Instructions for Kindergarten – 12th Grade Registrations

FOR ALL STUDENTS:

1. Please print out one copy of the registration forms for each student you need to register.

2. In addition to the completed registration forms, you will need an original birth certificate and three proofs of residency.* Please have one photocopy of the birth certificate and residency proofs. Originals will be returned to you.

3. Please note that your child will not be able to attend school unless the Physical Examination / Immunization Form is completed and signed by your child’s physician. The physical exam must be no more than one year old as of the first day of school. Also note that there are additional immunization requirements if you are registering a student in 6th grade or higher – please read the entrance requirements on the Physical Examination form carefully.

4. Once all of your paperwork is complete, please call our District Registrar, Michele Vitiello, at (908) 204-2585, Ext. 105, to set up a registration appointment. Mrs. Vitiello’s office is located in the Counseling Office at Ridge High School, 268 South Finley Avenue, Basking Ridge. PLEASE NOTE that if you will be enrolling your kindergartner in your districted school on registration day in February, you do not need to call the District Registrar for an appointment.

FOR WILLIAM ANNIN MIDDLE SCHOOL STUDENTS:

In addition to the general registration information above, please go to the William Annin Middle School website (under “Schools” tab on the district website, www.bernardsboe.com) and click on “Counseling.” Go to “Course Selection,” and download the grade-appropriate form. This form must also be completed and signed by you and your child and brought to the registration meeting with your child’s most recent report card. Your child does not need to accompany you to this appointment.

FOR RIDGE HIGH SCHOOL STUDENTS:

In addition to the general registration information above, please go to the Ridge High School website (under “Schools” tab on the district website, www.bernardsboe.com) and click on “Counseling.” Go to “Scheduling,” and download the grade-appropriate Course Selection sheet. Review the Program of Studies and then fill out the Course Selection sheet with your child and bring it to the registration/scheduling meeting with your child’s most recent report card (for incoming 9th grade students) or transcript (for incoming 10th through 12th grade students). Your child should attend this meeting.

* Acceptable proofs of residency include:

- HUD Settlement Statement (if you have just closed on the sale of a new residence)
- Deed or current Lease Agreement
- Mortgage statement
- Bernards Township property tax bill
- Bernards Township sewer bill
- Homeowner’s insurance bill
- Utility bills (e.g., gas, electric, cable, telephone)
REGISTRATION FORM

☐ Cedar Hill School ☐ Liberty Corner School ☐ Oak Street School ☐ Mt. Prospect School
☐ William Annin Middle School ☐ Ridge High School

Birth Certificate ____ Classroom Assignment: ____________________________
Proof of Residency (3) ____ Starting Date: ____________________________
Transportation _____ Student ID: ____________________________
Immunization/Medical ____ SID: ____________________________

In the space below, please write the student’s name EXACTLY as it appears on the birth certificate:

___________________________________________________ ___________________________________________________ ______________________
Last Name     First Name   Middle Name

___________________________________________________ ___________________________________________________ ______________________
Address (City, State, Zip)     Home Phone

Grade: ___________ Date of Birth: ___________________________ ☐ Male  ☐ Female

City/State of Birth: ___________________________ Country of Birth: ___________________________

Language student uses to communicate at home: ___________________________ First language spoken: ___________________________

If not born in the US, date child first enrolled in a US school: ___________ Does the child speak English? ___________

Ethnicity (Check all that apply – see page 2 for explanation):
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White or Caucasian
☐ Asian ☐ American Indian/Alaska Native ☐ Hispanic/Latino

Father Last Name __________________________________ Mother Last Name __________________________________
First Name __________________________________ First Name __________________________________
Home Phone* __________________________________ Home Phone* __________________________________
Work Phone __________________________________ Work Phone __________________________________
Cell Phone __________________________________ Cell Phone __________________________________

* If different from student’s home telephone number

Parent/Guardian Email Address (for all official correspondence): _______________________________________________________

Student resides with: ☐ Parents ☐ Mother ☐ Father ☐ Other (specify): ___________________________

If the student does not reside with both parents, please provide the contact information (including email address) of the joint custodial or non-custodial parent entitled by law to receive reports:

___________________________________________________ ___________________________________________________ ______________________
___________________________________________________ ___________________________________________________ ______________________

Name and Address of School Last Attended: _______________________________________________________

Has the student previously attended a Bernards Township School? ___________ If yes, dates: ____________________________
Emergency Contacts (other than parents) -- please list name and telephone number where contacts can be reached during the school day):

Emergency Contact #1: _____________________________ __________________ Phone #:________________________ ____________

Emergency Contact #2: _____________________________ __________________ Phone #:________________________ ____________

Emergency Contact #3: _____________________________ __________________ Phone #:________________________ ____________

Does student have siblings already attending school in the Bernards Township School District?  ☐ Yes  ☐ No

If yes, please list names below:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth</th>
<th>M/F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>Middle Name</td>
<td>Date of Birth</td>
<td>M/F</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>Middle Name</td>
<td>Date of Birth</td>
<td>M/F</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>Middle Name</td>
<td>Date of Birth</td>
<td>M/F</td>
</tr>
</tbody>
</table>

Explanation of ethnicity questions:

- **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race.

- **American Indian or Alaska Native** – A person having origins in any of the original people of North and South American (including Central American) and who maintains a tribal affiliation or community attachment.

- **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- **Black or African American** – A person having origins in any of the black racial groups of Africa.

- **Native Hawaiian or Other Pacific Islanders** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- **White or Caucasian** – A person having origins in the original peoples of Europe, the Middle East or North Africa.
Bernards Township Public Schools
Nursing Department

HEALTH HISTORY
(To be completed by Parent(s)/Guardian)

Student Name: ________________________________________
Date of Birth: ________/________/________
Sex: ___________

Father’s Name: _____________________________________ Mother’s Name: ______________________________________

Address: _________________________________________________ Phone Number: _________________________

Email Address: _________________________________________________ _________________________ (Please Print Clearly)

Place of Birth: ________________________________

Entering School From: _______________________________________ 

City / State / Country

Siblings: Name ___________________________ Age: ______
Name ______________________________ Age: ______
Name ___________________________ Age: ______
Name ______________________________ Age: ______

Please review the conditions listed below and indicate any that apply with a check (✓)
Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Bee Sting</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
</tr>
<tr>
<td>Anaphylactic Reaction (give date)</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Asthma / Bronchitis</td>
<td></td>
</tr>
<tr>
<td>Bowel Problem</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
</tr>
<tr>
<td>Chronic / Recurrent Illness</td>
<td></td>
</tr>
<tr>
<td>Convulsions/Seizures</td>
<td></td>
</tr>
<tr>
<td>Concussion/Head Injury (give date)</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
</tr>
<tr>
<td>Emotional / Psychiatric Problems</td>
<td></td>
</tr>
<tr>
<td>Fainting</td>
<td></td>
</tr>
<tr>
<td>Fracture / Dislocation / Sprain</td>
<td></td>
</tr>
<tr>
<td>Frequent Colds / Sore throat</td>
<td></td>
</tr>
<tr>
<td>Frequent Headaches</td>
<td></td>
</tr>
<tr>
<td>Frequent Stomach Aches</td>
<td></td>
</tr>
</tbody>
</table>

Please review the conditions listed below and indicate any that apply with a check (✓)
Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Problem</td>
<td></td>
</tr>
<tr>
<td>Heart Problem</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Kidney/Urinary Problem</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td></td>
</tr>
<tr>
<td>Lyme Disease</td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular Disease</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Problem</td>
<td></td>
</tr>
<tr>
<td>Operations / Conditions Requiring Hospitalization</td>
<td></td>
</tr>
<tr>
<td>PDD / Autism</td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td></td>
</tr>
<tr>
<td>Skin Condition</td>
<td></td>
</tr>
<tr>
<td>Speech Communication Problem</td>
<td></td>
</tr>
<tr>
<td>Strep Infections</td>
<td></td>
</tr>
<tr>
<td>Sustained illness past 3 months</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse (alcohol, drugs)</td>
<td></td>
</tr>
<tr>
<td>Toothache, Dental problem</td>
<td></td>
</tr>
<tr>
<td>Tumor</td>
<td></td>
</tr>
<tr>
<td>Vision Problem</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
</tr>
</tbody>
</table>

List any other concerns you may have about your child’s health, development, learning, behavior or home situation, which might affect his/her performance: ____________________________________________________________

Parent/Guardian Signature:____________________________________________ Date: ___________ / _________ / ___________
Bernards Township Public Schools  
Nursing Department

Health Entrance Requirements  
Kindergarten through 12th Grade

- Physical examination completed between September 1 of the year your child is entering school and September 1 of the previous year.

- Immunizations
  - DTP (Diphtheria, Tetanus Toxoid and Pertussis)
    - Age 1-6 years - 4 doses, with one dose given on or after the fourth birthday, OR any 5 doses
    - Age 7 or Older - 3 doses of Td or a combination of DTP, DtaP, and Td.
  - Tdap booster
    - Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher
  - Poliovirus Vaccine
    - Age 1 – 6 years - 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses
    - Age 7 – 17 years - 3 doses, either OPV or IPV separately or in combination
  - Measles
    - 2 doses of a measles containing vaccine. First dose given on or after the first birthday (if before first birthday, re-immunization is required). Intervals between first and second measles/MMR cannot be less than one month. Laboratory evidence of immunity is also acceptable.
  - Rubella
    - 1 dose OR laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).
  - Mumps
    - 1 dose OR laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).
  - Hepatitis B Virus Vaccine
    - 3 doses (age 1-15) OR 2 doses Adult Formulation (age 11-15) OR laboratory evidence of immunity.
  - Varicella (Chicken Pox) Vaccine
    - 1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity
  - Meningococcal Vaccine 6th - 12th grades
    - Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher
  - Mantoux Test (PPD)
    - Students entering a US school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test.

- Antigua and Barbuda
- Australia
- Austria
- Barbados
- Belgium
- Bermuda
- Canada
- Cayman Islands
- Cuba
- Cyprus
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greenland
- Grenada
- Iceland
- Ireland
- Israel
- Italy
- Jamaica
- Jordan
- Lebanon
- Luxembourg
- Malta
- Monaco
- Montserrat
- Netherlands
- Netherlands Antilles
- New Zealand
- Norway
- Oman
- Puerto Rico
- Saint Kitts and Nevis
- San Marino
- Sweden
- Switzerland
- Trinidad and Tobago
- United Kingdom of Great Britain and Northern Ireland
- United States of America
- United States Virgin Islands
**Health Entrance Requirements**

*Pre-Kindergarten*

- **Physical examination** completed between **September 1** of the year your child is entering school and **September 1** of the previous year.

- **Immunizations**
  - **DTP (Diphtheria, Tetanus Toxoid and Pertussis)**
    - *Age 1-5 years* - 4 doses
  - **Poliovirus Vaccine**
    - *Age 1 – 5 years* - 3 doses
  - **Measles**
    - 1 dose of a measles containing vaccine given on or after the first birthday.
  - **Rubella**
    - 1 dose given on or after the first birthday.
  - **Mumps**
    - 1 dose given on or after the first birthday
  - **Varicella (Chicken Pox) Vaccine**
    - 1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity
  - **Haemophilus influenza type b (Hib) conjugate Vaccine**
    - At least one dose of a separate or a combination Hib conjugate vaccine, on or after the first birthday.
  - **Pneumococcal Conjugate Vaccine**
    - At least 1 dose, on or after the first birthday
  - **Influenza Vaccine**
    - Shall receive one dose of influenza vaccine between September 1 and December 31 of each year.
  - **Mantoux Test (PPD)**
    - Students entering a US school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test.

- Antigua and Barbuda
- Australia
- Austria
- Barbados
- Belgium
- Bermuda
- Canada
- Cayman Islands
- Cuba
- Cyprus
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greenland
- Grenada
- Iceland
- Ireland
- Israel
- Italy
- Jamaica
- Jordan
- Lebanon
- Luxembourg
- Malta
- Monaco
- Montserrat
- Netherlands
- Netherlands Antilles
- New Zealand
- Norway
- Oman
- Puerto Rico
- Saint Kitts and Nevis
- San Marino
- Sweden
- Switzerland Trinidad and Tobago
- United Kingdom of Great Britain and Northern Ireland
- United States of America
- United States Virgin Islands
# Physical Examination

(To be completed by Physician)

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
<th>MO/ DAY /YR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Please Specify Type: Td, DT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Entering grade six OR above</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio- (Please Indicate)</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
<td>IPV / OPV</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus B (HIB)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal- (Please Indicate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Entering grade six OR above</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV (Human Papillomavirus) -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Please Indicate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ages 6-59 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mantoux TB Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>See EXEMPT countries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of Exam**: ______ / ______ / ______  
**Ht**: ______  
**Wt**: ______  
**B/P**: ______

**Allergies**:  
**Medications**:  

**Significant Medical / Surgical History**:  

**Vision (without glasses)**:  
Rt.: 20 / ______  
Lt.: 20 / ______  
(with correction):  
Rt.: 20 / ______  
Lt.: 20 / ______

**Hearing**:  
Rt.: ______  
Lt.: ______  
***Vision and Hearing MUST be completed by physician’s office***

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears (otoscopic)</td>
<td>Genito-Urinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Orthopedic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Glands</td>
<td>Structural</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td>Posture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td>Feet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat</td>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth / Mouth</td>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>Nervous System</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Based on the above physical exam, this patient is capable of **FULL** participation in all school activities: _____Yes _____No

**Exceptions**:  

**STAMP**

(MUST BE PRESENT FOR THIS TO BE VALID)

Examining Practitioner: ____________________________

Rev 1-2017
Bernards Township Public Schools
Nursing Department

EMERGENCY MEDICAL INFORMATION

Student Name ______________________________________ _________        School____________________________ ______

Reliable information is necessary should a sudden accident or illness occur while your student is at school.

We will attempt to contact you if any type of medical attention is needed. However, in the event that treatment is necessary and we are unable to contact you, your signature below will authorize the school authorities, doctor, or hospital to use their best judgment in the interest of your child’s health.

Emergency Treatment Permission

Authorization is given to perform necessary emergency treatment of my child whose medical history is listed on the bottom of this form.

_________________________________   _______________ _____   _________________________________   _______ _____________
(Signature of legal guardian)                       (Date)    (Signature of student if 18 or older)         (Date)

Tylenol Authorization

I hereby authorize the nurse with the school physician’s order to administer Tylenol (acetaminophen), (age and weight appropriate).

_________________________________   _______________ _____   _________________________________   _______ _____________
(Signature of legal guardian)                       (Date)    (Signature of student if 18 or older)         (Date)

Release of Medical Information

I hereby authorize the release of my child’s pertinent medical information to appropriate professional staff. I give consent and understand that the medical information may be shared, when necessary, with appropriate professional staff involved in the care of my child.

_________________________________   _______________ _____   _________________________________   _______ _____________
(Signature of legal guardian)                       (Date)    (Signature of student if 18 or older)         (Date)

Emergency Health Information

List any illnesses; injuries or surgeries that have taken place in the last year: ____________________________________________

List allergies to food, medications, insect bites or stings (list and be specific): ________________________________

List any physical disorders, conditions or limitations: __________________________________________________________

List ANY medications that are currently being taken: ____________________________________________________________

Epi-Pen: □ Yes    □ No    Inhaler for: ____________________________    Yes    No    Type_____________________________

Is this student covered by health insurance? ______
If yes, please provide Insurance Company name:
If no, you may release my name and address to NJ Family Care** to contact me about health insurance.

_______________________________________  __________ ___________________________ ______________
Signature     Printed Name    Date

** NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For information, call (800) 701-0710 or visit www.njfamilycare.org to apply online.