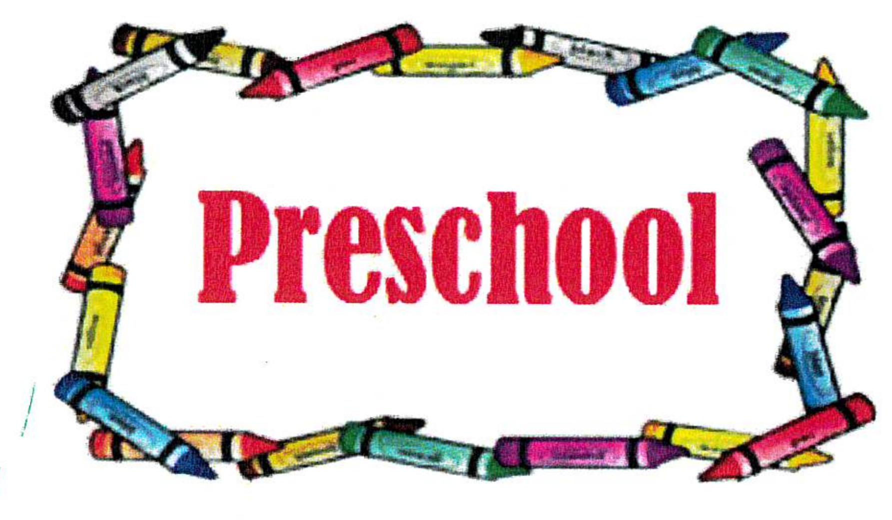
Preschool

Franklin Township School
226 Quakertown Road; P.O. Box 368; Quakertown, NJ 08868
(908)735-7929 Fax (908)735-0368

Nicholas Diaz
Superintendent

Lindsay Gooditis
Principal

Lori Tirone
Business Administrator

Preschool Application

MUST BE 3 YEARS OF AGE ON OR BEFORE 10/1 AND TOILET TRAINED

Date of Birth: ____________

Child's Full Name: ____

Place of Birth____________________________ **Ethnicity**_____________________

Gender: Male ☐ **Female** ☐

Address: ____

Home Phone:___________________________ **Cell Phone:** ________________

Email Address:____

Parent I Name: ____

Parent II Name____

Email: ____

A birth certificate and updated immunization record must be submitted before the start of school.

I understand I will be responsible for providing transportation for my child to and from school.

Parent Signature____________________________________ **Date**_____________

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.

Medical History Form – New Student Registration

Student Name: ______________________ Date of Birth: ______________

1. Your Child
   a. Pregnancy & Birth
      Birth Weight: ________ Full-Term Premature
      Describe any problems during pregnancy and/or birth:
   b. Developmental Milestones
      Age for Walking: ______ Talking: ______ Toileting: ______
      Describe eating habits: ______________________
      Describe sleeping habits: ______________________
      Describe difficulties during preschool years: ______________________
   c. Physical – Has/Does your child have any of the following? (Indicate Yes or No Below. If yes, explain in further comments.)

Hospitalizations		
Operations	Yes	No
Illness	Yes	No
Allergies	Yes	No
To: ______________		
Allergic Reactions	Yes	No
Medications	Yes	No
Foods	Yes	No
Other ________	Yes	No
Asthma	Yes	No
On Medication	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Finger/Thumb Sucking	Yes	No
Frequent Colds	Yes	No
Coordination Concerns	Yes	No
Bleeds Easily/Excessive	Yes	No
Dental Problems	Yes	No
Elimination		
Bed Wetting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Daytime Incontinence	Yes	No
Wears Pullups	Yes	No
Endocrine/Diabetes	Yes	No
Frequent Earaches	Yes	No[1]
Hearing Loss	Yes	No
Ear Tubes	Yes	No
Emotional Concerns	Yes	No
Headaches	Yes	No

Joint Pain, Swelling, Limping	Yes	No
Muscular/Skeletal/Accident Prone	Yes	No
Frequent Sore Throats	Yes	No
Skin Problems/Concerns	Yes	No
Speech Problems/Concerns	Yes	No
Seizures	Yes	No
Medications	Yes	No
Vision		
Problems/Concerns	Yes	No
Sees an Eye Doctor	Yes	No
Wears Glasses/Contacts	Yes	No
Worms/Parasites	Yes	No
Ever Passed Out/Unconscious	Yes	No
Prone to Nosebleeds	Yes	No
Tires Easily	Yes	No
Developmental Disabilities	Yes	No
Takes Medication Daily	Yes	No
Medication Name ______________		

Further Comments:

   d. Inner Self

Excessive Shyness	Yes	No
Temper Tantrums	Yes	No
Persistent Crying	Yes	No
Nail Biting	Yes	No
Social with Peers	Yes	No

1

2. Your Family

a. Family Members

Relationship	Birthdate	Name
Mother	XXXXXXX	________________
Father	XXXXXXX	________________
________	________	________________
________	________	________________
________	________	________________
________	________	________________
________	________	________________
________	________	________________
________	________	________________
________	________	________________

b. Medical History (Indicate Yes or No if immediate family members have history, as listed below)

Sudden Cardiac Death	Yes	No	Heart Disease	Yes	No
Allergies	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Development Disability	Yes	No
Bleeding Disorders	Yes	No	Mental Health Illness	Yes	No
Vision Disorder	Yes	No	Lead Poisoning	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Hearing Disorder	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Drug/Alcohol Addiction	Yes	No			

Please note the relative for any Yes, above: ____________________________

Further Comments/Information

Parent Signature: ____________________________ Date: ________________

Guidelines for Keeping Sick Children Home From School

Please keep me home if.....

I have a fever	I am vomiting	I have diarrhea	I have a rash	I have head lice/ nits	I have an eye infection	I am congested and/or have a thick constant runny nose	I have a sore throat	I have been diagnosed with strep throat or scarlet fever	I have been in the hospital	I'm just not feeling very good
Temperature of 100° F) and sore throat, rash, vomiting, diarrhea, earache, or not feeling well	Two or more times in 24 hours	Three or more watery stools in 24 hours	Body rash with itching or fever	Itchy scalp	White part of eye pink and/ or pus draining from the eye	Uncomfortable stuffed up feeling and/or runny nose	With fever or swollen glands	Red sore throat with patches on tonsils, swollen glands, fever and/or rash	Hospital stay and/or emergency room visit	Unusually tired and/or pale Lack of appetite, confused, and/ or cranky
To Return to School I need:				To be brought to to the school nurse by my parent guardian	To have clear eyes that are not draining. To have completed 48 hours of treatment	To be fever free without the assistance of medication for 24 hours (i.e. Tylenol, Advil or Motrin)	To be fever free without the assistance of medication for 24 hours	To be fever free without the assistance of medication for 24 hrs. To have completed 48 hours of treatment	A copy of the discharge Instructions and/ or doctor's note permitting me to return to class that includes any special instructions(ie. modifications to daily program and if so for what period of time)	To be feeling better and acting like I normally do
To be fever free without the assistance of medication for 24 hours (i.e. Tylenol, Motrin, Advil) A note from my parent/guardian	To be free from vomiting for 24 hours A note from my parent/ guardian	To be free from diarrhea for 24 hours A note from my parent/ guardian	A doctor's note permitting me to return to school	Prior to returning to class	A doctor's note permitting me to return to class	A note from my parent/ guardian/MD	A note from my parent/ guardian	A doctor's note permitting me to return to class		A note from my parent/ guardian

IF I SHOW ANY OF THE ABOVE SIGNS OF ILLNESS AT SCHOOL, IT WILL BE NECESSARY TO PICK ME UP AT SCHOOL. PLEASE KEEP ALL EMERGENCY CONTACT INFORMATION UP TO DATE. IF I SHOULD BECOME ILL OR INJURED AT SCHOOL I NEED TO BE ABLE TO CONTACT YOU.