PRESCHOOL & PRE-K INFORMATION 2022-2023

Your child will need a backpack each day for school. Please choose something that is a comfortable size for your child. Packing and unpacking our backpacks are part of our routine each day. A simple zipper will help encourage your child to work on self-help skills. Backpacks with clips or buckles often prove to be frustrating for small hands. The backpack needs to fit a folder and a snack each day, as well as any small art projects that will come home.

Your child will need a spare set of clothing to keep at school in case of an emergency. This includes a shirt, pants, underwear, and socks. If your child is not fully potty-trained, they will also need a supply of pull-up/diapers and wipes. If we return an item home to you, please replace it and send it back to school. Please send all items in a zip lock bag clearly labeled with your child's name.

Preschool & PreK Hours and Costs

Preschool: Monday through Friday 8:30am-11:00am at a cost of $3,600.00 per School year.

PreK: Monday through Friday 12:00pm-3:00pm at a cost of $3,600.00 Per School year.

TWO HOUR DELAY

Preschool: There will NOT be Preschool when we have a 2 hour delay.

PreK: Students will be dropped off at 12:00pm and dismissed at 3:00pm. The students will have snack time.

EARLY DISMISSAL 1:00PM

PRESCHOOL: Students can be dropped off at 8:20am and will be Dismissed at 10:30am. We will have a snack time.

PreK: Students can be dropped off at 11:00am and will be Dismissed at 1:00pm. We will have a snack time.

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
Email bsvercauski@oxfordcentral.org

Required Information for Pre-school and Prekindergarten Registration

The following must be provided to register for pre-school and pre-kindergarten:

- *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*

State of New Jersey Vaccine Requirements for Pre-school/ Prekindergarten Entry:

DTP/DTaP Series--- 4 doses
Hib Vaccine----------3-4 doses
Hepatitis B------------3 doses
MMR Series ---------1 dose
Polio Series ----------3 doses
Varicella --------------1 dose
Influenza Vaccine----1 dose
PCV--------------------4 doses

Please provide the school with an official copy of your child's immunization record.

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 pre-school/ prekindergarten at Oxford Central School. The required form can be found in this packet.

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

OXFORD CENTRAL SCHOOL
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.

OXFORD CENTRAL SCHOOL

17 Kent Street

Oxford, N.J. 07863

908-453-4101

www.oxfordcentral.org

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.

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

FORM C

OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, N.J. 07863

Student History

Child's Name ______________________________

1. Has there been any family incidents (i.e. death, separation, family financial concerns, etc.) recently that may have upset the child? Yes _____ No _____

   If checked yes, please describe below

   ____

   ____

2. Family:

   How many children are in your family? __________

   Any foster children? ______ Adopted? _______

   Any others living at home other than parents? ______________________________

   Relationship? ______________________________

   Who has legal custody of the child? ______________________________

   Do both parents work? ______________________________

   Who cares for the child? ______________________________

   Foreign language spoken at home? ______________________________

   How does the child react to situations when one or both parents leave home?

   _____ Cries _____ Accepts it well _____ Temper Tantrum _____ Adjusts quickly to situation

   Has the child traveled much? ________ Where? ______________________________

3. Development:

   Did you have any difficulties ___ Before ___ During ___ After the birth of your child?

   Please explain ______________________________

   ____

4. At what age (approximately) did the child learn to:

   Crawl _________ Walk _________ Toilet Trained _________

   Can dress him/herself _________ Tie shoe laces _________

   Button _________ Zip _________

Student History

Has the child had formal pre-school experience? ________

Where? ______________________ How long? ______________

How clear and well-formed was the child's speech and how is it now?

____

Does the child have children his/her age to play with in his/her neighborhood?

____

Did the child have difficulty learning to ride a bicycle ____, skip rope _____, learn to throw or catch? _____

Handedness ______________________ (left, right, or both)

What the child's favorite activities? ______________________

Does the child know his full name ? ______ Address? ______ Telephone number? ________

Does the child know nursery rhymes? _____ Songs? _____ Stories? _____ ABC's _____

Does your child listen to instructions when he is called, directed, etc.? ______________

Does your child have any fears? ______________ Please explain: ______________

____

____

Does your child take a nap? ______________________

Is there any other condition or experiences you would wish to mention that could affect the learning situation of your child? ______________________

____

____

______________________________ Signature of Parent/Guardian

______________ Date

OXFORD TOWNSHIP SCHOOL DISTRICT
17 Kent Street
Oxford, N.J. 07863
(Print or type all information)

FORM A

SECTION A: Pupil Background Section

Circle grade for which enrolling: PS PK K 1 2 3 4 5 6 7 8

Pupil: ____
Last Name First Name Middle Name

Address: ____
Street and Number Apt. # Home Phone

Birth Date: ____________ Birth Place ______________________________
mo/day/year City State Country

Transfer Card Received: ___ YES _____ NO Verified: B.C. ____ Passport____

Last school attended ____
Name of school /Address Phone Number Grade

Pupil is in a:

1. special education program ☐ YES ☐ NO
2. basic skills program ☐ YES ☐ NO
3. ELS, bi-lingual education program ☐ YES ☐ NO
4. speech/language program ☐ YES ☐ NO
5. gifted and talented program ☐ YES ☐ NO

Ethnicity Codes: W/White
B/Black/African American
H/Hispanic/Latino
A/Asian
I/American Indian/Alaska Native
P/Native Hawaiian/Pacific Islander
__________ Ethnicity

Check one: First language spoken at home is _______English _________ Other*
*(Indicate country/dialect) ______________

SECTION B: Parent/Guardian and Family Data Information

Parent/Guardian #1 ______________________________ Day time phone ______________
Cell Phone ______________

Employer ____________________________ Address ______________________________

Work Phone ____________________________

Parent/Guardian #2 ______________________________ Day time phone ______________
Cell Phone ______________

Employer ____________________________ Address ______________________________

Marital Status: ☐ married ☐ alternative ☐ separated ☐ single ☐ divorced ☐ widow ☐ widower

- Other children at home (list oldest first, youngest last)

Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB

SECTION C Medical Section

The following items if not submitted at the time of registration, must be completed prior to the first day of attendance. If compliance is not forthcoming by that time, the pupil will not be accepted for admission and this application shall be void.

Physician's certificate has been provided (or letter) attesting that the pupil has had a physical examination within the last school year.

Medical records have been provided certifying immunization per state requirements on form provided by district

OR

Modification or Exemption from requirements due to religious beliefs.

Dependency Verification (any one of the following)

Birth certificate/passport bearing same surname of pupil as parent/guardian
Copy of section of a court decree awarding custody of the pupil
Letter from a department of state or federal government
A properly executed affidavit of support

I/we fully understand that the Oxford Township School District retains the full right to verify any information contained in this application at any time during the period for which enrollment is pending or after enrollment has actually taken place. If at any time the pupil registered no longer qualifies as a Oxford Township pupil, I/we shall forthwith advise the office of the Chief School Administrator, Oxford Central School, 17 Kent Street, Oxford, NJ 07863. I/we fully understand that failure to do so shall hold me/us legally responsible for all tuition costs, legal costs, and any other expenses incurred by the Oxford Township School District during that period of time for which the pupil was not so qualified for enrollment. I/we understand that no documents or pupil records, awards, or diplomas shall be issued to the pupil or to his parent/guardian or be forwarded to any other school district or school until such costs have been settled with the Oxford Township School District.

Signature of parent/guardian Date

Signature of school registrar Date

Comments or notations by school district

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	

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

Todays: Date: ____________

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

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)** **<u>If yes, explain on other side.</u>**

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:
____
____
____