

CHESTER SCHOOLS

Annual Registration & Health History

PLEASE FILL OUT ONE FORM FOR EACH CHILD

STUDENT INFORMATION

County: 27 Dist: 0820 School: _____

Office Use:	HOMEROOM TEACHER: _____	District ID: _____
	District Entry Date: _____	School Entry: _____ State ID: _____

STUDENT LAST NAME: _____	MIDDLE: _____
STUDENT FIRST: _____	GENERATION: _____ (Jr, III, etc.)
BIRTH INFO: _____	
DATE: _____	NICKNAME: _____
CITY/STATE: _____	
COUNTRY: _____	GENDER: _____
	GRADE: _____

HISPANIC	Yes: _____	No: _____
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Race:	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific	<input type="checkbox"/> American Indian	<input type="checkbox"/> Multi	<input type="checkbox"/> Unknown
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PHYSICAL ADDRESS (Resident)

STREET ADDRESS: _____	Appt, Rm, etc _____
CITY: _____	STATE: _____
Township or Borough: _____	COUNTY: _____

MAILING ADDRESS

STREET ADDRESS: _____	PO Box, etc. _____
CITY: _____	STATE: _____ ZIP: _____
	COUNTY: _____ Country _____

PARENT / GUARDIAN INFORMATION

MOTHER'S NAME: _____	MOTHER'S HOME PHONE: _____
Maiden Name _____	MOTHER'S CELL PHONE: _____
Employer _____	MOHTER'S BUSINESS PHONE: _____
	MOTHER'S EMAIL ADDRESS: _____

FATHER'S NAME: _____	FATHER'S HOME PHONE: _____
	FATHER'S CELL PHONE: _____
Employer _____	FATHER'S BUSINESS PHONE: _____
	FATHER'S EMAIL ADDRESS: _____

EMERGENCY CONTACT (not a parent)

Name: _____ Relationship _____ Number _____

In case of illness, etc., list alternates in the area other than father and mother to be called.

NAME: _____	PHONE NUMBER: _____
NAME: _____	PHONE NUMBER: _____
NAME: _____	PHONE NUMBER: _____

Child's name, address and telephone number published in the PTO student directory? _____

Sibling(s)

Name: _____ DOB: _____	Name: _____ DOB: _____	Name: _____ DOB: _____
Grade: _____	Grade: _____	Grade: _____

Please write any additional on reverse.

CURRENT HEALTH INFORMATION:

PLEASE FILL OUT ONE FORM FOR EACH CHILD

«Grad»

STUDENT'S NAME: _____	GRADE: _____	DOB: _____	SEX: _____
ADDRESS: _____			
PARENT/GUARDIAN/MOTHER: _____		HOME PHONE: _____	
PARENT/GUARDIAN/FATHER: _____		CELL PHONE: _____	
HEALTH INSURANCE (Y/N): _____		HEALTH INSURANCE PROVIDER: _____	
PHYSICIAN'S NAME: _____		PHONE: _____	
DENTIST'S NAME: _____		PHONE: _____	

MEDICAL HISTORY

Was pregnancy normal? _____

Was delivery normal? _____

Was baby in good condition at birth? _____

Birth Weight? _____ Did baby come home with mother? _____

Was infancy normal? _____

Was development normal? _____

When did child walk alone? _____

Was speech on time? _____

Has child ever had hearing problems or ear infections? _____

Does your child have any difficulty with vision, hearing, or speech (glasses, contacts, ear tubes and hearing aides): _____

Has child had prior speech, hearing, vision or psychological exams? _____

Reason for exam _____

Does your child have any allergies (food, insects, medication, etc.)? _____

Does your child take any medication (daily, or occasionally)? _____

Has your child had any hospitalization, operation or major illness (specify below)? _____

Have there been any recent changes in the family (relocation, death, divorce, etc.)? _____

Please explain any yes answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time)

I give permission for release of essential information on this form for confidential use in the school for meeting my child's health and educational needs.

Signature of Parent/Guardian

Date

PART II – Medical Evaluation
To the Health Care Provider: Please complete and sign.

STUDENT NAME: _____	DOB: _____
GRADE: _____	

Required immunizations (give month, day and year)

DPT Series 1 _____ 2. _____ 3. _____ 4. _____ 5. _____

POLIO Series 1 _____ 2. _____ 3. _____ 4. _____ 5. _____

MMR Series 1. _____ 2. _____ 3. _____ 4. _____

HIB 1. _____ 2. _____ 3. _____ 4. _____

HBV 1. _____ 2. _____ 3. _____

VARIVAX 1. _____

Date of Most Recent Mantoux for Tuberculosis: _____

Date of Last Medical Evaluation: _____

Date of Last Lead Test: _____

Lead Level of Last Lead Test: _____

Findings for this student are as follows:

This student has the following conditions which may diversely affect his or her educational experience:

Vision Auditory Speech/Language Illness/Chronic Condition

Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school; e.g. seizures, allergies. **Specify Below**

The pupil is on long-term medication. **Specify Below**

Comments and recommendations (attach additional sheet if necessary):

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaption. **Specify Reason and Restriction)**

Signature of Health Care Provider

Name (Please type or print)

Phone Number

Address

HOME LANGUAGE

STUDENT NAME: _____	DOB: _____
ADDRESS: _____	TELEPHONE: _____
ETHNICITY: _____	SEX: _____
HOMEROOM TEACHER: _____	GRADE: _____

1. What language did your child first speak? _____
2. What language do you most often use when speaking to your child? _____
3. What language did your child first use for communication? _____
4. What language does your child use when speaking to brothers, sisters, and other children at home? _____
5. What language does your child often use when speaking with you or other adults in the home (grandparents, aunts, uncles)? _____
6. What language does your child most often use when speaking with friends at home? _____

In which language do you wish to receive communication? _____

FATHER/GUARDIAN SIGNATURE: _____ DATE: _____

MOTHER/GUARDIAN SIGNATURE: _____ DATE: _____

- Definition of native language from New Jersey Department of Education: The language first used by student, or the language most often spoken at home regardless of the language spoken by the student.

FOR SCHOOL USE: Language: «Language»

Code: _____

KINDERGARTEN ENROLLMENT ONLY:

To register, please bring:

- 1. Original birth certificate with the raised seal showing that he/she is five years old on or before October 1, 2005.*
- 2. A copy off proof of immunization signed by a physician. This Copy cannot be returned, as it become a part of your child's permanent health record.*
- 3. Proof of residency, i.e., utility bill, library card – not a driver's license.*
- 4. Enclosed papers completely filled out.*

Immunization dates must include month, day, and year. NJ State guideline require every student to have had a minimum of 4 doses of DPT, one does of which shall have been given on or after the 4th birthday, **at least 3 doses of polio** (with one given on or after the 4th birthday), **2 doses of M.M.R. vaccine** (with the first does on or after the 1st birthday and the second dose no less than one month after the first does), **and 1 dose of Varicella vaccine administered on or after the first birthday (or a physician's or parental statement of previous Varicella disease), 3 doses of hepatitis B vaccine prior to school entrance.** Also included in your packet is a physical form to be completed by your child's physician. Please return the completed forms by June 1.

CHESTER PUBLIC SCHOOLS
415 ROUTE 24, CHESTER, NEW JERSEY 07930

I, the undersigned parent or legal guardian of _____
(Student Name)

authorizes _____, Chester, New Jersey 07930 to obtain from or release
(School Name)

to _____ any and all
(New School Name)

information concerning this child (including health & Child Study Team information).

Date

Parent/Guardian Signature

Dickerson Elementary School (908) 879-5313
Fax Number (908) 897-7018

Bragg School (908) 879-5324
Fax Number (908) 879- 5438

Black River Middle School (908) 879- 6363
Fax Number (908) 879- 9085