Please bring the following to your school at the time of registration.

WELCOME TO THE BARNEGAT TOWNSHIP SCHOOL DISTRICT

KINDERGARTEN REGISTRATION INFORMATION

In order to register your child for 2017-2018 school year, you will need the following information:

- Immunization records (if you do not have one on hand your family doctor should be able to supply you with a copy)
- Original Birth Certificate with Raised Seal. The birth certificate must indicate that he/she will be 5 years of age (on or before October 1, 2017)
- Most recent physical
- Proof of residency (2) – (i.e. lease agreement, rental agreement, tax bill, utility bill)
- Parent/Guardian identification
- Current IEP – (if applicable)

In order for your child to have a smooth transition into our school district, we cannot register your child without the above information, If you have any questions, please contact your neighborhood school.

Thank you.

Barnegat Township School District
Kindergarten Registration Checklist

Parent's/Guardian's Name: _____

Home Phone Number: _____ Cell: _____

Child's Name: _____

Email Address: _____

All forms noted below must be **checked off** √ and turned in to the proper school official by the date listed below to ensure that your child is registered for school in September.

In order for your child's kindergarten registration to be complete, the following documentation is needed: (checked items have been received).

- o **Original Birth Certificate with Raised Seal**
  The birth certificate for the above named student indicates that he/she will be 5 years of age on or before October 1, 2017.

  School Official's Signature: _____ Date: _____

- o Proof of Residence (2)
- o Completed Polio Immunization Series (one on or after 4th birthday)
- o Complete MMR Series (first one on or after 1st birthday)
- o Completed DPT Series (one on or after 4th birthday)
- o Completed Hepatitis B Series
- o Varicella (Chicken Pox, Disease Date or Immunization on or after 1st birthday)
- o School Entrance Physical (dated prior to or within 1 year of school entrance)
- o Attended Pre-K
  - o YES
    Where: _____
    Years: _____
  - o NO
- o Other (specify)

_____

Note(s) to Parent/Guardian:

_____

_____

_____

After March 9, 2017, all completed forms and any questions should be directed to your neighborhood school.

Barnegat Township School District
PERMANENT RECORD BASIC DATA SHEET
KINDERGARTEN

PLEASE PRINT ALL INFORMATION

Today's Date:

STUDENT'S NAME:	Last:	First:	MI:			GRADE:					
HOME ADDRESS:											
HOME PHONE:						GENDER	M		F		
EMAIL ADDRESS:											
DATE OF BIRTH:		PLACE OF BIRTH:		DATE OF U.S. ENTRY (if applicable)							
EMERGENCY CONTACT INFORMATION		NAME:									
ADDRESS:				TELEPHONE:							
CUSTODY:	The Barnegat Township School District requires the following documentation when appropriate: (Please provide documentations with registration information)										
o Joint Custody Documentation		o Restraining Orders		o Student Name Change							
CHECK ALL THAT APPLY:	Parents Separated:		Father Remarried:		Mother Remarried:						
	Parents Divorced:		Father Deceased:		Mother Deceased:						
STUDENT RESIDES WITH: (CUSTODIAL PARENT)	Father		Mother		Step-Father		Step-Mother		Guardian		
FATHER'S NAME:	Last:	First:			OCCUPATION:						
FATHER'S ADDRESS:					CITY/STATE/ZIP:						
BIRTH PLACE:		Education: (Grade level Completed)			CELL NUMBER:						
					WORK NUMBER:						
MOTHER'S NAME:	Last:	First:			OCCUPATION:						
MOTHER'S ADDRESS:					CITY/STATE/ZIP:						
BIRTH PLACE:		Education: (Grade level Completed)			CELL NUMBER:						
					WORK NUMBER:						
NAME OF GUARDIAN: (IF NOT MOM OR DAD)	Last:	First:			OCCUPATION:						
GUARDIAN ADDRESS:					CITY/STATE/ZIP:						
BIRTH PLACE:		Education: (Grade level Completed)			CELL NUMBER:						
					WORK NUMBER:						
STEP-FATHER'S NAME			STEP-MOTHER'S NAME								
STUDENT'S SIBLING ORDER: (Example, third born in family)											
LIST NAME, AGE & BIRTHDATE OF OTHER CHILDREN IN THE FAMILY:											
I CERTIFY THAT THE ABOVE STATEMENTS REGARDING MY CHILD'S AGE AND ELIGIBILTY TO ATTEND KINDERGARTEN ARE CORRECT.											
PARENT/GUARDIAN SIGNATURE:					DATE:						

Barnegat Township School District
PERMANENT RECORD DEVELOPMENTAL HISTORY
KINDERGARTEN

BIRTH HISTORY					
	Check One				Comments
Was your pregnancy full term:	Yes		No		
Did you have any illnesses during pregnancy?	Yes		No		
Were there any birth complications	Yes		No		
What was the birth weight?	lbs.		oz.		

DEVELOPMENTAL HISTORY						
Indicate at what age your child:	Walked		Talked		Toilet Trained	

	Check one				Comments
Does your child get along well with other children their age?	Yes		No		
Has your child attended nursery school?	Yes		No		
Can your child identify colors?	Yes		No		
Can your child fasten or unfasten buttons?	Yes		No		
Can your child count fingers up to 5?	Yes		No		
Can your child bounce a ball?	Yes		No		
Did your child have an early interest in clocks and calendars and the ability to understand their function?	Yes		No		
Does your child know the relationships among and between the various coin denominations? (4 quarters equals $1.00)	Yes		No		
Did your child learn to read early with little or no formal teaching?	Yes		No		

Check all that apply to your child:							
Nail Biting		Cries Easily		Bed Wetting		Thumb Sucking	
Nightmares		Temper Tantrums		Jealousy		Stubbornness	

Other:

DID YOUR CHILD EVER ATTEND ANOTHER KINDERGARTEN OR PRE-SCHOOL PROGRAM?

IF YES, PLEASE CLARIFY:

Barnegat Township School District

PERMANENT RECORD REGISTRATION LANGUAGE DATA SHEET

Kindergarten

PLEASE PRINT ALL INFORMATION

In order to comply with existing school laws regarding spoken languages, we are required to survey each child in our school to determine whether another language is spoken at home.
Please complete the following information:

STUDENT NAME:	Last: First:	DATE:	
ADDRESS:		GRADE:	

1. WHAT WAS THE FIRST LANGUAGE YOUR CHILD SPOKE AT HOME?	
2. WHAT IS THE LANGUAGE YOUR CHILD SPEAKS MOST OFTEN?	
3. WHAT LANGUAGE IS MOST OFTEN SPOKEN IN YOUR HOME REGARDLESS OF THE LANGUAGE YOUR CHILD SPEAKS?	
4. DOES YOUR CHILD HAVE SUFFICIENT DIFFICULTY SPEAKING, READING, WRITING OR UNDERSTANDING THE ENGLISH LANGUAGE?	
5. IF YES, WOULD YOU RECOMMEND AN ADDED CLASS TO HELP LEARN ENGLISH (ESL) FOR YOUR CHILD?	
6. AT WHAT AGE DID YOUR CHILD BEGIN ATTENDING SCHOOL? NAME/LOCATION OF PRESCHOOL PROGRAM (if applicable)	
7. PLEASE LIST ANY PREVIOUS ESL/BILINGUAL EDUCATION PROGRAM ATTENDED (if any)	
8. WOULD YOU PREFER ORAL AND WRITTEN COMMUNICATION FROM SCHOOL IN ENGLISH OR IN YOUR NATIVE LANGUAGE?	

ETHNIC CATEGORY (Please check one)

White		Black		Hispanic		Asian		American Indian/ Alaskan Native		Other: (Please Specify)	

PARENT'S SIGNATURE:		DATE REGISTERED:	

OFFICE STAFF ONLY

If the answer to question # 1, 2 or 3 is other than English, please include the student in the Native Language Survey (State report).
If the answer to question # 4 is yes, please forward the information to the ESL teacher with a copy to the Office of Curriculum & Instruction.

Barnegat Township School District
PERMANENT RECORD HEALTH HISTORY
KINDERGARTEN

HEALTH HISTORY – ILLNESSES AND DISEASES (List Dates)							
German Measles		Strep Infection		Measles		Poliomyelitis	
Asthma		Mumps		Rheumatic Fever		Diabetes	
Otitis Media		Whooping Cough		Convulsive Disorders		Chicken Pox	
Allergies (List Type)				Emotional (List Type)			
Other:							
Operations or Injuries (List Dates):							

Check all that apply to your child	Vision Problems		Hearing Problems		Speech Problems		
	Glasses Prescribed		Hearing Aid		Other Prosthesis (Indicate type)		

Is your child taking any medications?	Yes		No		If yes, identify:

The Portion Below This Line Will Be Completed by School Nurse

---

PLEASE BRING IMMUNIZATION RECORD FROM THE DOCTOR'S OFFICE TO THE SCHOOL NURSE WHO WILL COMPLETE THIS SECTION									
STUDENT'S NAME:	Last:		First:		MI:		DATE OF BIRTH:		
IMMUNIZATIONS AND TESTS									
D.P.T.	1st		2nd		3rd		4th		Booster (on or after 4th Birthday)
OPV POLIO Virus Vaccine	1st		2nd		3rd		4th		Booster (on or after 4th Birthday)
MEASLES (RUBELLA)	On or after the 1st birthday							One before entering Kindergarten	
GERMAN MEASLES (RUBELLA)	On or after the 1st birthday				MUMPS IMMUNIZATION		On or after the 1st birthday		
M.M.R	On or after the 1st birthday						One before entering Kindergarten		
HEPATITIS B	1st		2nd				3rd		
MANTOUX TEST (recommended By State)	Date:		Reading:						MM
VARICELLA	On or after the 1st birthday								

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.

Sample Medicaid Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent .

Is there a cost to you?
No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one) ____Mailed to parent(s) ____Emailed to parent(s) ____IEP meeting ____ Hand Delivered

Special Education Medicaid Initiative (SEMI) Parental Consent form

_____ School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____/_____/_____

Parent/Guardian: _____

Date: ____/_____/_____

I give consent to bill for SEMI: Yes ☐
No ☐

This consent can be revoked at any time by contacting the administrator at your child's school.

Barnegat Township School District

Custody Alert

Must be filled out if one or both biological parents do not have equal custody.

A copy of each custody paper MUST be submitted with initial completed paperwork.

I. Basic Information (Please print)

Name of Legal Custodian (s):_____

Student's Name: _____

Student's School:_____ Student's Grade Level: _____

II. Required Documentation (Must be provided with registration information)

The Barnegat Township School District requires the following documentation when appropriate:

Joint Custody Documentation Restraining orders Student Name Change
Court Orders Regarding Custody/Guardianship

III. Permission Required for Access to Child (Written Documentation Required)

The following people **MAY NOT** have legal access to the child without written custodian permission:

	Name	Relationship to student	Address	Phone number
1.				
2.				

IV. Permission Permitted for Access to Child

The following people **MAY** have legal access to the child or child's records without written custodian permission:

	Name	Relationship to student	Address	Phone Number
1.				
2.				

____ **Please check here if there are NO custody problems concerning your child and sign below.**

The **SCHOOL MUST BE NOTIFIED IMMEDIATELY TO ANY CHANGES** on this form.

_____ _____

Signature of a Legal Custodian **Date**

For Office Use Only

Joint Custody Documentation	Restraining Orders	Student Name Change	Court Orders Regarding Custody/Guardianship

This form was changed on: _____ Initials: _____

Changes included:_____

_____

PARENT PORTAL ACCESS FORM
BARNEGAT TWP. SCHOOL DISTRICT

NEW ACCOUNT/NEW STUDENT(S) ONLY

Please complete <u>one form for all students</u> that will be listed under your account & return it to any of their attending schools for processing.

Parent/Guardian Information
(Please print clearly)

Parent/Guardian
First Name: _____ Last Name: _____

Daytime Telephone #: (_____) _____ - _____

Valid E-mail address: _____ @ _____

STUDENT(S) INFORMATION
(Please print clearly)

Student's Name: _____ School: _____ Grade: _____

Student's Name: _____ School: _____ Grade: _____

Student's Name: _____ School: _____ Grade: _____

Student's Name: _____ School: _____ Grade: _____

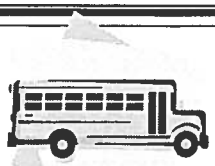
Student's Name: _____ School: _____ Grade: _____

Thank you for completing this Parent Portal Access Form.

For new accounts, you will receive an e-mail with your username & password information.

If you have any questions, please contact the web desk at (609) 660-7510 ext. 7029.

THANK YOU & HAVE A GREAT SCHOOL YEAR !



CHILD CARE PROVIDER FORM
2017-2018

Child Care Provider Forms **must be renewed each year** for bus scheduling purposes. Parents wishing to have their student(s) transported to and from a child care provider must complete this form and return it to the Transportation Department and/or the student(s) school. All bus changes take 48 hours to process. **Please do not wait until September to make child care arrangements.** Waiting until September to make arrangements to have your child ride the school bus to and from a child care provider could result in having your request denied because that particular bus is full. **Forms received the first week of school will not be implemented until the second week of school.**

Please note on this form if the student will be attending child care for both the morning and afternoon. Busing arrangements must remain the same every day. **Busing to a child care provider can only occur if the provider lives within the boundaries of the school which the student(s) attend**. Please call the Transportation Office at 609-698-5816 x2 with any questions or concerns.

NAME OF CHILD/CHILDREN	GRADE	SCHOOL

MORNING ONLY_____ AFTERNOON ONLY_____ MORNING & AFTERNOON_____

NAME OF CHILD CARE PROVIDER	PROVIDER'S TELEPHONE NUMBER	PROVIDER'S ADDRESS	DATE EFFECTIVE

The above named is acting as a child care provider for my children.

Signature of Parent/Guardian:_____ Date:_____

Phone Number (home):_____ (cell):_____

Address:_____

OFFICE USE ONLY

Approval: **Date:** **Bus Number:**

Barnegat Schools

Before and After School

Childcare Program

The Barnegat Township School District offers a before and after school childcare program for children in grades K – 8. This program is designed for working families who need a safe, well-supervised setting for their children before and after school hours. We offer a variety of activities that include games, crafts, homework club, and outside play under the supervision of experienced staff members.

- Fees are based on attendance! We bill based on time in/out and only charge for the time your child is present.
- No minimum day requirement! Use one day, two days, or five days...morning and/or afternoon – the rates are the same.
- The Before Care program is held at the Collins School. Children are bused to their home school every morning.
- Before Care hours are 6:00am - 8:45am.
- If there's a delayed opening, Before Care opens at 8:30am.
- Your child can still attend before (Collins,Brackman) and after school clubs (all schools) AND our program!
- The After Care program is held at each elementary school. Brackman children walk to Collins for the Aftercare program where they are met by a staff member in front of the Collins School.
- After Care is open from dismissal until 6:00pm.
- We remain open on half days! (with the exception of the last day of school)
- We work with the Children's Home Society for eligible families.
- Want to register? Forms can be found online or at your child's school. Questions? Contact Jill Sidote, Program Coordinator at 609-389-0484 or jsidote@barnegatschools.com

Important Information from your School Nurses

The following are some health office guidelines we would like you to be aware of. After reading them, please contact your school nurse with any health concerns/questions you may have regarding your child.

Children who enter a New Jersey school for the first time or enter a New Jersey school from another state must have a physical examination at a doctor's office or at a clinic before entering school. The doctor will fill out a medical form which must include the immunization record.

Each school has medical and emergency forms you need to complete. It is very important you fill out these forms and return them promptly.

Your child will also receive screenings for vision (eye), hearing (ear), and annual height, weight and blood pressure during the school year. The school nurse will perform these screenings. Scoliosis screenings begin at age 10.

What should I do if my child is sick?

Regular school attendance is necessary for optimal learning. However, there are times your child may not feel well enough to come to school. On those days, you must notify the school first thing in the morning. A parent note is also required on the day your child returns to school. If your child is absent 3 days or more, a doctor's note is required to return to school.

Do not send your child to school if:

- **The child has a fever of 100 degrees or higher**
- **The child threw up the night before and/or in the morning before school and/or has diarrhea**
- **The child is coughing constantly**
- **The child has a skin rash or sores**
- **The child has conjunctivitis (draining eyes)**
- **The child has a sore throat, fever and/or trouble swallowing**

When can my child return to school?

Fever: Your child may return to school after being fever free for 24 hours (without fever-reducing medicine such as Tylenol or Motrin).

Diarrhea/Vomiting: A child with diarrhea and/or vomiting should stay at home and return to school only after being symptom-free for 24 hours.

Conjunctivitis: Following a diagnosis of conjunctivitis, the child may return to school 24 hours after the first dose of prescribed medication. A doctor's clearance must be provided.

Rashes: Common infectious diseases with rashes are most contagious in the early stages. A child with a suspicious rash may return to school only after a health care provider has made a diagnosis and has authorized the child's return to school.

What if my child must take medication in school?

- **Every effort should be made to have any medications given at home. If this is not possible, remember that ALL medications (prescription AND over-the-counter) require written authorization from a doctor. This is NJ state law. A medication form can be obtained from your school nurse.**
- **Medication MUST BE BROUGHT to the nurse BY THE PARENT/GUARDIAN in the original labeled container.**
- **Students are not permitted to carry medication to/from school.**
- **Students who require Epinephrine for anaphylaxis or inhalers/nebulizer for asthma will need specific medication forms. Forms are available from your school nurse.**

Emergency Contact Information:

When filling out any emergency card or form, please include home, cell and work numbers as well as two local emergency contacts in the event your child is sick or injured. It is very important that the school is notified immediately if emergency contact numbers change.

Always feel free to call your school nurse at any time. Open communication is very important to us. Contact information for the school nurse, teachers and front office staff is provided in your first day informational/form packet.