WE ARE GLAD THAT YOUR CHILD WILL BE JOINING US TO CONTINUE THEIR EDUCATION HERE AT OCS FOR THE 2020 - 2021 SCHOOL YEAR. OUR PRE-SCHOOL /PRE-KINDERGARTEN CLASS WILL BE MEETING IN SEPTEMBER MONDAY THROUGH FRIDAY.

THE ANNUAL COST FOR THE 10 MONTH PROGRAM WILL BE $3,600.00 AND WILL BE INVOICED IN AUGUST OF 2020 AND WILL BE DIVIDED EQUALLY BY 10 MONTHS, ($360.00 PER MONTH) FROM OUR BOARD OF EDUCATION OFFICE.

TRANSPORTATION WILL NOT BE PROVIDED UNLESS OTHERWISE ELIGIBLE. CONTACT OUR MAIN OFFICE AT 908-453-4101 FOR A PACKET.

Thank you!
Mr. Magnuson
OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, N.J. 07863
908-453-4101
www.oxfordcentral.org

Mr. Robert Magnuson
Chief School Administrator

Ms. Nancy DeRicco
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:


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 be kept in student’s file.

Courage  Optimism  Respect  Responsibility  Empathy  Citizenship  Trustworthiness
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 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 #: ___________________________ Cell #: ___________________________
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) If yes, explain on other side.
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

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
Temper tantrums
Difficulty Interacting with other children
Persistent crying
Nail biting

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:

1/6/16
OXFORD CENTRAL SCHOOL
17 Kent Street
Oxford, NJ 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  ______ Tamper 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 himself/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 ________
<table>
<thead>
<tr>
<th>Pupil Background Section</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Circle grade for which enrolling:</strong></td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>Birth Date:</strong></td>
</tr>
<tr>
<td><strong>Transfer Card Received:</strong></td>
</tr>
<tr>
<td><strong>Last school attended:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil is in a:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. special education program</td>
</tr>
<tr>
<td>2. basic skills program</td>
</tr>
<tr>
<td>3. ELS, bi-lingual education program</td>
</tr>
<tr>
<td>4. speech/language program</td>
</tr>
<tr>
<td>5. gifted and talented program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>W/White</em></td>
</tr>
<tr>
<td><em>B/Black/African American</em></td>
</tr>
<tr>
<td><em>H/Hispanic/Latino</em></td>
</tr>
<tr>
<td><em>A/Asian</em></td>
</tr>
<tr>
<td><em>I/American Indian/Alaska Native</em></td>
</tr>
<tr>
<td><em>P/Native Hawaiian/Pacific Islander</em></td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check one:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First language spoken at home is:</strong></td>
</tr>
<tr>
<td><em>(Indicate country/dialect)</em></td>
</tr>
<tr>
<td><strong>English</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian and Family Data Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent/Guardian #1</strong></td>
</tr>
<tr>
<td><strong>Employer</strong></td>
</tr>
<tr>
<td><strong>Work Phone</strong></td>
</tr>
<tr>
<td><strong>Parent/Guardian #2</strong></td>
</tr>
<tr>
<td><strong>Employer</strong></td>
</tr>
</tbody>
</table>
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.nifamilycare.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 80 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
Mrs. Julie Rienzi
Director of Special Services

Ms. Nancy DeRiso
Business Administrator

Oxford Central School Students are C.O.R.R.E.C.T.
Name/Photo Video Release Form 2020 - 2021

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 website, public Internet site, in local newspapers, social media sites maintained by OCS, and in the school yearbook.

Yes    No

Student Name (print):_________________________ Grade:____

Parent/Guardian Name (print):______________________________

Parent/Guardian Signature:______________________________

Relation to Student:______________________________

Date:______________________________
**UNIVERSAL CHILD HEALTH RECORD**

**SECTION I: TO BE COMPLETED BY PARENT(S)**

<table>
<thead>
<tr>
<th>Child’s Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does Child Have Health Insurance?</th>
<th>If Yes, Name of Child’s Health Insurance Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td></td>
</tr>
<tr>
<td>[ ] No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Home Telephone Number</th>
<th>Work Telephone/Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Home Telephone Number</th>
<th>Work Telephone/Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I give my consent for my child’s Health Care Provider and Child Care Provider/School Nurse to discuss the Information on this form.

<table>
<thead>
<tr>
<th>Signature/Date</th>
<th>This form may be released to WIC.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

**SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER**

<table>
<thead>
<tr>
<th>Date of Physical Examination</th>
<th>Results of physical examination normal?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note If Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead: [ ] Capillary</td>
<td>[ ] Varous</td>
<td></td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Developmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name of Health Care Provider (Print)</th>
<th>Health Care Provider Stamp:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature/Date

CH-14 JUL 12

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