# Public Schools of Edison Township

ENROLLMENT CENTER
312 PIERSON AVENUE * EDISON, NEW JERSEY 08837
TELEPHONE (732) 452-4570 FAX (732) 452-4576

**Bernard F. Bragen, Jr., Ed.D.**
Superintendent of Schools

**Richard Benedict**
Manager of Enrollment/ Data Systems/
District Homeless Liaison/ Stability Liaison

Hello,

Welcome to the Edison Township Public School District. Please read through the Enrollment Packet carefully and remember, if you have any questions, please reach out via email at: enrollment.questions@edison.k12.nj.us or call 732-452-4570. You may call the office between the hours of 8:00AM – 4:00PM, Monday through Friday.

**Instructions for completing Health Forms within the Enrollment Packet**
If your child is in grades K-5, please complete Health Form #16 (2 pages)
If your child is in grades 6-12, please complete Health Form #14A (4 pages)

*Note: Both the Parent and Physician must complete the Health forms.*

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STUDENT ENROLLMENT FORM

*Enrolled by:* ______ *Date:* ____/____/____ *OFFICE USE ONLY* (Rev. 2/17) *Input By:* ______ *Date:* ____/___/_____

**NEW ENROLLMENT:** YES | NO **RE-ENROLLMENT:** YES | NO **CHANGE OF ADDRESS:** YES | NO

SSID# ______________ LOCAL ID# ______________ PCC CODE ____________ FAMILY CODE __________

Affidavit of Residency: _____ Affidavit of Domicile: _____ Change of Custody: _____ Homeless: _____

Edison School: ____________ Grade: _______ Previous School: ____________________ Grade: ______

Previous School Address ________________________________________ School Records Submitted: YES | NO

**Custody Document Submitted: YES** ____ **NO** ____ **Basic Skills:** ____ Speech: ____ **ESL:** ____

**SPECIAL EDUCATION:** YES | NO [**IEP Submitted:** YES | NO] **Copy sent to Special Services:** YES ___ NO ___

_______ **Does Qualify under McKinney-Vento Act** _____ **Does NOT Qualify under McKinney-Vento Act**

**Student Information (PLEASE PRINT CLEARLY)**

First Name ______________________________ Last Name ______________________________

Middle Name ______________________________ Birthdate: _____/_____/______ Gender: Male | Female
MM DD YYYY (Circle one)

**Ethnicity** ☐ Hispanic ☐ Non-Hispanic

**Race**
☐ White
☐ Black
☐ American Indian / Alaskan
☐ Asian
☐ Hawaiian native/other Pacific Islander

Birth City: ________________________

Birth State: ________________________

Birth Country: ________________________

If born outside of the U.S., ____________________________________________ (Country of Origin)

Original Entry in U.S.: _____/_____/_______ First Entry in U.S. School: _____/_____/_______
MM DD YYYY MM DD YYYY

Student's Primary Language: ____________________ Home Language: ________________________

Which language did your child learn first? ______________________________________

In which language do you prefer to receive information from the school? ____________________

**SPECIAL EDUCATION:** YES | NO [**IEP Submitted:** YES | NO] **Basic Skills:** ____ Speech: ____ **ESL:** ____

**Current Legal Home Address in Edison**________________________________________________Apt #: _______
Street Address /City/ Zip Code

Home Phone Number (_____) ______ - __________ Email: ______________________________

Mother/ Guardian 1 Mobile: (_____) ______ - __________ Father/Guardian 2 Mobile: (_____) ______ - __________

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Previous Legal Address: ________________________________________ Apt #: ______
Street Address /City/ Zip Code

CHECK HERE IF CURRENT ADDRESS IS THE SAME AS THE STUDENT ADDRESS: ____

*Note: If the parents are divorced or separated, or someone other than the parents has legal custody of the child, you are required to submit legal proof of residential custody.*

**Parent/Legal Guardian Information (PLEASE PRINT CLEARLY)**

**Mother/Legal Guardian 1 Name** ______________________ **Relation to Student:** __________

________________________________________ Apt #: ____________
Street Address / Zip Code

Home Phone Number (____) _____ - ________ Mobile (____) _____ - ________

Work Phone (_____) _____ - _________ Email: ____________________

Language Spoken: ______________ This parent/legal guardian has residential custody: ___ YES ___ NO

**Father/Legal Guardian 2 Name** ______________________ **Relation to Student:** __________

________________________________________ Apt #: ____________
Street Address / Zip Code

Home Phone Number (____) _____ - ________ Mobile (____) _____ - ________

Work Phone: (_____) _____ - ______________ Email: ____________________

Language Spoken: ______________ This parent/legal guardian has residential custody: ___ YES ___ NO

**Emergency Contact (NOT parent/legal guardian)**

Name ______________________ Name ______________________

Relation to Student ________________ Relation to Student ________________

Phone Number (___) _____ - ________ Phone Number (___) _____ - ________

PLEASE LIST ANY CHILD RESIDING AT THIS ADDRESS ELIGIBLE TO ATTEND SCHOOL

| NAME | GENDER | BIRTHDATE | CURRENT SCHOOL | GRADE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*I/we fully understand that the Edison School District retains the full right to verify any information contained in this application at any time during the period for which enrollment is pending or after enrollment has actually taken place. If at any time the pupil registered no longer qualifies as an Edison pupil, I/we shall forthwith advise the office of the Superintendent of Schools, 312 Pierson Avenue, Edison, NJ 08837. I/we fully understand that failure to do so shall hold me/us legally responsible for all tuition costs, legal costs, and any other expenses incurred by the Edison School District during that period of time for which the pupil was not so qualified for enrollment. I/we understand that no documents or pupil records, awards, or diplomas shall be issued to the pupil or to his parent/guardian or be forwarded to any other school district or school until such costs have been settled with the Edison School District. I/we swear that the information contained herein is true. Any false information concerning residency shall be penalized according to N.J. Statute 18A:38-1.*

______________________________ ______________
Parent/Legal Guardian Signature Date

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PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

## REGISTRATION HEALTH HISTORY

**Student's Name:**____________________________ **Date of Birth:**__________

**School:**__________________________________ **Grade:**__________

## IMMUNIZATION RECORD

Immunization Document Received Date ____________________

Requested from parents/guardian Date ____________________

---

**CHILDHOOD ILLNESSES, INJURIES, OPERATIONS, ORTHOPEDIC CONDITIONS: Please give age of child when illness, injury, occurred explain:**

Asthma ______________
Chicken Pox ______________
Diabetes ______________
Heart Condition ____________
Kidney/Bladder Condition ______
Strep Infection _____________

Measles__________
Mononucleosis____________
Ear Infections______________
Pneumonia/Bronchitis________
Rheumatic Fever____________
Seizure(s) _________________

**Other**

Any known speech/hearing problem: ______________________________________
Any known Visual Problem: __________________________________________
Allergies or Eczema: __________________________________________
Behavioral Difficulties: __________________________________________
Gastrointestinal Problem: __________________________________________
Toileting Difficulties: __________________________________________
Neurological Disorders: __________________________________________
Muscle or Bone Problems: __________________________________________
Other Medical Conditions: __________________________________________
Previous Injuries/Accident: __________________________________________
Sleeping Problems: __________________________________________
Significant or Frequent Illness: __________________________________________
Surgery: __________________________________________
Breathing Difficulties: __________________________________________
Nutritional/Eating Problems: __________________________________________
Other difficulties: __________________________________________

Has the child ever had prolonged use of medication, or is any medication or therapy being given at this time? If so, please explain:________________________________________________________

________________________________________________________________

(over)

Physical Limitations:

______________________________________________________________

______________________________________________________________

Has your child ever been confined to a hospital? If so, please explain:

______________________________________________________________

______________________________________________________________

Has your child ever been advised not to participate in a sport or to reduce activity?
If so, please explain:

______________________________________________________________

______________________________________________________________

Has your child had a loss of, or serious impairment of a paired organ such as a kidney, eye, lung, etc. If so, please explain:

______________________________________________________________

______________________________________________________________

List additional health information.

______________________________________________________________

______________________________________________________________

I/we give permission for the nurse to share any health-related information with principal, guidance counselors & teachers on a "need to know" basis for as long as my child is a student in Edison Public Schools.

My child is covered by health insurance ___ yes ___ no

My child receives his/her health care at: ________________________________
Name of health care provider or clinic

________________________ ________________________
Signature of Parent/Guardian Date

8/96, 5/98,6/99,3/03,1/05

OFFICE USE ONLY:
GE: ___ SE: ___

# Public Schools of Edison Township

312 PIERSON AVENUE * EDISON, NEW JERSEY 08837
TELEPHONE (732) 452-4948 FAX (732) 452-4992

ID#:

## SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI) PARENTAL CONSENT FORM

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: ______________________________ (please print)

Child's Date of Birth: ______/________/________

Parent/ Guardian: ______________________________________________

Date: _____/_____/_____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

PCG SEMI Notice – Rev. 11/13

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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO Box 712
TRENTON, NJ 08625-0712

CHRIS CHRISTIE
*Governor*

KIM GUADAGNO
*Lt. Governor*

JENNIFER VELEZ
*Commissioner*

VALERIE HARR
*Director*

August 25, 2014

Dear Parent/Caregiver:

The purpose of this letter is to let you know about the **Special Education Medicaid Initiative (SEMI)** program. Your child may be receiving special education services in school such as speech therapy, occupational therapy or physical therapy under SEMI.

Here are three things you should know about SEMI:

1. Your school district may be eligible to receive federal money through the SEMI program which helps to pay for special education services.
2. A school district may receive SEMI money only if a consent form is signed by the parent.
3. Signing the consent form will have no effect on your child's Medicaid health coverage for services outside of school.

If you do not sign the consent form, it will <u>not</u> affect the services your child receives in school since the district is required to provide a free and appropriate public education, including all services listed in your child's Individualized Education Plan (IEP).

The SEMI program is an important source of funding for the school districts. We appreciate your assistance in this program and hope that you will consider the importance of signing the parent consent form and submitting it to your district.

Please feel free to contact your district's special education department if you have any questions.

Sincerely,

Valerie Harr
Director

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Superintendent of Schools

Richard Benedict
Manager of Enrollment/Data Systems/
District Homeless Liaison/Stability Liaison

## PARENT/GUARDIAN CONSENT FOR RELEASE OF RECORDS

NAME OF PREVIOUS SCHOOL ______________________________

ADDRESS ______________________________

______________________________

NAME OF STUDENT ______________________________

GRADE ______________ DATE OF BIRTH ______________

The above student has enrolled in the Edison Township Public School System. Please send a transcript of his/her past and current grades (report card), health records, standardized test scores, special services records and any other pertinent information concerning this student.

Thank you.

______________________________ ______________
Signature of Parent/Guardian Date

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**Please send records to:** (name and address of new Edison school)

______________________________

______________________________

______________________________

RB/ka

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## FRAUDULENT STATEMENTS

_______ Any false statements, answers, or declarations provided during the enrollment process may be subject to criminal prosecution for the crime of false swearing in violation N.J.S.A. 2C:28-2. If convicted of such crime, you may be punished by a fine of up to $10,000.00 and/or be imprisoned for up to eighteen (18) months.

_______ Pursuant to N.J.S.A. 18:A:38-1 if you fraudulently allow a student to use your residence and you are not the primary financial supporter of the student, you will have committed a disorderly persons offense. If you are convicted of such offense, you may be fined up to $1,000.00 and/or be imprisoned for up to six (6) months.

**The Edison Township Board of Education will prosecute to the fullest extent of the law.**

_______________________________ _______________________
Signature of Parent/Guardian Date

RB/ml
12/9/19

# Public Schools of Edison Township

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REMINDER:

If your child is in grades **K-5**, please complete **Health Form #16 (2 pages)**

If your child is in grades **6-12**, please complete **Health Form #14A (4 pages)**

*Note: Both the Parent and Physician must complete the Health forms.*

**PUBLIC SCHOOLS OF EDISON TOWNSHIP**
**EDISON, NEW JERSEY 08837**
**HEALTH SERVICES**

**HS FORM #16**

**HEALTH CARE PROVIDER EXAMINATION (Grades Pre K-12, Excluding Sports or Intramurals)**
**RETURN TO THE SCHOOL NURSE**

**N.J.A.C. 6A:16-2.2 requires all medical examinations must be done by the student's family physician or clinic where the student receives his/her healthcare.**
**If you do not have a family physician or clinic who provides medical care for your child, please contact the school nurse for a school physician exam request form.**

Student: ______________ Grade: ________ School: ______________

Male/Female (circle one) Date of Birth: ______________

IMMUNIZATIONS ADMINISTERED LABORATORY TESTS DONE

______________ ______________

______________ T.B. Mantoux Test: (date) ______________ Result ________ mm.

RECORD OF PHYSICAL EXAMINATION: Hearing R: ______ L ______

Height: ______ Weight: ______ BMI Percentile: ______ Blood Pressure: ______ Pulse: ______

Vision R: ______ L ______ Vision correction (glasses/contacts): ______________
Hearing/Ears (tubes/hearing aides): ______________
Skin and scalp: ______________ Abdomen: ______________
Rashes ______ Jaundice ______ Infection ______ Hepatomegaly ______ Splenomegaly ______ Mass ______
Head and neck: ______________ Lymph nodes: ______________
Nose and throat: ______________ Teeth: ______________
Extremities: ______________ Inguinal area (hernia): ______________
Mobility ______ Deformity ______ Joint Instability ______
Lungs: ______________ Spine (scoliosis,etc.): ______________
Neurological: ______ Reflexes Balance Coordination
Females: Normal Menstruation Males: Hernia: Testes Descended
Heart (any irregularity? If yes, please explain): Murmurs ______ Rhythm/Rate ______
Injuries, operations? Explain: ______________
Chronic Illness Condition or Disease:
______________
Orthopedic defects: Yes ______ No ______ Accommodations necessary? ______________
Mobility ______________ Instability ______________ Deformity ______________
Medications being taken by the student? No ______ Yes ______ If yes, please list: ______________

*****************************************************************************************************************************

Assessment of Physiologic Maturation:

______________

General condition of student:

______________

Are there any health findings which might have an effect on the educational management of the student? If yes, please explain:

______________

In your opinion, is the student capable of carrying a full program in physical education, and field trips?

Yes ____ No ___. Explain:

______________

Restrictions of Activity Recommended: ______________

Name of Healthcare Provider (please print) Signature of Healthcare Provider Telephone Number

Address Date of Exam

Revised:12/03, 4/04, 8108, 9/10
file:NHSM Form 16

(over)

HS FORM 16

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08337

## HEALTH HISTORY
## (TO BE COMPLETED BY PARENT OR GUARDIAN)

**Student's Name:**________________________ **Grade/Section:** ________ **School:** ____________

| | | | |
|---|---|---|---|
| 1. | Has student ever been hospitalized or had surgery? | Y | N |
| 1a | Significant illness or injury in past year or less? (sprain, mononucieosis,etc.) | Y | N |
| 2. | Is student presently taking any medication? (daily or occasionally) | Y | N |
| 3. | Does student have any **severe allergies** to (medicines, foods, or insects)? | Y | N |
| 3a. | Does student have an Epi-Pen for severe allergic reaction? | Y | N |
| 4. | Has student ever passed out during or after exercise ? | Y | N |
| | Has student ever been dizzy during exercise? | Y | N |
| | Has student ever had chest pain during or after exercise? | Y | N |
| | Has student ever had high blood pressure? | Y | N |
| | Has student ever been told you had a heart murmur? | Y | N |
| | Has student ever had racing of your heart or skipped beats? | Y | N |
| | Has anyone in your family died of heart problems or sudden death before the age of 50? | Y | N |
| | | Y | N |
| 5. | Does student have any skin problems under treatment (itching, rashes, acne)? | Y | N |
| 6. | Has student ever had a head injury or concussion? | Y | N |
| 7. | Has student ever been dizzy or passed out in the heat? | Y | N |
| 8 | Does student have any problems with hearing loss? | Y | N |
| 9 | Does student have trouble breathing during or after exercise? | Y | N |
| 9a. | Does student have asthma? | Y | N |
| 9b. | Does student use asthma inhaler(s)? | Y | N |
| 10. | Has student had any problems with eyes or vision? | Y | N |
| 10a. | Does student wear contact lenses or glasses during sports? | Y | N |
| 11. | Does student have any medical conditions (diabetes, seizure disorder, severe headaches, etc.) | Y | N |
| 12. | Has student ever fractured or dislocated any of the following?<br>Skull Neck Shoulder Arm Elbow Wrist Hand Thigh Leg Knee Ankle Foot | Y | N |
| 13. | Does student wear orthodontic braces or retainer? | | |
| 14. | Explain any YES answers (include dates): ________________________________ | | |

________________________________________________________________

________________________________________________________________

________________________________________________________________

**Signature of Parent/Guardian:** ________________________________ DATE:____________

Revised:12/03,4/04, 8/08
file: NHSM Form 16

ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

# PREPARTICIPATION PHYSICAL EVALUATION
# HISTORY FORM

HS Form# 14-A



*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)*

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ________ Age ________ Grade ________ School ____________________ Sport(s) ____________________

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____________________

____________________

____________________

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ________ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ________ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ________

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HE0503

9-2681/0410

*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# PREPARTICIPATION PHYSICAL EVALUATION
# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

| |
|---|
| 1. Type of disability |
| 2. Date of disability |
| 3. Classification (if available) |
| 4. Cause of disability (birth, disease, accident/trauma, other) |
| 5. List the sports you are interested in playing |

| | Yes | No |
|---|---|---|
| 6. Do you regularly use a brace, assistive device, or prosthetic? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | | |
| 9. Do you have a hearing loss? Do you use a hearing aid? | | |
| 10. Do you have a visual impairment? | | |
| 11. Do you use any special devices for bowel or bladder function? | | |
| 12. Do you have burning or discomfort when urinating? | | |
| 13. Have you had autonomic dysreflexia? | | |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | | |
| 15. Do you have muscle spasticity? | | |
| 16. Do you have frequent seizures that cannot be controlled by medication? | | |

**Explain "yes" answers here**

____________________

____________________

____________________

____________________

____________________

**Please indicate if you have ever had any of the following.**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

**Explain "yes" answers here**

____________________

____________________

____________________

____________________

____________________

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ______

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*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

# PREPARTICIPATION PHYSICAL EVALUATION



# PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ____________

Date of Physical________

**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, 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 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 (questions 5–14).

| EXAMINATION | | |
|---|---|---|
| Height Weight | ☐ Male ☐ Female | |
| BP / ( / ) Pulse | Vision R 20/ L 20/ | Corrected ☐ Y ☐ N |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________

Reason ______________________

Recommendations ______________________

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)______________ Date ________

Address ______________________ Phone ________

Signature of physician, APN, PA ______________________

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HE0503

# PREPARTICIPATION PHYSICAL EVALUATION
# CLEARANCE FORM

Name ________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ________________________

________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ________________________

Reason ________________________

Recommendations ________________________

________________________

________________________

________________________

________________________

________________________

**EMERGENCY INFORMATION**

Allergies ________________________

________________________

________________________

________________________

________________________

________________________

Other information ________________________

________________________

________________________

________________________

DATE OF PHYSICAL ________________

**HCP OFFICE STAMP**

**SCHOOL PHYSICIAN:**

Reviewed on ________________________
(Date)

Approved ______ Not Approved ______

Signature: ________________________

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) ________________________ Date __________

Address ________________________ Phone __________

Signature of physician, APN, PA ________________________

**Completed Cardiac Assessment Professional Development Module**

Date ______________ Signature ________________________

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*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

3/2015cm

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

## DENTAL HEALTH FORM

Dear Parent/Guardian:

An important part of your child's total well-being is the care of the teeth and prevention of decay. In order to promote positive dental health maintenance at an early age, we are asking you to have your family dentist complete the dental form below and return it to the school. This dental form then becomes an essential part of your child's school and health records.

The condition of a child's teeth often affects not only attendance at school but also performance including speech development, in school. Statistics demonstrate that many children have not achieved as well as their capabilities indicate because of discomfort and pain due to cavities and discomfort, pain and illness from teeth that are abscessed.

All parents are interested in the scholastic achievement, health and welfare of their children. In order to improve the dental health of the children of our township, especially those who will be entering kindergarten in September, you are urged to arrange for dental examination of your child's teeth by your family dentist without appreciable delay. The preventive measure of determining tooth defects and decay and obtaining early corrective treatment will help protect permanent teeth and assist in their proper development.

Following the dental examination, please ask your dentist to complete the attached form and return it to school as soon as possible.

Respectfully,

______________________ ______________________ ______________________
School Nurse School Phone

==========================================================

**TO BE COMPLETED BY FAMILY DENTIST**

I have examined ________________________________ D.O.B. ____________

Please check one: _____ Patient under treatment.

_____ Dental treatment completed.

_____ No treatment necessary.

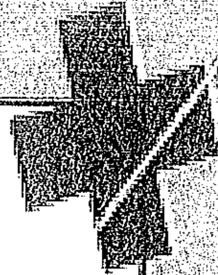
Remarks: ____________________________________________________

______________________________________________________________

______________________________
Signature of Dentist

______________________________
Date

SC:mpl
file:NHS form 15
8/96,6/99,1/01,12/03



# STUDENT IMMUNIZATION

**STUDENTS UNDER 7 YEARS OF AGE ENTERING KINDERGARTEN MUST HAVE AT LEAST ONE OF EACH OF THESE IMMUNIZATIONS TO REGISTER:**

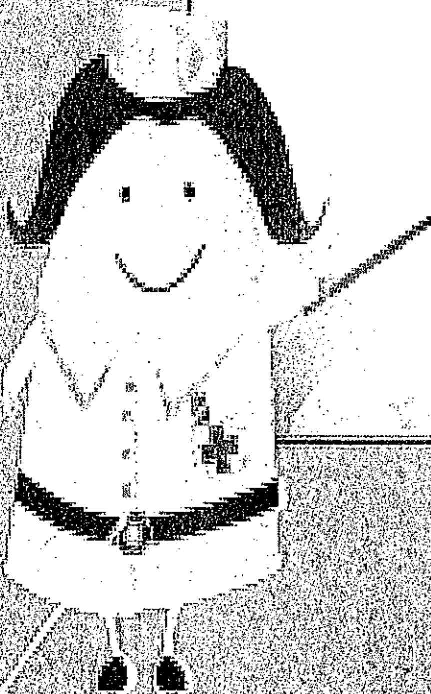
**1 DTP or DTaP**

**1 OPV or IPV (Polio)**

**1 MMR**

**1 Hepatitis B (HBV)**
**(Enrolling in Kindergarten for the first time)**

**1 Varicella (VZV, Varivax)**
**(Enrolling in Kindergarten for the first time)**



**STUDENTS BORN ON OR AFTER**
**JANUARY 1, 1997**
**AND ENTERING OR ATTENDING**
**$6^{TH}$ GRADE**
**MUST HAVE**

**Meningococccal Vaccine**