CARTERET PUBLIC SCHOOLS

KINDERGARTEN REGISTRATION CHECKLIST

Please bring the following items with you to your scheduled registration appointment

	Required Item	**Check off each item (X)**
1	**Original** birth certificate with the raised seal	
2	Proof of residency with last name noted on the proof (**5 items in total**) • Must bring deed or lease agreement • Must bring appropriate completed affidavit (available during online pre-registration) • Choose 3 additional items such as: property tax bill, mortgage, voter registration, vehicle registration, license, permit, bank statement, utility bills, credit card bill, phone bill, and cancelled checks.	
3	Universal Child Health Record Form • Physical & Immunizations (completed by physician) Current records must be submitted at registration appointment	
4	Any legal document concerning a settlement agreement and/or court orders (if applicable) regarding parental rights/limitations due to divorce or separation	
5	Any previous public school records or IEP/Evaluation	

- To be eligible for Kindergarten, a child must be five (5) years of age on or before October 1, 2016.
- Kindergarten is housed in Columbus, Minue and Nathan Hale Schools and is a full-day program.

Carteret Public Schools
599 Roosevelt Avenue
Carteret, New Jersey 07008

Dear Parent/Guardian,

We would like to take this opportunity to welcome you and your child to the Carteret Public Schools. Kindly take a moment to review this important information regarding your child's health/immunization requirements.

All new entrants are required to have a physical examination within 365 days of enrollment into the Carteret Public Schools.

Should you not have a primary care physician, please be advised that Doctors' Medi Center located at Plaza 12, Suite 4A, 835 Roosevelt Avenue in Carteret. Medi Center will not process claims through insurance companies.

Additionally, state law mandates that your child will not be allowed to attend school in September without proof of completed immunizations with a doctor's signature. You must show evidence that your child has received the following immunizations.

DPT (Diptheria and Tetanus Toxoids and Pertusis Vaccine	At least four (4) doses, one (1) dose after the fourth birthday, or any vaccine combination containing DTP, such as DTP/Hib, or DTaP, one dose after the fourth birthday. Students born after 1/1/97 and entering Grade Six (6) on or after 9/1/08 are required to have one dose of Tdap provided at least 5 years have elapsed from the last Td dose.
Meningococcal Vaccine (Menactra)	Students born after 1/1/97 and entering or attending grade 6 on or after 9/1/08 shall have received one dose of meningococcal containing vaccine. *Please note this: This applies to students when they turn 11 years of age and attending grade six.
OPV (Oral Polio Vaccine)	At least three (3) doses, one dose after the fourth birthday or four doses spaced by a minimum of one month (28 days); (ages 1-6) three (3) doses (ages 7 or older).
MMR (Measles, Mumps, Rubella)	All students born on or after January 1, 1990, must receive two (2) doses of a measles-containing vaccine, preferably MMR, one (1) dose administered after the first birthday and the second dose at least one month later (28 days), or a documented laboratory evidence of immunity. Mumps and Rubella vaccine must be administered on or after first birthday, or documented laboratory evidence of immunity.
Varicella	All students born on or after January 1, 1998, must receive one (1) dose of varicella vaccine no earlier than their first birthday prior to school entry, as well as students who

	attend, transfer from another state or country, or documented laboratory evidence of immunity or previous varicella infection.
Hepatitis B	Three doses of Hepatitis B vaccine, or any vaccine combination containing Hepatitis B virus.
Haemophilus Influenza Type B (Hib) Conjugate Vaccine	12 months to 59 months of age, at least one (1) age-appropriate dose, 2 months – 11 months, a minimum of two (2) age-appropriate doses. Pre-School Students are required to receive an annual **influenza** vaccine.
Pneumococcal Conjugate Vaccine (PCV)	Pre-School students must have received age-appropriate dose.
Required Mantoux Testing	Students born in a country, as determined by the NJ Department of Health and Senior Services and entering school in the United States for the first time, regardless of age or grade.

Note: Failure to comply with immunizations requirements will result in exclusion.

Doctors' Medi-Center will administer immunizations by appointment only. Doctors' Medi-Center participates in the following health care insurance:

- Aetna
- Blue Cross/Blue Shield
- Cigna
- United Healthcare
- Great West

Medicaid participants may receive a prescription from the Doctors' Medi Center for immunizations.

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.

Elementary Dress Code Policy

Columbus, Minue and Nathan Hale Schools

Polo/Button Down Shirt: Plain Navy Blue or White shirt. (Short or long-sleeve). Turtleneck shirts may be worn, but must match the color shirt. The shirts may not have any images, logos, stripes, etc.	**Pants, Shorts, Skirts, Capris, or Skorts, Jumpers**: Khaki (Skirts must not be shorter than two inches above the knee.)
	
Shoes: Brown or Black School Shoes and/or Sneakers 	**OPTIONAL ITEMS*** • Navy Blue Cardigan Sweater • Navy Blue Vest • Navy Blue Tie (Boys & Girls) • Gym (Only to be worn on gym days: Navy Blue Sweats (Top & Bottom) or Navy Blue T-Shirt and Navy Blue Basketball (Gym) Shorts ***Parents do not need to purchase**

Uniform Locations and Prices

Store	Address	Shirt	Pants	Skirt/Skort
Old Navy	Linden	$5.00- $8.00	$6.00 - $10.00	$6.00 - $8.00
Children's Place	Linden Woodbridge Center	$7.00 – $9.99	$9.99- $14.95	$12.95- $14.95
Target	Linden	$6.39- $8.99	$10.39-$11.99	$6.99-$9.99
Walmart	Linden	$5.99- $8.99	$6.99- $12.89	$8.99- $12.99
Kids Town	Jersey Gardens, Elizabeth	$6.99 -9.99	9.99-14.99	$8.99 - $12.99

Please note the following:

- Accessories such as belts, socks, ties, and stockings, etc., must match accepted uniform colors.
- **No hoodies or clothing with attached hats may be worn in classroom. All jackets and outerwear will be required to be kept in classrooms.**

Carteret Public Schools

Student Attendance Contract

Student Name:	**Grade:**
Parent Name:	**Date:**

The purpose of this contract is to establish methods for improving school attendance and to provide support and interventions that will reduce or eliminate future absences from school.

As the parent or guardian, I will:

- Assume responsibility for assuring my child attends school on a regular basis as required by New Jersey laws for compulsory school attendance.
- Assist my child in getting to school and to the first class of the day on time each day that school is in session except for major illness, injury, or other absences excused by the school district.
- Contact the school the morning of an absence to explain the reason for the absence.
- When taking my child to see a doctor, I will get a written note from the doctor stating my child was seen and the number of days to be excused from the school. I will provide that note to the school upon my child's return to school.

As the school, we will:

- Monitor daily attendance and contact the parent/guardian if we have any concerns regarding absences or tardies.
- Request a meeting with the parent/guardian if excessive absences or tardies are not resolved.
- Seek to provide assistance to the parent/guardian in resolving circumstances that are making it difficult for your child to be at school each day on time.
- Follow district guidelines with reporting excessive absences to the municipal court administrator.

As the student, I will:

- Attend school and all assigned classes on time each day that school is in session except for major illness, injury or other excused absence by the school district.

As parent/guardian/child, we understand and agree to the terms and conditions of the Attendance Contract, and as parent/guardian I agree to support my child in this plan. We further understand that regular attendance in school is required by law because of the importance of academic learning time for all students.

_____ _____

Printed Name of Parent/Guardian Parent/Guardian Signature

_____ _____

Student Signature School Administrator Signature

*A copy of this contract will be provided to the parent/guardian once the signatures of all parties have been obtained.