East Brunswick Public Schools

Welcome to East Brunswick Public Schools – Bears and Cubs program. Please use the checklist below to ensure all necessary documents are compiled for student registration. All the requested items below are necessary to process registration. Please understand that failure to provide requirements may delay registration.

Bears and Cubs Registration Checklist: ***All documents are due August 31st***

_____ **Enter preliminary information for each child in our online portal by clicking here.**
DO NOT type information in all capital letters. (Please note the portal does not support the use of Internet Explorer).

_____ **Proof of Residency (2 documents)**
Documents must be in the name of the parent/guardian. Acceptable documents: *current mortgage, deed, or lease*. *TWO* additional *UTILITY bills* must also be provided to complete the residency requirement within 30 days of registration.

_____ **Parent/Guardian Photo ID**

_____ **Student's Birth Certificate (copy – no originals)**

_____ **Student's current immunization record**

_____ **Custody Documentation (if applicable)**

_____ **Registration Packet** printed, and all forms completed.

- _____ **Bears and Cubs Registration Data Sheet**
  All fields and check boxes must be filled in completely.
- _____ **Student Health History firm**
- _____ **Student Physical Exam Form**
  (must be completed by physician and returned within 30 days of registration).
- _____ **Authorization for Administration of Medications in Schools and Physicians instructions (if applicable)**

_____ ****Please mail all documents by August 31st to the following address:**

East Brunswick Public Schools
Attn: Magaly Alvarez
760 Rt. 18
East Brunswick, NJ 08816

EAST BRUNSWICK PUBLIC SCHOOLS
BEARS AND CUBS REGISTRATION DATA SHEET

SCHOOL _____ **DATE** _____ **STUDENT ID** _____

PLEASE PRINT CLEARLY – ALL INFORMATION MUST BE COMPLETED

_____ _____ _____ _____

Student Last Name | Student First Name (Legal) | M. I. | Nickname

Date of Birth: (M)/ _____ (D)/ _____ (Y)_____ Age: _____ Gender: _____ Grade: _____

_____

Student Street Address | Town | Zip Code

Student resides with (Relationship): _____ Parent Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐

If divorced or separated, who has legal custody? _____ Who has residential custody? _____

Student's previous Address & Telephone #: _____

If you have a residence elsewhere, what is the address and when do you live there? _____

Student's previous Preschool/Daycare address: _____

Do you have other children attending East Brunswick Public Schools? Yes ☐ No ☐ (List Full Names Below)

(1)_____ (2)_____ (3)_____ (4)_____

First U.S. School Entry Date: (M)_____ (D)_____ (Y)_____ Original U.S. Entry Date: (M)_____ (D)_____ (Y)_____

SPECIAL EDUCATION: Yes ☐ No ☐ **IEP?** Yes ☐ No ☐ **In Basic Skills?** Yes ☐ No ☐ **Have a 504 Plan?** Yes ☐ No ☐

Required for State/Federal Reports: (these questions must be answered)

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native **Ethnicity:** Hispanic Yes ☐ No ☐

PARENT/GUARDIAN INFORMATION

Please Circle: Parent Guardian Other _____	**Please Circle: Parent Guardian Other** _____
(Ms.) (Mrs.) (Mr.) (Dr.)	(Ms.) (Mrs.) (Mr.) (Dr.)
Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Parent Preferred E-mail Address: _____	Parent Preferred E-mail Address: _____
Home Phone #: ( ) _____	Home Phone #: ( ) _____
Cell Phone #: ( ) _____	Cell Phone #: ( ) _____
Business #: ( ) _____	Business #: ( ) _____
Occupation: _____	Occupation: _____
Employer's Name: _____	Employer's Name: _____
Employer's Address: _____	Employer's Address: _____

I certify that the foregoing statements made by me are true. I am aware that if any of them are willfully false, I will be subject to legal action. As per State Law and Board Policy, if it is discovered that my child (children) is (are) illegally attending the East Brunswick Schools and not living in East Brunswick, I will be responsible for the payment of all accrued tuition fees. In addition, I acknowledge that I will be responsible for any legal expenses incurred by the East Brunswick Board of Education in relation to the situation.

Print Name _____ **Signature** _____ **Date** _____

East Brunswick Public Schools

Student Services Department
Student Health History Form

It is necessary that the following confidential information concerning the health history, growth and development of your child be completed. This information is essential for a total understanding of each child as an individual. It also assists in planning the child's individual education plan.

Student Name :_____ Date of Birth: _____

Preschool experience: Yes ☐ No ☐ Preschool attended:_____ How Long?_____

Primary language spoken at home:_____ Language(s) spoken by child:_____

Physician Name and Phone:_____

List siblings (name, age, general health):

_____

Does your child have vision problems? Yes ☐ No ☐ If yes, please indicate:_____
Does your child wear glasses? Yes ☐ No ☐ Does your child wear contact lenses? Yes ☐ No ☐
Does your child have hearing problems? Yes ☐ No ☐ If yes, please indicate:_____
Does your child have any allergies? Yes ☐ No ☐ If Yes, please indicate: _____
Does your child require Epinephrine? Yes ☐ No ☐ If Yes, please indicate reason:_____
Does your child have any skin conditions (eczema, etc.)? Yes ☐ No ☐ If yes, please indicate:_____
Does your child have difficulty concentrating and/or a short attention span? Yes ☐ No ☐
If yes, list any medication given if applicable :_____
Has your child been treated for a medical condition/mental illness? Yes ☐ No ☐ List illness, duration, medications given: _____

List any serious accidents (i.e. head injury, etc), operations, hospitalizations, emergency room visits:

_____

Infections/Illness	Circle One		Infections/Illness	Circle One	
Chicken Pox	Yes/ Age:_____	No	Strep	Yes/ Age:_____	No
Measles	Yes/ Age:_____	No	Lyme Disease	Yes/ Age:_____	No
Mumps	Yes/ Age:_____	No	Arthritis	Yes/ Age:_____	No
Seizures/Convulsions	Yes/ Age:_____	No	Pneumonia	Yes/ Age:_____	No
Tuberculosis	Yes/ Age:_____	No	Migraines	Yes/ Age:_____	No
Asthma	Yes/ Age:_____	No	Hepatitis	Yes/ Age:_____	No

List any information you wish to share with the school which might be beneficial to your child and helpful to the school:

_____

Screening procedures are conducted on students in the East Brunswick Public Schools according to the following regulations and Board of Education policies. PLEASE READ AND SIGN this form to indicate your approval of these procedures for your child. This form will become part of the student's permanent health record. The school nurse will answer any questions you may have concerning these procedures.

HEIGHTS, WEIGHTS AND BLOOD PRESSURE will be done annually on all students in grades K-12. **AUDIOMETRIC SCREENING: NJAC 6A:16-2.2, NJSA 18A:40-4** - Audiometric screening for hearing acuity is done annually for all students in preschool programs, grades K-3, 7 and 11, students new to the district with no available record of audiometric screening, students referred to the Child Study Team for evaluation, students at risk of hearing impairment and those referred by teacher, parent or self. **VISION SCREENING: NJAC 6A:16-2.2** - Vision screening is done annually on students in preschool programs, grade K-1, 3, 5-8 and 10, students referred to the Child Study Team for evaluation or review, students entering the district with no available record of vision screening and those referred by teacher, parent or self.

Parent/Guardian Signature:_____ Date:_____

East Brunswick Public Schools
East Brunswick, New Jersey 08816
Student Services

Student Physical Examination Form

Student Name: _____ Date of Birth: _____

School: _____ Date: _____

School Address: _____

Dear Parent:

Please present this form to your physician at the time of your child's examination. Upon completion, please return this form within 30 days of student's registration. Thank you.

Height: _____ Weight: _____ B.P.: _____ Pulse: _____

Vision-Right: _____ Left: _____ Both: _____

Glasses-Right: _____ Left: _____ Both: _____

Physical Findings	Please indicate with a √ (check) in the appropriate column. Normal	Abnormal	Specify and Recommend
EYES			
VISION			
COLOR PERCEPTION			
EARS - OTOSCOPIC			
HEARING			
Left			
Right			
TEETH/MOUTH			
NOSE			
THROAT			
LYMPH GLANDS			
THYROID			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
GENITO-URINARY			
ORTHOPEDIC (STRUCTURAL)			
SCOLIOSIS SCREENING			
SKIN			
NUTRITION			
NERVOUS SYSTEM			
SPEECH			
OTHER			
GENERAL APPEARANCE			

Student Physical Examination Form

Student Name: _____

DATE OF MOST RECENT MANTOUX TUBERCULIN:

TEST: _____ RESULT: _____ FOLLOW-UP: _____

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

DPT/DTaP					
Tdap (Grade 6)					
Polio					
MMR					
Measles (on or after 1st birthday)					
Mumps (on or after 1st birthday)					
Rubella (on or after 1st birthday)					
Hib					
Hepatitis B (min spacing intervals)					
Varicella (on or after 1st birthday)					
Meningococcal (Grade 6)(after 10th birthday)					
Pneumococcal (Pre-School)					
Influenza (Pre-School)					

PLEASE LIST ANY HEALTH PROBLEMS WHICH MIGHT INTERFERE WITH THE STUDENT'S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR PHYSICAL EDUCATION PROGRAM:

INDICATE ANY RESTRICTIONS:

COMMENTS:

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____

PRINTED NAME, ADDRESS AND TELEPHONE: _____

_____

_____

_____

EAST BRUNSWICK PUBLIC SCHOOLS
Student Services

TO: Parents/Guardian of _____
Name of Child

Name of School: _____ Grade:_____

FROM: School Nurse DATE:_____

RE: Authorization for Administration of Medications in School

Administrative policy of the East Brunswick Public Schools requires the school nurse to have the written permission of a child's parent/guardian and physician in order to administer any medication during the school day. (This includes non-prescription medication)

The medication must be given to the school nurse, by an adult, in a pharmacy labeled container which includes the name and the telephone number of the pharmacy, the prescription number, the student's name, directions for administering the medication, and the name of the physician prescribing the medication. No medication is to be kept in the classroom. Information regarding medication will be shared with staff on a need-to-know basis.

Parent will provide a physician's note if this student suffers from a life threatening condition which requires immediate use of an inhaler or pre-filled auto-injector mechanism (Epi-Pen). Student must report to the school nurse to demonstrate they have proper knowledge and use of these medications. Self-management privileges will be revoked if students do not use these medications properly.

Any student whose physician orders a pre-filled auto-injector mechanism (Epi-Pen) for anaphylaxis shall have a volunteer, non-medical designee to administer one dose of prescribed epinephrine via a pre-filled auto-injector mechanism when the school nurse is unavailable. This also pertains to those students who are capable of and have self-medication orders.

I release, indemnify, and hold harmless the Board of Education and its employees against any and all liability for damage or injury arising out of approval of this request.

Please return this form to the school nurse after completed by parent and physician. This request must be reviewed each school year.

I hereby authorize the school nurse to administer his/her medication to:

_____, as prescribed by:_____
Child's Name Physician's Name - please print
(STAMP NOT ACCEPTABLE)

_____ _____
Parent's Signature Date
Comments (optional)
_____

EAST BRUNSWICK PUBLIC SCHOOLS
Student Services

PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING MEDICATION IN SCHOOL

Students Name: _____ Grade_____

School_____

TO BE COMPLETED BY THE PHYSICIAN:

Medication for the above-named child is necessary during the school day and should be administered as follows:

Date of Order:_____ Name of Medication_____

Diagnosis:_____

Purpose of medication:_____

Dose:_____ Time:_____A.M. _____P.M. _____P.R.N.

Can a reaction be expected: _____

If so, describe:_____

In the event of a field or class trip, the above named child may do without prescribed medication on that day. (Effective for this school year only) __ Yes may omit for trips __ No may not omit for trips

Student may self-carry and administer inhaler-epipen ____Yes ____No Hx: Anaphylaxis: ____ Yes ____No
Parent will provide an additional inhaler or pre-filled auto-injector mechanism (Epi-Pen) identical to the one the student is authorized to carry which will be retained by the school nurse in accordance with the district medication policy.

I certify that student has been trained in the use of the Inhaler____and /or Epipen_____

ASK/ENCORE program - permission for students to self administer inhaler or EpiPen. _____Yes _____No

Please note: NO other medications may be self carried or self-administered by the student.

Name of physician (please print): _____

_____
(Signature of physician) STAMP NOT ACCEPTABLE

Address: _____

Phone #:_____ Date: _____

_____ _____
Parent's Signature Date