OXFORD CENTRAL SCHOOL

17 Kent Street

Oxford, N.J. 07863

908-453-4101

www.oxfordcentral.org

Kindergarten Registration at Oxford Central School
2018-2019 School Year

Oxford Central School will hold kindergarten registration for the 2018-2019 school year on **Tuesday, March 20th** at the school. To register, your child must be 5 years old on or before October 1st, 2018. The following must be brought to registration:

- *Updated official immunization record from the doctor. This must show evidence of immunizations for diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hepatitis B and varicella.*
- *Original Birth Certificate*
- *Proof of residency (2 documents)*
- *Recent picture of your child*

Please call Barbara Svercauski (OCS School Nurse) at the following number to schedule your appointment—(908) 453-4101 Ext. 2106. Also, please call this number should you have any questions.

Registration packets will be available for pick up at the school beginning the week of February 5th. This packet will also be available on the school's homepage.
These forms and requirements should be brought to your scheduled registration appointment.
Your child does not need to be present during registration.

Please note: Kindergarten Round-up is scheduled for **Tuesday April 10th**. You will be contacted with additional information.

Thank you,
Barbara Svercauski
OCS School Nurse

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Mr. Robert Magnuson
Chief School Administrator

Ms. Nancy DeRiso
Business Administrator

Oxford Central School Students are C.O.R.R.E.C.T.

Proof of Residency Certification

Registration Date: _____

I/We _____, parent/guardian of _____
(Print Parent/Guardian's Name) (Print Student's Name)

Affirm that I/We reside in the town of Oxford at the property located at:

_____, Oxford, N.J. 07863.

I certify that the address provided is my home that "is permanent when the parent or guardian intends to return to it when absent and has no present intent of moving from it, notwithstanding the existence of homes or residences elsewhere" and is where we return to each night. If the board of education finds this to be untrue, I understand that I will be liable for back tuition to be paid to the district.

Two of the following documents have been provided and copies attached as proof of residency: (Note: If unable to provide documentation at time of registration, proof of residency information must be provided with thirty (30) days of the date of registration.)

_____ **Current driver's license**

_____ **Current property deed, lease agreement or property tax bill**

_____ **Current utility bill**

_____ **Other – Please describe (other acceptable items may include pay stub from current employer showing property address, post office mailbox number showing property address, automobile registration, or voter registration card).**

Office Use Only:
I_____ have reviewed the material(s) presented on _____ and
(Administrator's Signature) (Date)
Approve/ deny (circle one) the above named student's admittance to the Oxford Central School. Original certification and copies of documentation are to e kept in students file.

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17 Kent Street, Oxford, N.J. 07863

EMERGENCY CONTACT

1. **Student Information**
   Name _____
   Address _____
   Home Telephone # _____ Date of Birth _____
   Grade _____ Teacher _____

2. **Parent/Guardian Information**
   Guardian #1 name _____ Home # _____
   Work tel. # (w. ext) _____ Cell # _____
   E-mail _____
   Guardian # 2 name _____ Home # _____
   Work tel. # (w. ext.) _____ Cell # _____
   E-mail _____

Are either parent/guardian members of a branch of the Military? ___ yes/no
Active Duty / Retired _____ Branch of Military _____ Rank_____

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated. Notify the school immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the school with a copy of the order.

3. **Child Care Provider Information**
   Those designated below are authorized to pick up my child from school in an emergency:
   Child care provider's name _____
   Tel. # _____ Cell tel. # _____
   Child care provider's name _____
   Tel. # _____ Cell tel. # _____

4. **Local Contact Information (Designate 1 parent in our school)**
   1. Local contact's name _____ Relationship to child _____
   Home tel. # _____ Work tel. # (w. ext.) _____
   Cell tel. # _____
   2. Local contact's name _____ Relationship to child _____
   Home tel. # _____ Work tel. # (w. ext.) _____
   Cell tel. # _____

5. **Out of Town Contact Information**
   Name _____ Relationship to child _____
   Home tel. # _____ Work tel. # (w. ext.) _____
   Cell tel. # _____

6. **Medical/Physician Information**
   List student's known allergies or medical conditions _____
   _____
   Doctor's name _____ Tel. # _____
   Hospital preference _____
   Insurance company _____
   Dentist's name _____

PLEASE COMPLETE REVERSE SIDE

7. Does child have Health Insurance?

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 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJ Family Care 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).

I, the undersigned, do hereby authorize officials of New Jersey Public Schools 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 card, 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.

Signature of Parent(s)/Guardian(s) Date

Please keep a copy of this form for your records. Important: Please update your school immediately if any information changes.

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Name/Photo/Video Release
Form 2018-2019

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personal identifiable information to be published on the district and/or school's web site.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as a school do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, e-mail address, phone numbers and locations and times of class trips.

If you,as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of the school and such rescission will take effect upon receipt by the school.

Check the following choices:

I GRANT permission for this student's photo/image and other personal identifiers listed above to be published on the school, public Internet site, and in local newspapers.

_YES _____NO

GRANT permission for my child's photo to be used in the school yearbook.

_____YES _____NO

Student Name (print):_____ Grade _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature:_____ Date: _____

Relation to Student: _____

Courage *Optimism* *Respect* *Responsibility* *Empathy* *Citizenship* *Trustworthiness*

Oxford Central School Health Office
Barbara Svercauski, RN, BSN, CSN
17 Kent Street
Oxford, NJ 07863
Ph: 908-453-4101 Ext. 2106
Fax: 908-453-0022

Required Health Information for Kindergarten Attendance

State of New Jersey Vaccine Requirements for Kindergarten Entry:

DTP/DTaP Series--- 4 to 5 doses needed depending upon age at school entry
Hepatitis B Series---3 doses
MMR Series ---------2 doses
Polio Series ----------3 to 4 doses needed depending upon age at school entry
Varicella ----------1 dose

Please provide the school with an official copy of your **child's immunization record. This copy is provided by your child's physician.**

The State of New Jersey also requires that your child have **a physical** performed and documented by your physician before entrance into school. This may have been completed up to one calendar year prior to your child's entrance into kindergarten at Oxford Central School. The required form can be found in this packet.

PLEASE NOTE: All immunization and physical requirements must be completed and on file with the school nurse by Friday, July 27th, 2018. If this is not done, your child will not be allowed to attend school on the first day.

It is also suggested that your child have a dental evaluation.

Please feel free to contact me with any questions you may have.

Thank you,
Barbara Svercauski RN
School Nurse

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Oxford Central School Kindergarten and Preschool/PreK Registration Health Inventory

PARENT TO COMPLETE

Please complete the following information and return to the school nurse at registration. Please use the back of the form if necessary.

STUDENT: _____ DOB:_____
Mother's name_____ Cell #_____
Father's name_____ Cell#_____
Home phone #_____
Child's Physician_____ Phone #_____
Specialist Name _____ Phone #_____
Please list names of child's siblings and birthdates of each:
_____
_____
_____

1. Please indicate any problems that occurred with either pregnancy or birth of this child. (i.e. premature or full term, c- section, diabetes (mom), hypertension (mom), etc.)_____
   _____
   _____
   _____

2. **DEVELOPMENTAL ISSUES:**
   Age at walking: _____ Age began talking: _____
   Age at toilet training: _____
   Describe present eating and sleeping habits:
   _____
   Any difficulty with: bed wetting _____;
   bowel habits _____; speech _____;
   other _____

3. **HEALTH HISTORY:** Has your child had any of the following? **(Please circle any that apply) <u>If yes, explain on other side.</u>**

Hospitalizations	Constipation (frequent)
Operations	Diarrhea (frequent)
Frequent colds	Joint pain, swelling or limping
Frequent sore throats	Frequent earaches
Hearing loss	Tubes placed in ears
Vision problems	Wears glasses
Dental issues	Headaches
Urinary issues	Bronchitis
Speech problems	Coordination problems
Skin issues	Pneumonia

over →

Heart disease Lyme disease

Asthma or Reactive airway disease diagnosed by doctor
Allergic reaction to foods, medications, other_____
Seizure disorder; if yes on meds_____
ADHD or other behavior issue_____
List any medication prescribed by doctor taken by child_____

Any comments: _____

List any recent significant injuries:

List any recent medical tests:

Date of last physical by doctor: _____

4. **EMOTIONAL/BEHAVIOR HISTORY**:
Describe relationship with parents:

Describe relationship with any siblings:

Does your child exhibit any of the following? **(Please circle any that apply)** **If yes, explain on other side.**

Excessive shyness Persistent crying
Temper tantrums Nail biting
Difficulty interacting with other children

5. **OTHER**
Please list any significant medical, social or behavioral history in child's immediate family:

Please provide any further information that you feel would help provide a more healthful environment for your child: