LINDEN PUBLIC SCHOOLS

RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE

District Registration Packet

GRADE: ☑ PK-5 ☐ 6-12

Central Registration • 100 Edgewood Road, Door #1 • Linden, NJ 07036
908-986-9307 | registration@lindenps.org

ALL PAGES OF THIS PACKET MUST BE FILLED OUT COMPLETELY.

REQUIRED AT TIME OF REGISTRATION

☐ ***You MUST complete the online pre-registration at lindenps.org/central-registration or by scanning the QR code***

***** These documents are required at the time of registration, regardless if you have completed the online pre-registration. *****

☐ **Original Birth Certificate or Passport**

**A LEGAL PARENT MUST BE PRESENT AT THE TIME OF REGISTRATION. If the individual registering the student is not the legal parent, Proof of Custody must be provided at that time. **

If applicable: ☐Proof of Custody *(Court Order, Judgment, or Power of Attorney)*

Notarized letters are not acceptable as proof of custody.
In this situation, an affidavit will be required, and must be completed prior to registration.

☐ **Parent/Guardian Photo I.D.**

☐ **"6 Points" Proof of Residency (see page 2)** If required: ☐Affidavit *(completed with an Attendance Officer)*

☐ **Immunization/Vaccination Record** ***IF NOT IN ENGLISH, IT MUST BE TRANSLATED BY A DOCTOR***

☐ **REQUIRED IF STUDENT IS COMING FROM ANOTHER NJ PUBLIC SCHOOL:**
Transfer Card/Form/Papers (If applicable: WIDA/ACCESS/ELL Scores)

☐ **REQUIRED IF STUDENT IS COMING FROM A PRIVATE SCHOOL OR OUTSIDE OF NJ**
Most recent report card and/or transcript

If applicable: ☐Copy of current IEP or 504

Registration is by APPOINTMENT ONLY, available at the following dates and times:

Monday	8:00 AM – 11:30 AM; 1:00 – 2:30 PM
Tuesday	8:00 AM – 11:30 AM; 1:00 – 2:30 PM
Wednesday	8:00 AM – 11:30 AM
Thursday	8:00 AM – 11:30 AM; 1:00 – 2:30 PM
Friday	8:00 AM – 11:30 AM; 1:00 – 2:30 PM

Please note: *These hours are subject to change without notice. The Central Registration office follows the Linden Public Schools calendar for holidays and closures. During Summer Hours, the office is closed on Fridays through August and hours may differ slightly. Please call for more information.*

[Revised 6/27/2024]

Linden Public Schools
"6 Points" for Proof of Residency

As per N.J.A.C 6A:22-3.4, and Linden Public Schools Policy 5111, parents/legal guardians registering students into Linden Public Schools must provide proof of residency. Linden Public Schools uses a 6-point system to fulfill this requirement.

At the time of registration, parents/legal guardians must provide:

☐ **Mortgage, Deed, Property Tax Bill, or Closing Documents/Contract of Sale [3 points]**

OR

☐ **Complete copy of Lease or Leasing Agreement [1 point]**

In the event one of the above documents cannot be provided, an affidavit for residency will be required. Affidavits may only be picked up in person from the Central Registration office.

The remaining documentation may be any combination of the documents below, as long as the point value totals at least 6 points. All documents must be dated within 30 days of the time of registration:

☐ Gas Bill **[2 points]**	☐ Water Bill **[2 points]**	☐ Electric Bill **[2 points]**
☐ Pay Stub **[2 points]**	☐ Cable Bill **[2 points]**	☐ Car Registration **[2 points]**
☐ Car Insurance **[2 points]**	☐ Government Mail **[2 points]**	☐ Bank Statement **[1 point]**
☐Cell Phone Bill **[1 point]**	☐ Credit Card Bill **[1 point]**	☐ NJ Driver's License/State ID **[1 point]**
☐ Letter from Doctor, Lawyer, or Court **[1 point]**		

Please note, all applicants must physically reside in Linden, in addition to providing proof of residency. The district reserves the right to investigate the residency of all students. Should the district discover that a student is not a resident of Linden, the district may assess the parent/guardian the full cost of tuition for any period of ineligible attendance.

By signing this, you state that you understand this requirement, and agree to provide the required documentation.

_____ _____

Signature of Parent/Legal Guardian *Date*

LINDEN PUBLIC SCHOOLS

RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE

CENTRAL REGISTRATION

[OFFICE USE ONLY]

_____/_____/20____
REGISTRATION DATE

STUDENT NAME:_____ _____ ID: _____
(FIRST NAME) *(LAST NAME)* *OFFICE USE ONLY*

BIRTH DATE: _____/_____/_____ COUNTRY OF BIRTH: _____ U.S. ENTRY DATE: _____/_____/_____

SEX AT BIRTH: ☐MALE ☐FEMALE **PREFERRED GENDER:** ☐MALE ☐FEMALE ☐NON-BINARY | ☐**PREFER NOT TO ANSWER**

PREFERRED PRONOUNS: ☐He/Him | ☐She/Her | ☐They/Them | ☐Other: _____| ☐**PREFER NOT TO ANSWER**

Language/s spoken at home: ☐English ☐Spanish ☐Ukrainian ☐Creole ☐Portuguese ☐Polish ☐Georgian ☐Arabic

☐Other (Please specify): _____

YOU MAY ONLY CHECK ONE DOMINANT LANGUAGE

Student's Dominant Language: ☐English ☐Spanish ☐Ukrainian ☐Creole ☐Portuguese ☐Polish ☐Georgian ☐Arabic

☐Other (Please specify): _____

HAS YOUR STUDENT ATTENDED SCHOOL BEFORE? ☐**YES** ☐**NO**, THIS IS MY STUDENT'S FIRST TIME IN SCHOOL

IF **YES**, WHERE WAS THE LAST SCHOOL YOUR STUDENT ATTENDED? _____

WERE THEY EVER ENROLLED IN OR DID THEY EVER ATTEND ANY PUBLIC SCHOOL, CLASS, OR PROGRAM IN LINDEN, NJ? ☐**YES** ☐**NO**

ADDRESS: _____

GUARDIAN 1

NAME: _____ PREFERRED LANGUAGE:_____

☐MOTHER ☐FATHER ☐COURT APPROVED LEGAL GUARDIAN WITH OFFICIAL DOCUMENTATION

☐OTHER (MUST PROVIDE LINDEN PUBLIC SCHOOLS AFFIDAVIT):_____

PHONE NUMBER: _____ WORK PHONE NUMBER: _____

EMAIL ADDRESS (REQUIRED): _____

GUARDIAN 2 (IF APPLICABLE)

NAME: _____ PREFERRED LANGUAGE:_____

☐MOTHER ☐FATHER ☐COURT APPROVED LEGAL GUARDIAN WITH OFFICIAL DOCUMENTATION

PHONE NUMBER: _____ WORK PHONE NUMBER: _____

DOES THIS GUARDIAN RESIDE AT THE ABOVE ADDRESS? ☐YES ☐NO

IF NO, PLEASE PROVIDE THE ADDRESS: _____

EMERGENCY CONTACTS (NOT LISTED AS GUARDIAN 1 OR 2 ABOVE)

NAME: _____ PHONE NUMBER: _____

☐MOTHER ☐FATHER ☐STEP-PARENT ☐GRANDPARENT ☐AUNT ☐UNCLE ☐COUSIN ☐FRIEND ☐SIBLING

NAME: _____ PHONE NUMBER: _____

☐MOTHER ☐FATHER ☐STEP-PARENT ☐GRANDPARENT ☐AUNT ☐UNCLE ☐COUSIN ☐FRIEND ☐SIBLING

LINDEN PUBLIC SCHOOLS

Special Education Department

170 Hussa St. Linden, NJ 07036

Atiya Y. Perkins
Superintendent

Dr. Marie Stefanick
Director of Special Education
Phone: 908-587-3285

SCHOOL:	GRADE:

THIS PAGE IS REQUIRED TO COMPLETE FOR ALL GRADES.

STUDENT NAME:_____ **BIRTH DATE:** ____/____/_____
(FIRST) (LAST) MO. DAY YEAR

PARENT/GUARDIAN NAME: _____
(FIRST) (LAST)

ADDRESS: _____ **PHONE NUMBER:** _____

Has the above-named student received any Special Services and/or related services, i.e.:

	YES	NO
• Speech & Language Services at previous school (non-ESL):	☐	☐
• Special Education Classes such as:	☐	☐
○ Resource Center	☐	☐
○ In-Class Support	☐	☐
○ Self-Contained Academic Classes	☐	☐
○ Alternative School Placement	☐	☐
○ Special Transportation	☐	☐
• Does your student have an **IEP**?	☐	☐
○ **If yes**, do you have a copy of the IEP with you?	☐	☐
• Do you have a **504 plan** for your student?	☐	☐

Previous School District: _____ Last day of attendance: _____
Previous School: _____

Additional comments from parent/guardian:

_____
_____
_____
_____

_____ _____
Parent/Guardian Signature [OFFICE USE ONLY] Entry Date Into Linden

Please send this form with student IEP to: Special Education Department
Att: Dr. Marie Stefanick mstefanick@lindenps.org

LINDEN PUBLIC SCHOOLS
RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE
Office of Central Registration

REQUEST FOR RELEASE OF STUDENT RECORDS – PLEASE COMPLETE ALL YELLOW SECTIONS

SCHOOL REQUESTING RECORDS: **[FOR OFFICE USE ONLY]**

1☐ | 2☐ | 4☐ | 5☐ | 6☐ | 8☐ | 9☐ | 10☐

Soehl Middle School ☐ | McManus Middle School ☐ | Linden High School ☐

Special Services Department ☐ | Central Registration ☐

ADDRESS: _____ Linden, NJ 07036

PHONE NUMBER: _____

EMAIL: _____ FAX: _____

This form authorizes Linden Public Schools to request records from the student's previously attended school.

_____ _____
STUDENT NAME BIRTH DATE

To assist us in our evaluation and placement of this student, please forward all student records and pertinent information, including the following:

☐ Complete official transcript, including grades for this year up to date of withdrawal

☐ Complete attendance records

☐ Complete discipline records

☐ A-45; Complete health records, including immunization records

☐ Standardized test results, including required state tests and other achievement and intelligence tests (WIDA/ACCESS/ELL Scores, PARCC, NJASK, HSPA/GEPA, etc.)

☐ IEP Records

☐ Other: _____

AUTHORIZATION STATEMENT AND SIGNATURE

I authorize _____, Phone #: _____
(Name of school prior to Linden Public Schools)

to release the information specified above to Linden Public Schools, Central Registration.

_____ _____
Signature of Parent/Guardian *Date*

LINDEN PUBLIC SCHOOLS
RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE

Screening Inventory-Parent Questionnaire

Child's Name: _____Date of Birth: _____Age: _____Sex: M or F (circle one)

MEDICAL HISTORY – BIRTH

Were there any significant problems during pregnancy? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____
_____

Was your child more than 3 weeks premature? ☐ Yes ☐ No

If Yes, how many weeks premature? _____

Baby's birth weight _____

Did the baby stay in the hospital longer than the mother? If yes, please explain: ☐ Yes ☐ No

_____
_____
_____
_____

At the time of birth, did the baby – have seizure? ☐ Yes ☐ No
turn blue?

Child's Health Since Birth – EYES

Has your child ever had trouble seeing? ☐ Yes ☐ No

Does your child hold books and objects close to his/her face? ☐ Yes ☐ No

Has your child's eyes ever looked crossed? ☐ Yes ☐ No

Have you ever suspected that your child has vision problems? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____

EARS

Has your child had frequent ear infections? ☐ Yes ☐ No

Has your child ever had trouble hearing? ☐ Yes ☐ No

Have you ever suspected that your child has hearing problems ☐ Yes ☐ No

If yes, please explain:

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? ☐ Yes ☐ No

If yes, please explain:

Has your child ever had any significant injuries or hospitalizations? ☐ Yes ☐ No

If yes, please explain:

Does your child have allergies? ☐ Yes ☐ No

If yes, please describe:

Is your child presently on any medication? ☐ Yes ☐ No

If yes, please describe:

Please describe any other health concerns:

_____
_____
_____
_____

CHILD'S DEVELOPMENT

Can your child:	Feed him/herself using a spoon and/or a fork?	☐ Yes	☐ No
	Wash and dry his/her own hands?	☐ Yes	☐ No
	Help with dressing or dress with little assistance?	☐ Yes	☐ No
	Stay with a babysitter?	☐ Yes	☐ No
	Speak so that he or she can be understood by others?	☐ Yes	☐ No
	Express his/her thoughts and needs easily?	☐ Yes	☐ No
	Play with other children?	☐ Yes	☐ No

Do you have any concerns about your child's appetite or willingness to try different foods? If yes, please explain:

_____
_____
_____
_____

Do you have any concerns about your child's behavior? If yes, please explain:

_____
_____
_____
_____

Is your child toilet trained? ☐ Yes ☐ No
If no, please explain:

_____
_____
_____

Parent/Guardian Signature_____ Date_____

LINDEN PUBLIC SCHOOLS
RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE

GROWTH AND DEVELOPMENT HISTORY
(Please Print)

REGISTRATION DATE: _____

_____/_____/_____ _____
Child's Last Name First Middle Date of Birth

Did child ever attend a Linden Public School? Yes_____ No_____

_____
Address (Number, Street, City, Zip Code)

Telephone #: Home_____
Work_____
Cell_____

Siblings:_____ _____
Name Age

Emergency #: _____

_____ _____
Parent/Guardian (Father) Parent/Guardian (Mother)

Does your child have: **(Please circle Yes or No)**

Frequent Colds	Yes / No	Chronic Cough	Yes / No	Difficulty focusing/ concentrating	Yes / No
Bronchitis	Yes / No	Hearing Loss	Yes / No		
Frequent Sore Throats	Yes / No	Poor Posture	Yes / No		
Speech Difficulties	Yes / No	Emotional Problems	Yes / No		
Earaches/Discharge	Yes / No	Vision Loss	Yes / No		
Weight Problem	Yes / No	Eye Injury	Yes / No		
Poor Eating Habits	Yes / No	Eye Disease	Yes / No		
Difficulty Sleeping	Yes / No	Eye glasses prescribed	Yes / No		

Development: Age Walked_____ Age Talked _____

Family History: **(Please Circle)**

Tuberculosis	Kidney Conditions	Asthma	Cancer
Diabetes	Heart Disease	Deafness	Allergies

Does your child have a history of: **(Please circle-give dates)**

Allergy*****	Enuresis (bed wetting)	Mononucleosis	Tonsillitis	Operations: Appendectomy_____
Asthma	Heart Disease	Pneumonia	Tuberculosis	Hernia_____
Attention Deficit Disorder	Hepatitis	Rheumatic Fever		Tonsils removed_____
Chickenpox	Hernia	Scarlet Fever		Ear operation_____
Diabetes	High Fever	Seizures		Other_____

******Allergy to: Medication_____, Food_____, Seasonal_____, Other_____

Taking Medication Now _____If yes, what and why?_____

Hospitalization _____If yes, what and why?_____

Please list other childhood diseases, accidents, problems or medical tests._____

I give my consent to have my child's medical information shared, when necessary, with school personnel to insure proper care and treatment while my child is in school and/or participating in school sponsored activities.

_____ _____
Parent/Guardian Signature Date

LINDEN PUBLIC SCHOOLS
RESPECT FOR DIVERSITY - EXCELLENCE IN EDUCATION - COMMITMENT TO SERVICE

Student's Name:_____

As I plan future activities and events, I want each experience to be meaningful and have your child be able to participate to the fullest extent. Therefore, it is very important for me to have the following information about your child:

*Does your child have any food allergies?

_____NO _____YES, PLEASE LIST:_____

_____

_____

*Any Other allergies?

_____NO _____YES, PLEASE LIST:_____

_____

_____

*Any special needs/conditions?

_____NO _____YES, PLEASE EXPLAIN:

_____

*Any other information I may need that could be found helpful?

_____NO _____YES, PLEASE EXPLAIN:

_____

Thank you for your continued support.

_____
SCHOOL NURSE

_____ _____
Parent/Guardian Signature Date

LINDEN PUBLIC SCHOOLS DEPARTMENT OF
MEDICAL INSPECTION ACADEMY OF SCIENCE &
TECHNOLOGY 128 WEST ST. GEORGES AVENUE
LINDEN, NEW JERSEY 07036

Atiya Y. Perkins
Superintendent

J. Schulman, D.O. Chief
Medical Inspector
Patricia Ryan-James, R.N.
Head School Nurse
(908) 486-2212 ext.8460
Fax (908) 925-8613

MEDICAL INFORMATION RELEASE

I authorize the Medical Department of the Linden Board of Education to disseminate all necessary medical information to the appropriate Board of Education Staff members, for the health and safety of my child.

This is in accordance with the Family Educational Rights and Privacy Act (FERPA) AND THE Health Insurance Portability and Accountability Act (HIPAA).

Student:_____

Parent/Guardian:_____

Date:_____

LINDEN PUBLIC SCHOOLS
DEPARTMENT OF MEDICAL INSPECTION
ACADEMY OF SCIENCE & TECHNOLOGY
128 WEST ST. GEORGES AVENUE
LINDEN, NEW JERSEY 07036

Atiya Y. Perkins
Superintendent

J. Schulman, D.O.
Chief Medical Inspector
Patricia Ryan-James, R.N.
Head School Nurse
(908) 486-2212 ext.8460
Fax (908) 925-8613

Date:_____

Dear Parent/Guardian:

For the 2024-2025 school year the medical department is asking that you fill out the information on whether you have or do not have health insurance. Please complete this form and return it to your child's school as soon as possible.

Child's Last Name_____First_____

Does your child have Health Insurance? Please check one of the following:

Yes_____If Yes, name of insurance company_____
No_____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. 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).

9/11

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.