for school nurse to administer medications

School _____ School Nurse _____

Student's Name _____ Date _____

Diagnosis _____ Grade _____

Medication _____ Dosage _____

Parent Signature _____ Time _____

Physician Signature _____ Stamp _____

Action to be taken when no licensed individual is available to administer medication: Hold? _____
Asthma inhalers & Epipens ONLY – Can student self-administer and carry medication? _____

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LACEY TOWNSHIP SCHOOL DISTRICT
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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Student Medical Concerns Form

Parent to complete this section:

Student's Full Name _____ School Year _____

Date of Birth _____ Grade _____ School Attending _____

Physician's Name _____

Address _____

_____

Phone _____

My child has the following medical concerns that I wish to make the school nurse aware of:

_____

_____

_____

_____

If your child requires medication to be administered during school hours:

1. Complete the appropriate **Medical Authorization Form** listed on the District website.
2. Provide medication in its **original container**.
3. Prescription medications must have a **pharmacy label**.
4. A parent **must bring medication in person** to the nurse's office. Students are not permitted to carry as per school policy.
5. For students that are permitted by their physician to self-administer their medication, please complete the **Medication Self-Administration Form**.

Signature of Parent _____ Date _____

Return this form directly to the nurse at your child's school

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JASON KING
PRINCIPAL

Dear Parent:

Under the federal "No Child Left Behind" Act, public high schools must give the names, addresses and telephone numbers of students to military recruiters, college/university recruiters, and prospective employers if the recruiters request the information (P.L. 107-110, Section 9528, 10 USC 503). However, students or their parents have the right to instruct the school in writing that this information is not to be released.

If you do not consent to the release of this information to 1) military recruiters, 2) colleges/university recruiters and/or 3) prospective employers, please check the appropriate line or lines below. To be certain your wishes are respected, please return this form to the **Guidance Office** at Lacey Township High School.

_____ DO NOT release student contact information to Military Recruiters

_____ DO NOT release student contact information to College/University Recruiters

_____ DO NOT release student contact information to Prospective Employers

_____
Student's Name

_____
Name of School

_____
Signature of Student or Parent *** Date

*** Students have the right to request that their contact information not be released to recruiters. Parents can override a child's decision by notifying the school in writing, only if the student is under age 18. We encourage parents and students to discuss this information.

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JASON KING
PRINCIPAL

September 5, 2024

Dear Parent/Guardian:

Once again, Lacey Township High School will sponsor the "Random Testing for Student Alcohol or Other Drug Use" program. This Board of Education Policy and Regulation enhances our ability to provide our students with a safe and drug free learning environment. In order for students to participate in interscholastic athletics and/or extracurricular activities or obtain a parking permit, students and their parents must sign and return the attached consent/policy acknowledgement form. Parents who choose to voluntarily enroll their children into the program may also sign and return the consent form.

Information regarding the Lacey Township School District Random Testing for Student Alcohol and Other Drug Use program can be found on our website. Please visit laceyschools.org, navigate to your parent portal and open the current year Back to School paperwork under the documents tab on the high school site. Acknowledgment of receipt of these documents will be required for this and a few additional forms.

We ask your assistance in completing the paperwork in a timely manner. The “Consent to Participate in Random Testing” found on the back of this letter must be signed by both the parent and student and returned to the high school. All forms may be handed in during homeroom or to the main office. Students participating in fall interscholastic athletics and/or extracurricular activities must submit a signed consent form before being allowed to participate.

Thank you for your continued support and commitment in establishing a safe and healthy school environment so that our students can learn and reach their full potential.

If you have any questions or concerns about this new policy, please contact me at (609) 971-2020.

Sincerely,

Jason King
Principal

LACEY TOWNSHIP HIGH SCHOOL
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JASON KING
PRINCIPAL

Consent to Participate in Random Testing for Student Alcohol or Other Drug Use Program

Student Name (Please Print) _____***Grade***_____

We hereby consent to permit the above named student to participate in the **Random Testing for Student Alcohol or Other Drug Use Program** as approved by the Lacey Township School District. In issuing consent, we permit the student above named to undergo random urinalysis testing for the presence of alcohol or other drugs as outlined in district policy.

We understand that a qualified vendor will oversee the collection process.

We understand that any urine samples will be sent only to a certified laboratory for testing and that the samples will be coded to provide confidentiality.

We hereby give consent to the vendor selected by the Lacey Township School District to perform urinalysis testing for the presence of alcohol or other drugs as named in district policy.

We further give permission to the vendor selected by the Lacey Township School District to release all results of these tests to the Medical Review Officer working for the vendor.

We understand these results will be forwarded to the Building Principal and will also be made available to us. We understand that this consent agreement will be in effect for a period of twelve months from the date listed below.

We understand that the urinalysis conducted will include the following substances and be based on the following levels:

Substance	*Screen/Initial Level*	*Confirmation Level*
AMPHETAMINES (CLASS)	500 ng/ml	250 ng/ml
ECSTASY SCREEN	500 ng/ml	250 ng/nl
COCAINE METABOLITES	150 ng/ml	100 ng/ml
MARIJUANA METABOLITES	20 ng/ml	15 ng/ml
OPIATES	300 ng/ml	300 ng/ml
PCP	25 ng/ml	25 ng/ml
BARBITURATES	300 ng/ml	300 ng/ml
BENZODIAZEPINES	300 ng/ml	300 ng/ml
METHADONE	300 ng/ml	300 ng/ml
PROPOXYPHENE	300 ng/ml	300 ng/ml
OXYCODONE/OXYMORPHONE	100 ng/ml	100 ng/ml
ALCOHOL, URINE	0.02 ng/ml	0.02 ng/ml

STUDENT SIGNATURE:_____DATE:_____

PARENT SIGNATURE: _____DATE:_____

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www.laceyschools.org

Lacey Township School District
1 to 1 Technology Program Student/Parent Agreement

Student Section

My signature below indicates that I carefully read, understand and agree with the information and the stipulations contained within the 1 to 1 Technology Program Student/Parent Handbook which includes the District Acceptable Use Policy and Regulation #2361.

Furthermore, by signing below, I have been informed about the district policies regarding the technology device lent to me by Lacey Township School District and understand it is my responsibility to return in the same condition it was borrowed. I have also read and understand the information regarding the Anti-Big Brother Act.

Lastly I have received a Chromebook issued to me, and it is in good mechanical working order with no obvious defects or damage.

Student Name (Please Print): _____

Grade:_____

Student Signature:_____

Date:_____

Parent Section

My signature below indicates that I carefully read, understand and agree with the information and stipulations contained within the 1 to 1 Technology Program Student/Parent Handbook which includes the District Acceptable Use Policy and Regulation #2361.

Furthermore, by signing below, I have been informed about the district policies regarding the technology device lent to me by Lacey Township School District and understand it is my responsibility to return in the same condition it was borrowed. I have also read and understand the information regarding the Anti-Big Brother Act.

Parent Name (Please Print):_____

Parent Signature:_____

Date:_____

This form must be signed and returned before a Chromebook is issued to a student.

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION
TRANSFER FORM

THE UNDERSIGNED HEREBY CERTIFY THAT THE STUDENT NAMED HEREIN HAS TRANSFERRED TO HIS/HER PRESENT SCHOOL OF ENROLLMENT WITHOUT INDUCEMENT OR RECRUITMENT OR TO SEEK AN ATHLETIC ADVANTAGE. THE PARENTS/GUARDIANS ALSO AGREE TO THE SUBMISSION TO THE NJSIAA OF ANY PERTINENT RECORDS, INCLUDING TRANSCRIPTS, MAINTAINED BY THE SCHOOLS. REFUSAL TO SIGN THE TRANSFER FORM **MAY NOT** BE BASED UPON NONPAYMENT OF FEES, FAILURE TO RETURN SCHOOL PROPERTY AND THE LIKE. **THE TRANSFER FORM IS NECESSARY FOR STUDENTS WHO ARE RESIDING WITH THEIR PARENTS WHO HAVE MOVED TO THE UNITED STATES OR WHO HAVE MOVED FROM ONE SECONDARY SCHOOL DISTRICT TO ANOTHER SECONDARY SCHOOL DISTRICT.**

STEP 1 – TO BE COMPLETED BY **PRESENT SCHOOL** AND FORWARDED TO PREVIOUS SCHOOL (PLEASE PRINT LEGIBLY)

Name of **Present School:** City: ☐ Check if Choice School?

Student's Name: Student's Date of Birth:

Date of Enrollment at Present School (If enrollment occurs after the beginning of the school year, Month, Day, Year, student first attended class:

Principal's Name: Principal's Signature: Date:

Athletic Director's Name: Athletic Director's Signature: Date:

Student's Name: Student's Signature: Date:

Parent/Guardian Name: Parent/Guardian Signature: Date:

Parent/Guardian **PRESENT** complete Address:

STEP 2 – TO BE COMPLETED BY **PREVIOUS SCHOOL** IMMEDIATELY AND RETURNED TO PRESENT SCHOOL

Name of **Previous School:** City:

Date of Withdrawal: Student first entered 9th grade/school: Date:

Parent/Guardian **PREVIOUS** Address:

A. List all sports in which the student participated on a varsity level in a sports season during the calendar year prior to the transfer:

1.	2.	3.

Student is ineligible for thirty (30) calendar days from the start of the Present School's regular schedule for each sport listed above.

B. Has the student participated in a 9-12 program while in the 6, 7, 8th grade? _____Yes _____No (See Bylaws, Art.V, Sec.4.I)

ATTENTION: If the student is from a high school in a foreign country which does not sponsor interscholastic athletics, the adult(s) with whom the student is domiciled must attach a summary of the sports in which the student participated in a non-school community and/or national team/program for participants 14 years old or above. Said participation will be evaluated in "non-school" play to determine varsity status.

Check box if there is evidence that the student transferred for athletic advantage ☐

Check box if there is evidence that the student was recruited. ☐

IF EITHER BOX IS CHECKED, WRITTEN EVIDENCE OF SUCH MUST BE SENT DIRECTLY TO NJSIAA FOR REVIEW.

(If either of the two boxes is checked, or the form is not signed by the Principal and/or Athletic Director of the previous school, the transfer student is not eligible for regular season interscholastic competition until a hearing is held by NJSIAA.)

Principal's Signature: Date:

Athletic Director's Signature: Date:

If unsigned, please state reason(s):

PLEASE FORWARD ALL FORMS/DOCUMENTS TO LARRY WHITE AT THE NJSIAA OFFICE:
lwhite@NJSIAA.org OR Fax to: 609-259-3047 OR Mail to: P. O. Box 487, Robbinsville, NJ 08691

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

STUDENT-ATHLETE RESIDENCY AFFIDAVIT

Print Student's Full Name	School	Date

I, _____, of full age, being duly sworn to law, upon my oath depose and say:

1. I am the parent/legal guardian of the above listed student. (circle)
2. I currently reside at: _____

   I have resided at the above address since: _____
3. The above-named student moved with me at my new address on: _____
4. Prior to moving to the new residence address listed above, I resided at the following address:

   _____
5. Prior to moving to the new address listed in #2 above, the student resided at the following address:

   _____

   with named parent/legal guardian_____
6. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.
7. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.
8. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Parent/Guardian Signature	Print Parent/Guardian Full Name

STATE OF NEW JERSEY, COUNTY OF _____. The above-named affiant appeared before me, a notary public of the State of New Jersey, on the _____day of _____, 20_____and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

Notary Public: _____

Copies of this Affidavit must be sent to the New Jersey State Interscholastic Athletic Association upon request

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*

APPENDIX H

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 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	

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 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.)
   - **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.
   - **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.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **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. The Immunization record must be attached for the form to be valid.
   - "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 care plan should be completed and attached for any of the medical issue 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 from 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 as 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. Note 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 heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings 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)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.