June 2018

Dear Parents/Guardians,

Thank you for registering your child/children in Saint Joseph Regional for our **Pre-Kindergarten Program.** We are happy that you chose a Catholic Education and that you wish to enroll him/her in Saint Joseph Regional.

For our Pre-Kindergarten 3 Year Old Program your child must be 3 years old and bathroom independent.
For our Pre-Kindergarten 4 Year Old Program your child must be 4 years old on or before September 30, 2018.

In order for us to enroll your child in our school, please complete the following forms and return them to the school office. They may be emailed, mailed or dropped off.

1. Immunization Information/Nurse Forms
2. License, Release and Hold Harmless Agreement

A copy of the Student's Birth Certificate and Baptismal Certificate (if applicable) must accompany the paperwork.

If you have any questions, please call Ellen Fletcher in the school office at 609 927-2228 x11 or email efletcher@sjrs.org.

Thank you,

Janice DeCicco Fipp, Ed. D.
Principal

APPENDIX H

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.

Office of the School Nurse

Dear Parents/Guardians,

Let's take a minute to make sure your child's immunizations are up to date for the new year! Proper documentation of immunizations is required prior to the start of the school year in September for newly enrolled students, and when any additional vaccines have been administered. Please find New Jersey's required immunization schedule for school attendance for your information.

Only an official copy of the immunization record from your child's medical provider will be accepted.

The influenza vaccine is required for all students less than 59 months (less than 5 years old). The influenza vaccine must be administered between September 1st and December 31st for those students.

The meningococcal vaccine and Tdap booster is required for those students who are entering 6th grade and once the child turns 11. If your child will turn 11 shortly before or after the start of school they will have 30 days to receive their immunizations and send in written documentation to my office.

If you have any questions about the immunizations please see your child's heath care provider. Please do not hesitate to phone or email if I can be of any assistance to you or your family at any time.

God Bless,

Nicole Russell RN

Saint Joseph Regional School, 11 Harbor Lane, Somers Point, NJ 08244
Phone 609 927-2228 x 12 ~ Fax 609 927-7834
nurse@sjrs.org

MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: Immunization of Pupils in School

DISEASE(S)	MEETS IMMUNIZATION REQUIREMENTS	COMMENTS
DTaP	(AGE 1-6 YEARS): 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. (AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses.	Any child entering pre-school, pre-Kindergarten, or Kindergarten needs a minimum of four doses. Pupils after the seventh birthday should receive adult type Td. DTP/Hib vaccine and DTaP also valid DTP doses. Laboratory evidence of immunity is also acceptable.
Tdap	GRADE 6 *(or comparable age level for special education programs)*: 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child does not need a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
POLIO	(AGE 1-6 YEARS): 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. (AGE 7 or OLDER): Any 3 doses.	Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years of age or older. Laboratory evidence of immunity is also acceptable.
MEASLES	If born before 1-1-90, 1 dose of a live Measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday. If entering a college or university after 9-1-95 and previously unvaccinated, 2 doses of a live Measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Previously unvaccinated students entering college after 9-1-95 need 2 doses of measles-containing vaccine or any combination containing live measles virus administered after 1968. Documentation of 2 prior doses is acceptable. Laboratory evidence of immunity is also acceptable. Intervals between first and second measles/MMR/MR doses cannot be less than 1 month.
RUBELLA and MUMPS	1 dose of live Mumps-containing vaccine on or after the first birthday. 1 dose of live Rubella-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Each student entering college for the first time after 9-1-95 needs 1 dose of rubella and mumps vaccine or any combination containing live rubella and mumps virus administered after 1968. Laboratory evidence of immunity is also acceptable.
VARICELLA	1 dose on or after the first birthday.	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering a school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is also acceptable.
HAEMOPHILUS INFLUENZAE B (Hib)	(AGE 2-11 MONTHS)[1]: 2 doses (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months. [2] Minimum of 1 dose of Hib vaccine is needed after the first birthday. DTP/Hib and Hib/Hep B also valid Hib doses.
HEPATITIS B	(K-GRADE 12): 3 doses or 2 doses [1]	[1] If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation. Laboratory evidence of immunity is also acceptable.
PNEUMO-COCCAL	(AGE 2-11 MONTHS)[1]: 2 doses (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months. [2] Minimum of 1 dose of Pneumococcal vaccine is needed after the first birthday.
MENINGO-COCCAL	(Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose [1] (Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose [2]	[1] For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. [2] Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable.
INFLUENZA	(AGES 6-59 MONTHS): 1 dose ANNUALLY	For children enrolled in child care, pre-school or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year.

AGE APPROPRIATE VACCINATIONS (FOR LICENSED CHILD CARE CENTERS/PRE-SCHOOLS)

CHILD'S AGE	NUMBER OF DOSES CHILD SHOULD HAVE (BY AGE):
2-3 Months	1 dose DTaP, 1 dose Polio, 1 dose Hib, 1 dose PCV7
4-5 Months	2 doses DTaP, 2 doses Polio, 2 doses Hib, 2 doses PCV7
6-7 Months	3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza
8-11 Months	3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza
12-14 Months	3 doses DTaP, 2 doses Polio, 1 dose Hib, 2-3 doses PCV7, 1 dose Influenza
15-17 Months	3 doses DTaP, 2 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose PCV7, 1 dose Influenza
18 Months-4 Years	4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, 1 dose PCV7, 1 dose Influenza

PROVISIONAL ADMISSION:

Provisional admission allows a child to enter/attend school but must have a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. If a pupil is <5 years of age, they have 17 months to complete the immunization requirements. If a pupil is 5 years of age and older, they have 12 months to complete the immunization requirements.

GRACE PERIODS:

- 4-day grace period: All vaccines doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

SAINT JOSEPH REGIONAL SCHOOL
11 HARBOR LANE
SOMERS POINT, NEW JERSEY 08244

LICENSE, RELEASE AND HOLD HARMLESS AGREEMENT

I, _____, who resides at _____

am the parent/legal guardian of _____, _____, _____, _____.

CHECK ONE

____ I hereby agree:

1. to allow my child/children to be photographed or interviewed for the Star Herald and any school or parish publications, including but not limited to, press releases, bulletins, newsletters, brochures, videos, computer images, web pages;

2. to waive, release, and forever discharge any and all claims that I may have with respect to the use of the said photograph by The Diocese of Camden, New Jersey, Saint Joseph Regional School, Somers Point, New Jersey, and their respective agents, servants, employees, officers, trustees, administrators, and volunteers; and

3. to indemnify, hold harmless, protect and defend The Diocese of Camden, New Jersey, Saint Joseph Regional School, Somers Point, New Jersey, administrators, and volunteers, from any and all claims, losses, liabilities, damages, suits, fines, penalties, costs and expenses, including reasonable attorneys' fees, brought or incurred by or on behalf of any person whomsoever or entity whatsoever, arising out of or in any way connected with the said use of the aforementioned photograph by any person or entity.

OR

____ I do not agree to allow any interview or photograph of my child/children to be published in the Star Herald or any school or parish publications, including but not limited to, press releases, bulletins, newsletters, brochures, videos, computer images, web pages.

IN WITNESS WHERETO the parties have signed this Agreement on this ____ day of _____, 2017.

_____ _____

SIGNATURE OF PARENT/GUARDIAN PRINT NAME OF PARENT/GUARDIAN