Alpha Public School
Student Registration Form

Date: _____/_____/_____ Grade/Teacher: _____

STUDENT INFORMATION:

_____
Full Legal Name: (Last, First, Middle)

_____
Current Address: (Number/Street, City, State, Zip)

_____ _____ _____
Gender (M/F) Home Telephone Cell Telephone

_____/_____/_____ _____
Date of Birth Place of Birth (City, State, County, Country)

_____
Name of Previous School Address (City, State, Zip) Phone

Ethnic Data: (Please check the category that best describes your child.)
/_____/ White /_____/ Hispanic/Latino /_____/ Black/African American
/_____/ Asian /_____/ American Indian/Alaska Native /_____/ Native Hawaiian/Pacific Islander

Is English the primary language spoken at home? _____ Yes _____ No

If no, please print the language(s) spoken: _____

_____ _____
Student Resides With - Name(s) of Parent/Guardian Relationship to Student

All Other Members of Household	Relationship to Student	Birthdate	Grade in School

PARENT INFORMATION:

Mother: Contact: 1st _____ 2nd _____ (Choose one)

_____ _____
Mother (Last Name, First Name) Home Phone

_____ _____
Mother's Address: (Number/Street, City, State, Zip) Cell Phone

_____
Email Address

_____ _____ _____
Employer's Name Occupation Work Phone

Father: Contact: 1st _____ 2nd _____ (Choose one)

_____ _____
Father (Last Name, First Name) Home Phone

_____ _____
Father's Address: (Number/Street, City, State, Zip) Cell Phone

_____
Email Address

_____ _____ _____
Employer's Name Occupation Work Phone

Please answer the following questions. If you answer Yes to any of these questions, please provide documentation.

1) Is student in Foster Care or in a court placement?

_____No _____Yes (If yes, please provide further information/documentation.)

2) Parents status: ____ Never Married ____Married ____ Separated ____ Divorced

- Is there a Court Custody Agreement or any Legal Documents regarding this student?

_____No _____Yes (If yes, please provide further information/documentation.)

3) Is there a guardianship agreement?

_____No _____Yes (If yes, please provide further information/documentation.)

4) Is the student currently receiving or received Special Education Services or been eligible under Section 504?

_____No _____Yes (_____ 504 / _____ SE - Classification, description of handicap currently or previously)

_____

_____

5) Does the child have any chronic medical problems, special needs or handicapping conditions?

_____No _____Yes (Please explain) _____

_____

6) What kind of health insurance does the child have? (Please check one.)

_____ Private or employment based health insurance
_____ Medicaid
_____ NJ FamilyCare
_____ Other health insurance: _____
_____ Uninsured

RESIDENCY:

Please be advised that I, the parent(s)/guardian(s) of _____,
(Print Student's Name)
entering grade _____, would like to register my child with the Alpha Public School District. I certify that I am domiciled in the Town of Alpha, New Jersey, and that the requested information and/or documentation provided herein is true and accurate. I further certify that to determine a student's eligibility for enrollment in the District, the Alpha Board of Education has the right to request documentation of domicile, residency, or affidavit of student status.

I further certify that if information/documentation of residency is falsely represented to the Alpha School District, legal action may be taken against me for payment of full tuition (back to the start date of the student's attendance in our district) together with Attorney's fees that may be incurred by the District.

I understand that I am responsible for full tuition payment to the Alpha Public School District if I am not domiciled in the Borough of Alpha, New Jersey. I affirm that all the information provided on this registration form is true and accurate. I also understand that if my residency status changes during my child's enrollment in the Alpha School District, it is my responsibility to notify the district immediately.

Name (printed): _____

Signature: _____ Date: _____

If you are residing with someone in Alpha please answer the following questions. A separate form will need to be completed by resident.

1) Is the student's home address a ___ temporary or ___ permanent living arrangement?
2) Is this a living arrangement due to loss of housing or economic hardship? ___ Yes ___ No

REQUIRED DOCUMENTATION:

1) An original birth certification with raised seal (will be copied and returned);

2) Report of Physical Exam completed by the child's physician (examination must be conducted with 1 year before the start of school);

3) Vaccination Record completed by the child's physician;

4) Proofs of residency – At least one from Column A and one from Column B (will be copied and returned)

Column A	Column B
Property Tax Bill	Driver's License
Contract of Sale	Court Order
Mortgage	Utility Bill
Deed	Cancelled Check
Lease	

2024-2025 Student Emergency Form

(This form needs to be completed **EVERY** school year)

****NOTIFY SCHOOL OFFICE OF ANY CHANGES DURING THE YEAR****

Date: _____/_____/_____ Date of Birth: _____/_____/_____

Student Name: _____ _____ _____

Last First Middle

Address: _____ Alpha 08865

Street Address City Zip Code

Child Resides with: _____

Are there any legal documents affecting your child? Yes___ No___ If **Yes**, please attach documents.

Mother's/Guardian's Name: _____ Mother/Guardian will be contacted: **1st** __ **2nd** __

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Email Address: _____

Father's/Guardian's Name: _____ Father/Guardian will be contacted: **1st** __ **2nd** __

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contacts: In case the child listed above becomes ill or is injured at the school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following. These contacts will also be contacted if your child is absent from school without notification. They will be contacted in numerical order in case of emergency.

1. _____ _____ _____

   Name Relationship Phone

2. _____ _____ _____

   Name Relationship Phone

3. _____ _____ _____

   Name Relationship Phone

Health Insurance

Does your child have health insurance? Yes_____ No ____ My child does not have health insurance. You may release my name and address to NJ FamilyCare Program to contact me about health insurance. 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.

Provider:_____

Date:_____ Printed Name: _____

Signature: _____

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

In an emergency when parents cannot be reached, I authorize the school to call:
(Name, Address & Phone Number)

Physician / Clinical Facility: _____

Dentist: _____

Hospital: _____

Update Health Records: (List any medical/surgical care your child has received during the past year)

_____ _____
Recent Serious Illness Recent Serious Hospitalization

_____ _____
Recent Immunizations Restrictions

_____ _____
Recent Dental Exam (Date/Braces?) Recent Eye Exam (Date/Contact/Glasses?)

Current Medications: Yes _____ (Describe Below) No_____

_____ _____
Medication/Dosage For What Condition

Allergies: _____

Additional Medical Notes:

I, the undersigned, do hereby authorize officials of Alpha Public School to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent's / Guardian's Signature: _____ Date: _____

To finalize any new Student Registration, Alpha Public School requires three proofs of residency.

We require one document from each category below:

Category A-

- Driver's License or Non- driver Photo Identification Card from NJ Division of Motor Vehicles with your current address

Category B-

- The most recent real estate tax bill for your residence showing you as the taxpayer
- A signed lease or deed for your residence
- A closing statement for the purchase of residence
- A Notarized affidavit from you and the owner of the residence stating that you reside at the residence on a full-time basis. Affidavits are available in the school office

Category C-

- Gas, electric or water bill dated within 3 months
- Home/apartment Insurance Certificate
- First class mail/letter from state or federal agency dated within the past 3 months
- Bank statement dated within the past 60 days

If you have any questions or concerns, please contact the main office at 908-454-5000 ext. 200, or bascolese@apsedu.org. Forms may be dropped off to the office, mailed to the school with the attention to Bethany Ascolese or emailed to bascolese@apsedu.org.

Residency within Alpha Public School

Please indicate if any of the following apply:

_____ The student is currently receiving special education services. **A copy of the current IEP must be provided.**

Classification	Case Manager	Telephone

_____ The student has qualified under section 504 of the Rehabilitation Act.

_____ The student is sharing the housing of others due to the loss of housing or economic hardship.

_____ The student as been placed in the home of a district resident other than the parent or guardian by court order. **(You will be required to provide a copy of the order.)**

_____ The student as been placed in the district by the Department of Children and Families acting as the student's guardian.

Name of Agency	Caseworker	Telephone	Date of Placement

_____ The student is a child of a parent or guardian who is a member of the New Jersey National Guard or the United States Reserves ordered to active service in time of war or national emergency.

Branch	Base Assigned	State

Residency:

Please indicate the section on the following pages that you will be completing according to the situation that best describes student's residency circumstances.

_____ Complete Section A (Domicile) if your permanent home is in Alpha.

_____ Complete Section B (Temporary Resident) if the parents/guardian is staying with a resident of Alpha.

_____ Complete Section C (Affidavit Student) if the student is living with someone other than parent/guardian.

In the case of divorce, separation, or one parent:

Does the student reside with one parent for the entire year? If so, with which parent and what address? _____

_____

Is there a court order or written agreement between the parents designating the district for the school attendance, and if so, where does it require the student to attend school? **(You must provide a copy of the order.)**

If not, for what portion of the time does the student reside with each parent and at what addresses? _____

_____

If the student lives with both parents on an equal-time, alternating week/month or other similar basis, with which parent did the student reside on the last school day prior to October 16th preceding the date of this application?

_____

******** PLEASE SEE REVERSE SIDE ********

SECTION A (DOMICILE): Complete this section if your permanent home is in the Alpha Public School District.

How long have you lived in this home? _____

Do you own or rent this home? _____ If Rent, Lease Start date _____ End date _____

Do you have any present intention of moving from this home? If so, when and to where? _____

_____

Do you have residences(s) elsewhere, and if so, where are they and when do you live there? _____

_____

Please list three forms of proof (see attached list) you will provide to demonstrate that the address given on page 1 of this application is your permanent home.

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

SECTION B (TEMPORARY RESIDENT): Complete this section if parent is staying with a resident of Alpha.

How long have you lived in this residence? _____

Please explain why you are temporarily living with the resident _____

_____

_____

_____

How long do you expect to stay at this residence? _____

Do you have a domicile or residences(s) elsewhere, and, if so, where are they and when do you live there? _____

_____

_____

Please list three forms of proof (see attached list) you will provide to demonstrate that you are residing at the address given on previous page of this application, and that such residence is not solely for the purpose of the student attending school in the district.

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

SECTION C ("AFFIDAVITT" STUDENT): Complete this section if the student is living with a person other than the parent or guardian.

Is the person domiciled in the district, supporting the student without remuneration as if the student were his or her own child, keeping the student for a longer time than the school term and assuming all personal obligations for the student relative to school requirements? **Please explain.** (You will be asked to file a sworn statement, along with a copy of the person's lease if a tenant, or a sworn landlord's statement if a tenant without written lease.)

_____

_____

_____

_____

ALPHA PUBLIC SCHOOL

817 North Boulevard
Alpha, New Jersey 08865
Telephone: (908) 454-5000 Fax: (908) 454-4347
www.apsedu.org

Mr. Seth Cohen
Chief School Administrator

August 2024

To: Parents/Guardians

From: Laura Griffiths, BSN, RN,CSN-NJ School Nurse

Dear Parent/Guardian,

Welcome to another school year! Attached is a Health History & Emergency Treatment Form. **Please legibly fill it out and return it to my attention as soon as possible.**

I would like to share some information with you regarding our school health services program. This is a summary of some of the contacts your child will have with the school nurse this year:

- Screening for height, weight and blood pressure shall be conducted annually for each pupil in kindergarten through grade 8.
- Screening for visual acuity shall be conducted biennially for pupils in kindergarten through grade 8.
- Screening for auditory acuity shall be conducted annually for pupils in kindergarten through grade 3 and in grade 7 pursuant to NJSA 18A:404.
- Students in grades 5 and 7 will receive a spinal screening for scoliosis. Any student will be exempt from the scoliosis screening **upon written request from a parent or guardian** (NJSA 18A:4-4,3).
- All new students must be examined upon entry into the school district. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program. The "Universal Child Health Record" form is available through the school website.
- The nurse may administer prescribed medication. However, authorization is required from both the physician and the parent. The medication must be in its original container and must be brought to school by the parent/guardian. This policy also applies to over the-counter or non-prescription medications. Please contact the school nurse for these forms.
- The REQUIRED district form(s) are available from the school nurse or at the school website www.apsedu.org.

Please feel free to contact the school nurse at 908-454-5000 x205 with any questions you may have.

Physical Examination

New Jersey State Board of Education and the New Jersey Department of Health and Senior Services require that each student: is not diminished by a remediable physical disability, that the student is able to participate in the school program, and that the school community is protected from the spread of communicable disease.

The physical examination must be done no more than 365 days prior to the entry of school. If any modifications are required for full participation, please provide the school with proper documentation.

A healthcare provider chosen by the student's parent/guardian, also referred to, as the students' MEDICAL HOME, must conduct the medical examination. A full report must be presented to the school on approved school district form. Please be sure that your physician signs and dates the form.

If the student does not have a "medical home" please contact the school nurse or school secretary for more information.

Rev. 11/02 Physical Examination

SCOLIOSIS SCREENINGS ARE REQUIRED OF ALL 5TH AND 7TH GRADE STUDENTS.

- I do wish to have my child included in the scoliosis screening program.

Yes _____ No _____

- I will have my 5th or 7th grade child examined by our family physician AND SUBMIT THE REPORT TO THE SCHOOL NURSE.

Yes _____ No _____

PERMISSION FOR RELEASE OF HEALTH INFORMATION

This release authorizes the school nurse to send or receive pertinent medical information necessary for my child's health, well-being and safety. This authorization is valid for one year.

Student's Name: _____

Date of Birth: _____

Grade/Teacher: _____

Parent/Guardian's Name (MUST PRINT): _____

Parent/Guardian's Signature: _____

Date: _____

Student Health History & Emergency Medical Treatment Consent Form **School Year 202 - 202**

Student:	School: Alpha	Grade/Teacher:
Address:	Birth Date:	Gender:

Parent/Guardian Emergency Contacts:	Relationship:	Phone:
Call 1st:		Home: Cell: Work:
Call 2nd:		Home: Cell: Work:
Call 3rd:		Home: Cell: Work:

Student's doctor/healthcare provider:_____ Phone:_____

Insurance Information:_____ (Include Group's Name, ID #, Group # & Subscriber)

Indicate if student has been diagnosed by a licensed Healthcare Provider with any of the following:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies			List:
Allergies (other)			List:
Food Allergies			Food(s): Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Allergy to Bee Stings			Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Asthma			Rate the Severity : Mild Moderate Life-Threatening Asthma medication taken at home: Medication required at school:
Diabetes			Type 1 (Insulin Dependent) Type 2 Medication Required at School:
Seizure Disorder			Type of Seizure: Medications:
Neurological Disorder			Specify:
Heart Condition			Specify:
Blood Disorder			Specify: Treatment:
Cancer			Specify: Treatment:
Bowel/Bladder Issues			Specify:
Migraine Headaches			Triggers: Treatment:
Bone/Muscle Problems			Specify: Activity Restrictions:
ADD/ADHD			Medication for ADD/ADHD:
Mental Health /Behavioral Issues			Specify: Treatment/Medication:
Wears Glasses/Contacts			Glasses Contacts For Distance For Reading
Hearing Loss			Hearing Loss Right Ear Hearing Loss Left Ear Hearing Aides
Other Serious Illness			Specify: Dates of Onset:
Serious Injury			Specify: Date(s):
Surgery			Specify: Date(s):
Medication Taken at home (if not already listed)			List:

The information on this form may be shared confidentiality with school staff and emergency responders as needed. In the event of medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury, and/or unforeseen circumstance.

_____

Parent/Guardian Signature Printed Name Date

Reviewed by School Nurse:_____

ALPHA PUBLIC SCHOOL
817 North Boulevard
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Mr. Seth Cohen
Chief School Administrator

Mrs. Lori Walker
Supervisor of Instruction

Dear Parents/Guardians of students starting Alpha Public School,

As required by NJ law, N.J.A.C. 8:57-4.2, all students entering Alpha Public School must have documentation of their current immunizations and current health physical to begin the school year. Please complete the enclosed Student Health History/Emergency Medical Treatment Consent form and Universal Child Health Record form completed by your doctor. The health form must also note any allergies, vision or hearing difficulties, or any significant medical conditions.

The following immunizations are required for admittance:

- DTaP - a total of 4 doses with one of these doses on or after your child's 4th birthday or any 5 doses. Polio (IPV) a total of 3 doses with one of these doses given on or after your child's 4th birthday or any 4 doses.
- MMR - 2 doses
- Varicella - 1 dose
- Hepatitis B -3 doses

All new families must complete and submit all required forms and documents for each child entering the district. Registration will be considered pending until all required documentation has been verified.

If the student has a religious exemption, please forward a signed document by a parent or guardian stating this. If there is a medical exemption, please show the necessary documentation from your physician.

Any documentation may be sent to Alpha School District addressed to the school nurse. If you have any questions, please call me at (908) 454-5000 Ext 205.

Thank you for your time and cooperation. Stay safe and healthy!

Laura Griffiths, RN, BSN

School Nurse, Alpha Public School

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.