REGISTRATIONS ARE BY APPOINTMENT ONLY AT THIS TIME BY CALLING 732-505-2600. Once you have an appointment scheduled, please bring this completed packet along with photo I.D. of the registering parent, the ORIGINAL BIRTH CERTIFICATE, proofs of residency, immunizations and physical. Transfer paperwork should be obtained from the previous school, including IEPs, 504 plans, health records and any other pertinent information regarding your student's academic records.

1. RESIDENCY - **If you own or rent** a home within Toms River Township, Beachwood Borough, South Toms River Borough or Pine Beach Borough you will need to complete only the RESIDENCY CHECKLIST and provide those proofs detailed on that form. Seaside Park Borough tax paying students register with Toms River Schools *from grades K through 6 only*.

If you reside with someone who owns or rents a home within those same areas, the person who owns or rents the home must complete the Residency Checklist and provide their proofs as designated on the form. Additionally, that person must also complete the Affidavit for Admission of a Domiciled Student form. The parent or legal guardian must provide two proofs of residency as detailed on the Affidavit form. The form must be signed by both parties (resident and parent/guardian) before a notary!

2. REGISTRATION FORM – List only the first natural parent (or a **legal** guardian) the student resides with that you would like contacted for all issues and any other applicable phone #s for that parent only. The second parent/**legal** stepparent/guardian *that resides in the same home with the student* will be listed in the Additional Contacts section below the first parent's information. If divorced or separated, the parent residing in a different home would be listed in the section regarding custody information.

3. HEALTH QUESTIONNAIRE – Must be completed by the parent regarding the student's general health.

4. PARENT PORTAL FORM – Allows access to your child's records online (Attendance, Progress Report, Gradebook, Report Card, etc.) If you already have students in the district, please check the box at the top of the form and list every student that is enrolled in the district, including the newly registering student.

5. AUTHORIZATION FOR RELEASE OF RECORDS – Allows us to formally request your child's records from the previous school. Please provide the school that your child last attended prior to coming to our district, including the phone and fax numbers.

6. **LANGUAGE SURVEY – MUST BE COMPLETED FOR ALL STUDENTS!** *(even if English is the primary language).*
Visit this link for the survey translated into twenty languages:
https://www.trschools.com/registration/home-language-surveys

7. PHYSICAL & IMMUNIZATIONS FORM – To be completed by your child's doctor and the physical must be dated within one year of the first day of each new school year. *PLEASE NOTE:* All health records are subject to the school nurse's review. If the nurse finds incomplete or inaccurate health records and/or a health issue that prevents the safe entry of the student, she may exclude the child from starting until the health requirements are met.

TOMS RIVER REGIONAL SCHOOL DISTRICT

CENTRAL REGISTRATION OFFICE at the High School North Campus

1245 Old Freehold Road, Toms River, N.J. 08753
Telephone: 732-505-2600 Email: centralregistration@trschools.com

Michael Citta
Superintendent of Schools

John H. Green
District Supervisor of Student Services

APPLICATION FOR REGISTRATION – PROOF OF RESIDENCY CHECKLIST

This document is required for all student registrations and address changes. This checklist provides a list of required documents accepted by the School District as proof of residency.

I, _____, am providing the attached **four (4) documents** as detailed below for
(Resident name – please print)

verification of my residency in the communities of Beachwood, Pine Beach, South Toms River or Toms River, New Jersey.

ONE (1) DOCUMENT from the items listed here:

- ☐ Property Tax Bill
- ☐ Deed
- ☐ Mortgage
- ☐ Contract of Sale or Settlement Statement
- ☐ Lease signed by Landlord
- ☐ Other evidence of property ownership, tenancy or residency (subject to approval)

AND THREE (3) DOCUMENTS from the items listed below, **two (2)** of which must have been **issued within the past 45 days**:

- ☐ Utility Bills w/service address
- ☐ Financial Account Information
- ☐ Licenses
- ☐ Benefits Statement
- ☐ State Agency/Court Orders
- ☐ Other monthly billing
- ☐ Employment Documents
- ☐ Unemployment Documents
- ☐ Car Insurance Billing
- ☐ Delivery Receipts
- ☐ Documents pertaining to military status & assignment
- ☐ Other evidence of established residency _____ **(Subject to approval)**
- ☐ Permits
- ☐ Medical Billing
- ☐ Vehicle Registration
- ☐ Voter's Registration

- Questionable residency documentation may require a residency investigation and/or determination of ineligibility to attend.
- **Transfer forms from the previous district are required to schedule students who are moving from another district. Additionally, parents must provide proof of the child's age with the ORIGINAL BIRTH CERTIFICATE (with a raised seal), up to date health records and a photo I.D. (i.e. Driver License) of the registering parent or legal guardian.**
- It is the parent's responsibility to provide Settlement Agreements and/or Court Orders regarding parental rights/limitations due to divorce or separation. I have attached documentation to this form that has been signed by a Judge regarding unique circumstances concerning the legal guardianship/custody of my child. Please check the appropriate box: ☐Yes ☐No
- ***I am aware that I am guilty of a Disorderly Persons Offense according to N.J.A.C. 6A:22, specifically N.J.S.A. 18A:38-1(c), if I fraudulently allow my student to be registered to this address for school admission purposes, which is punishable under the New Jersey Criminal Code.***

Resident Signature: _____ Date: _____

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Michael Citta
Superintendent of Schools

John H. Green
District Supervisor of Student Services, H.S. Level

APPLICATION FOR REGISTRATION - ADMISSION OF DOMICILED STUDENT

This **additional** document is required **with the Proof of Residency Checklist** for all student registrations and address changes **only when an entire family will be residing with a town resident**. This additional checklist provides a list of required documents accepted by the School District as proof of residency.

Resident Name (please print): _____

This notarized document serves as notification to the Toms River Regional Board of Education that:

_____

(List all domiciled family members living with resident – please print)

reside in my home located at: _____

(Address of resident)

Resident family must provide **four (4) proofs of residency as per the Proof of Residency Checklist**. The Proof of Residency Checklist must be submitted with this form and include all supporting documentation.

Domicile family must provide **one (1) document from Group A and one (1) document from Group B below** to verify domicile status (proof of residency) with the Resident family, one of which must have been issued within the past 45 days.

Group A:

- ☐ Bank Statement
- ☐ Pay Stub
- ☐ Benefits Statement
- ☐ Counselor/Social Worker Assessments/Court Order
- ☐ Other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency: _____

Group B:

- ☐ Driver's License
- ☐ Medical Billing
- ☐ Car Insurance Billing
- ☐ Other monthly billing

It is necessary for the parent/legal guardian of the student to attest that the permanent address of the parent/legal guardian is within the boundaries of the Toms River Regional School District. Should the information provided prove false, financial responsibility to the Toms River Board of Education for tuition at the current rate for all days found ineligible shall be assessed. Investigation and random visits by District Attendance Officers should be expected. **Please be advised** that in addition to the Department of Education Regulations N.J.A.C. 6A:22 prohibiting such conduct, New Jersey State Law, specifically N.J.S.A. 18A:38-1(c), provides that any person who fraudulently allows a child or another person to use his/her residence for school admission purposes is guilty of a Disorderly Persons Offense punishable under the New Jersey Criminal Code.

Resident Signature: _____ Phone: _____ Date: _____

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Sworn to before me this _____ day of _____, 20 _____.

_____ (Notary Signature/Seal)

TOMS RIVER REGIONAL SCHOOLS
STUDENT REGISTRATION FORM

Anticipated start date for student _____

Student Name (*as listed on Birth Certificate* – First, Middle, Last) _____ Gender Male ☐ Female ☐

Date of Birth _____ Birth City, State & Country _____ _____

Race (must check all that apply): ☐White ☐Black/African American ☐Asian ☐Hawaiian/Pacific Islander ☐American Indian/Alaskan

Ethnicity: (must check one): ☐Hispanic or Latino ☐ Non-Hispanic or Latino

What language is primarily spoken at home? _____

Who does student currently live with (check one) ☐Both Parents ☐Mother ☐Father ☐Legal Guardian

Contact information for 1st primary parent/guardian student currently lives with:

Parent _____ Relationship to student _____

Address _____ City, State, Zip _____

Automated Call system phone # _____ (this # will be used for all School Closings, Attendance Calls &/or Immediate School issues)

Other contact #s for this person: Cell _____ Work _____ Home _____
Parent Portal Email address: _____

Additional contact #s for this household (other parent/legal guardian or stepparent only): Name _____

Relation to student _____ *Cell* _____ *Work* _____ *Home* _____

Are there any custody issues? ☐No ☐Yes If yes, do you have legal custody with supporting documents? ☐No ☐Yes

Is there a need for Restricted Release? (court documents must be provided) ☐No ☐Yes

Is there a need for Dual Notification of the other parent? ☐No ☐Yes *If yes*, please provide the following information:

Do you wish this parent to be contacted if Custodial Parent cannot be reached? ☐No ☐Yes *AND/OR*

Do you need copies of progress reports and report cards sent to this parent? ☐No ☐Yes *If yes*, complete the following:

Contact Name _____ Relationship to student _____

Contact Address _____ Phone # _____

Has child had (Check all that apply): ☐Child Study Team evaluation/IEP? ☐Speech? ☐Gifted & Talented?

☐ESL? ☐Basic Skills? ☐504 Plan? ☐Free/Reduced Lunch?

Last school attended _____ City, State _____ Grade _____

Has student ever been previously enrolled in or attended Toms River Regional Schools? ☐No ☐Yes

List other siblings *in the home* who attend Toms River Regional Schools below (please use other side to list additional siblings):

Name _____ School attending _____ Grade _____

Name _____ School attending _____ Grade _____

Name _____ School attending _____ Grade _____

Name _____ School attending _____ Grade _____

Parent/Guardian Signature: _____

Central Registration Office Use Only!

School to Attend: ☐BCH ☐CG ☐JAC ☐ED ☐HAE ☐ND ☐PB ☐SB ☐STRE ☐WAL ☐WAS ☐WD ☐IE ☐IN ☐IS ☐HSE ☐HSN ☐HSS

Session: ☐KA ☐KP ☐KG

Home School, if different: _____

ENROLLMENT UNDER MCKINNEY VENTO ☐ *Yes* ☐ *No*

☐ Babysitter Trans fom Letter Request/Approval Enclosed: ☐ Yes ☐ No

Grad Year: _____

Grade Level: _____

Entry Code: _____ Previous District: _____ Enroll Date: _____

Student ID# _____ SID# _____ Family Code: _____

Registration Date: _____ Registrar: _____

Toms River Regional Schools
Genesis Parent/Guardian Student Access Security Form

Please complete the following form to receive a login and password to access the Genesis Parent Portal. **A photo ID is required.** PLEASE NOTE: Blended families may only receive access to those students for whom they are parent/guardian. You will receive an email with the necessary login information when your ID has been assigned.

☐ **Check here if you already have a Parent Portal for other students in the district.**

Parent/Guardian Information: *(Please Print all info)*	
Parent/Guardian (Last name, First name):	Daytime phone to reach you:
Email address: **PLEASE PRINT LEGIBLY!** @	Parent/Guardian Signature: X_____

Student Information: *(No nicknames, please!)*		
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:
Student (Last name, First name):	School to Attend & Grade Level:	Birthdate:

District/School Use Only:	
Type of Photo ID presented:	Parent/Guardian authorized to access students? Yes No
Principal (or designee) Signature:	Date: ___/___/___
Date Account Created: ___/___/___	Date Notification Emailed to Parent: ___/___/___
Notes:	

Toms River Regional Schools

AUTHORIZATION FOR RELEASE OF CUMULATIVE RECORDS

In accordance with the "Family Educational Rights and Privacy Act of 1974" (PL 93-380), I authorize the release of my child's records from your school. Such request for disclosure is for the purpose of enrollment and shall include the following:

Cumulative Records To Include:	*Confidential Records to Include:*
- Scholastic Records *- Standardized Test Scores* *- Immunizations and Health Records* *- Grades averaged from date of latest report card to date of withdrawal from your school*	*- All Special Education components which include psychological, sociological, educational, and medical/audiovisual evaluations.* *- Up-to-date individualized educational program (IEP) with handicapping condition specified.*

Name of Student: _____

Grade Enrolling Into: _____

From: List information of **last** school attended:

Name of School: _____

Address: _____

_____

_____

School Phone #: _____

School Fax #: _____

_____ _____

Signature of Parent/Guardian Date

For office use only: ***THIS FORM IS NOT VALID IF NOT SENT FROM TRSCHOOLS!***

The above student has been enrolled with the Toms River Regional Schools.

Please forward original school records to:

For District use only:_____**School Year**	
District ID #:_____Home School:_____	Former District:_____
Grade level:_____	_____**emailed/faxed to Sara McNerny** _____**File copy only**

Toms River Regional Schools

English Language Learner (ELL) Identification Process for Grades K-12

Home Language Survey Form

For translated forms visit (https://www.trschools.com/registration/home-language-surveys)

Introduction

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Information

Student name: _____ Student birth date:_____

Street Address:_____

City:_____ State: ____ Zip Code:_____ Phone number:_____

Survey Questions *(Circle your response)*

Question 1: List all languages used in the student's home and go to #2.

Question 2: Was the first language used by the student a language other than English?

- No (Go to #3)
- Yes (Go to #3)

Question 3: Does the student speak or understand a language other than English?

- No (Go to **Result C**)
- Yes (Go to #4)

Question 4

When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English most of the time?

- No (Go to #5)
- Yes (Go to #5)

Question 5
When interacting with others outside of the home (example: friends, caregivers), does the student understand or use a language other than English most of the time?

- No (Go to **Result A**)
- Yes (Go to **Result B**)

District USE ONLY:

Did they answer "yes" to either Question #4 or #5?

- No (Go to **Result C**)
- Yes (Go to **Result B**)

Result B:
The student is a *possible* ELL. Reviewer should proceed to Step 2 of the Identification Process: Conduct Records Review Process.

Result C:
The student is *not* an ELL. Reviewer should not proceed to Step 2: Identification Process is complete.

Notes:

ESL Signature:_____

TOMS RIVER REGIONAL SCHOOLS

Health Office-New Entrance Questionnaire

Student Name:_____ DOB:_____ Date_____

Birthplace:_____ Age:_____ Sex:_____ Grade:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN ANY "YES" ANSWERS IN THE SPACES PROVIDED

****

MEDICATIONS: Taken Daily? ▫ **YES** ▫ **NO** **If YES**, List names and doses:_____

_____

Medication required during school hours? ▫ **YES** ▫ **NO** **If YES**, Please see Nurse for instructions

****

ALLERGIES: Life threatening? ▫ **YES** ▫ **NO** Medication Required? ▫ **YES** ▫ **NO**

If YES, Please see Nurse for Instructions

Medication type: ▫ **EpiPen** ▫ **Benadryl** ▫ **Other**_____

ALLERGY TYPE: ▫ **Insect Sting/Bite** ▫ **Food** ▫ **Medication** ▫ **Seasonal** ▫ **Other**

Specify Allergy Name/Type of reaction: _____/_____

_____/_____

_____/_____

_____/_____

ASTHMA: ▫ **YES** ▫ **NO** ▫ **SEASONAL** ▫ **WEATHER RELATED** ▫ **ILLNESS RELATED**

Known triggers: _____

Frequency of attacks (estimated):

▫ **REGULARLY (1-2x a week)** ▫ **Occasionally (1-2x a month)** ▫ **RARELY (1-2x a year)**

Current Daily Asthma Medications:_____

**See Nurse if Medication will be required to be kept in school*

HEART DISEASE: ▫ **YES** ▫ **NO** **Heart Murmur:** ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition: _____

PLEASE NOTE: *Child will not be permitted to participate in Gym, Health or Recess without a Cardiac Clearance Note from Physician. See Nurse for further instructions.*

DIABETES: ▫ **YES** ▫ **NO** **If YES,** *We will discuss and formulate a care plan for the school year.*

SEIZURE DISORDER: ▫ **YES** ▫ **NO** **FEBRILE EPISODES** ▫ **OTHER** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify _____

If YES, *We will discuss and formulate a care plan for the school year.*

Medications / Limitations: _____

Date of Last Seizure: _____ Type: _____

Other Neurological Disorder: ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition:_____

KIDNEY DISEASE: ▫ **YES** ▫ **NO** Specify type of condition:_____

LYME Disease: ▫ **YES** ▫ **NO** **If YES, Diagnosis Date**_____

Medications / Limitations_____/_____

HEALTH OFFICE NEW ENTRANT QUESTIONNAIRE: Continued

EYES: ▫ GLASSES ▫ CONTACTS ▫ BOTH ▫ ALL THE TIME ▫ AS NEEDED

Disorder (Specify): _____ Last eye exam_____

NOSE: ▫ NOSE BLEEDS ▫ NASAL DISCHARGE ▫ SINUS INFECTIONS ▫ FREQUENT ▫ OCCASIONAL

EARS: HEARING DIFFICULTIES ▫ YES ▫ NO *If YES:* HEARING AID ▫ YES ▫ NO

AUDITORY PROCESSING DISORDER ▫ YES ▫ NO

FREQUENT EAR INFECTIONS ▫ YES ▫ NO If YES, how many and what age(s)?_____

MOUTH / THROAT: ▫ DENTAL CAVITIES ▫ FREQUENT STREP INFECTIONS ▫ ENLARGED TONSILS

Other concerns_____

History of any of the following (check all that apply, give dates and explain below):

▫ HEAD INJURIES ▫ BROKEN BONES ▫ HOSPITALIZATIONS ▫ SURGERIES

_____/_____

_____/_____

****

Please check any of the following *diagnosed or under evaluation by a physician*, and provide supporting medical documentation.

▫ AUTISM / ASD / Asperger's Syndrome ▫ ADD / ADHD ▫ Anxiety Disorder / OCD

▫ Disruptive Behavioral Disorder ▫ Dissociative Disorder

▫ BEHAVIORAL / EMOTIONAL DISORDER ▫ Pervasive Developmental Disorder

▫ MOOD DISORDER

LEARNING DISORDER: ▫ *Dyslexia* ▫ *Dyscalculia* ▫ *Dysgraphia* ▫ *Oral / Written Language Disorder* ▫

Non-Verbal Learning Disabilities ▫ *Dyspraxia* ▫ *Executive Function* ▫ *Apraxia* ▫ *Speech Disorder*

Other Learning Disorder:_____

****

Please list any other disabilities, limitations or health concerns not already addressed or check ▫ N/A:

_____

_____

****

PREVIOUS SCHOOL ATTENDED- Name_____

Address_____

Phone____(_____)_____-_____ Last Date Attended:_____

Parent Signature:_____ Date:_____

Does this child have any health insurance, including NJ Family Care / Medicaid, Medicare, private or other?

▫ YES Name of Insurance Company_____ ▫ NO,

but you may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature:_____Printed Name:_____Date:_____

Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34 C.F.R. 99.30 (b)

*NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

Revised 5/2020

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.

TOMS RIVER REGIONAL SCHOOLS

1144 Hooper Avenue, Toms River, NJ 08753
732-505-5000

IMMUNIZATION REQUIREMENTS

Dear Parent/Guardian:

At the time of registration, please submit proof of the following information to the Health Office.

1. Physical Examination Record: A physical must be provided to your child's school prior to starting school. You are encouraged to go to your "medical home" (private MD) to complete the physical.
2. Immunization Record consisting of dates of Primary Series and booster doses. N.J.S.S.C. Chapter 14 requires that immunizations must be complete and up-to-date, otherwise, the student may be excluded from school.

DPT: Diphtheria and Tetanus Toxoids and Pertussis (DTP) Vaccine
- a. FOUR (4) doses for children less than 7 years of age. One does must have been administered on or after the fourth birthday....Or any 5 doses.
- b. THREE (3) doses for children 7 years of age or older.
- c. Tdap: Required on all sixth grade students born on or after January 1, 1997, effective September 1, 2008.

Polio Virus Vaccine
- a. THREE (3) doses for those children less than 7 years of age. OPV or enhanced IPV is required provided at least one dose is given on or after the fourth birthday... or any doses.
- b. THREE (3) doses for children 7-17 years, OPV or IPV will satisfy the polio vaccine requirement.

Measles Vaccine
- a. TWO (2) doses of a measles-containing vaccine given on or after the first birthday. (Preschool requires a minimum of one (1) dose.

Rubella Vaccine: Mumps Vaccine
- a. ONE (1) dose rubella and mumps vaccine administered on or after the first birthday

Hepatitis B Vaccine – Kindergarten through Grade 12
- a. Appropriate 2 or 3 dose Hepatitis Vaccine, or laboratory evidence of immunity

Varicella (Chicken Pox) Vaccine
- a. ONE (1) dose after the first birthday is required starting September 2004 for all pre-school, kindergarten and grade one students...OR...
- b. Statement of past history of chicken pox or laboratory evidence of immunity is required for all students born after January 1, 1998.

Meningococcal Vaccine
- a. ONE (1) dose required on all sixth grade students born on or after January 1, 1997, effective September 1, 2008.

PRE-SCHOOL ONLY

Haemophilus Influenzae B (HIB) – ONE (1) dose required after first (1st) birthday
Pneumococcal – Minimum ONE (1) dose after first (1st) birthday
Flu (Influenza) Vaccine – ONE (1) dose annually between September 1 and December 31
- a. Mantoux Tuberculine Test: Required ONLY on those students entering the Toms River Regional School System coming directly from a high TB incidence country, according to the most current NJ State guideline.

Students entering this district are REQUIRED to provide appropriate immunization records prior to entry.