MILL POND ELEMENTARY SCHOOL

A Tradition Of Pride · A Tradition Of Excellence

JOANIE DONOHUE
PRINCIPAL

Welcome to Mill Pond Elementary School

Preschool Program

- **All new students** must pre-register on the Lacey Township School District website prior to making an in-person registration appointment in Mill Pond Elementary School.
- Pre-registration is located on our website at www.laceyschools.org
- Once the on-line registration is completed, contact the Mill Pond Elementary School Main Office located at 210 Western Blvd. (609) 971-2070.
- Please bring all required documents and completed forms to your in-person registration appointment.

210 Western Boulevard · Lanoka Harbor, NJ 08734 · Phone: (609) 971-2070 · Fax: (609) 971-2057
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

Prior to attending Pre-School (18 mos. To 4 years), your child must have:

- DTaP – 4 doses
- Varicella (Chicken Pox) – 1 dose
- Polio – 3 doses
- PCV7 (Pneumococcal vaccine) – 1 dose (given after 1st birthday)
- MMR – 1 dose
- Influenza – 1 dose annually (6-59 months)
- HIB – 1 dose (given on or after the 1st birthday)

Prior to attending Kindergarten, your child must have:

- DTaP – 4 doses with one dos given on or after the 4th birthday or any 5 doses. If DT is submitted for DTaP, a written explanation from the child's physician MUST be provided
- Polio – 3 doses with one dose given on or after the 4th birthday or any 4 doses.
- Measles, Mumps and Rubella – 2 doses of live vaccine MUST be given if born after 1/1/90
- or laboratory evidence of immunity MUST be submitted.
- Hepatitis B – 3 doses
- Varicella – 1 dose for Chicken Pox or laboratory evidence of immunity.

Prior to attending 6th grade, your child must have:

- Tdap
- Meningitis

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Lacey Township School District
Student Health Assessment

To be completed by parent/guardian

Child's name_____Birth date_____Gender M/F

Address_____Phone Number_____

Parents/Guardians name:_____

To the best of your knowledge, does your child have a history or any problems with the following? Please check yes or no.

	NO	YES	DATE	Comments
Varicella Vaccine				
Chicken Pox				
Birth Defects				
Difficult birth/prematurity				
Heart problems				
Serious allergic reactions				
Allergies-food, insects, drugs				
Hospitalizations (when/where/why)				
Surgery				
Head injury or concussion				
Lead Poisoning				
Eye or vision problems/glasses				
Ear problem or deafness				
Speech problem				
Orthopedic problems/fractures				
Gross/fine motor problems				

	NO	YES	DATE	Comments
Problems with bladder				
Problems with bowels				
Asthma				
Bleeding Problems				
Cerebral Palsy				
Diabetes				
Lyme's Disease				
Seizures				
Sickle Cell Disease				
Skin Conditions				
Behavior or Emotional Problem				
Separation Anxiety				
Social Problems				
Limits on activity				
Takes medication regularly				
Will need to take medication at school				
Other: Please note on back				

Students Primary Healthcare Provider

Name:_____Office phone #_____

Address:_____

I, the parent/guardian, understand that this information will only be shared with the appropriate staff members on a need to know basis. I give permission for the school nurse to communicate directly with the child's physician. YES / NO (Please circle one.)

Parent/Guardian Signature:_____Date:_____

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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:

Mill Pond Elementary School
210 Western Blvd.
Lanoka Harbor, NJ 08734

Parent's Name: _____
(please print)

Parent's Signature: _____ Date: _____

LACEY TOWNSHIP SCHOOL DISTRICT
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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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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.