CHERRY HILL PUBLIC SCHOOLS

REGISTRATION DEPARTMENT
MALBERG ADMINISTRATION BUILDING
45 RANOLDO TERRACE
CHERRY HILL, NJ 08034-0391

REGISTRATIONS FOR ALL SCHOOLS TAKE PLACE AT THE MALBERG ADMINISTRATION BUILDING - PLEASE CALL FOR AN APPOINTMENT
(856) 429-5600 - EXTENSIONS 4430/4432/4436
FAX: (856) 429-3874
www.chclc.org

Welcome to Cherry Hill Public Schools
Information and requirements for registering new students to our district are as follows:

1. **Pre-Registration:**
   Begin Pre-Registration online at Cherry Hill Public Schools web-site www.chclc.org. Once you're on the web-site, go to Departments, then Registration. Follow just Step 2 of the registration process. All additional forms are included in this packet. Please see below for Required documentation needed to complete registration.

2. **Parent/Guardian ID:**
   Preferred Identification: Photo ID issued by a government, public body or authority (Ex., driver's license, military ID or passport), Employee ID or other appropriate form of identification. Other forms of identification are acceptable but may delay the registration process. We make our determination on eligibility to register upon the totality of information and documentation offered by the applicant.

3. **Parent/Guardian Proofs of Residency:**
   In accordance with New Jersey Administrative Code 6A:28-2.5 **Proof of eligibility**:
   A district board of education representative shall accept the following forms of current documentation from persons attempting to demonstrate a student's eligibility for enrollment in the Cherry Hill School District. **The documents must be originals that have been mailed to your address.**

   ● **If you own a house any TWO forms will be accepted**
   Property tax bill, mortgage statement, current utility bills (i.e., PSE&G, water, sewer, cell phone, cable), financial account information, employment documentation, or any other business record or document issued by a government entity (dated within the two months before registration).

   ● **If you rent you must have your Current Signed Lease (original) including student(s) name(s), PLUS ONE** current utility bill, (i.e. PSE&G, telephone, cell phone, cable), financial account information, employment documentation, or any other business record or document issued by a state or local government entity (dated within the two months before registration).

   ● **If you live with someone who owns a house in Cherry Hill:**
   Please call the registration office for a Landlord Affidavit **prior** to calling for an appointment. Owner and tenant must **each** provide two proofs of residency (dated within the two months before registration) and sign the affidavit in the presence of a Notary.

4. **Student(s):**
   An **Original** Birth Certificate **or** Passport. (If you do not have either of these, please contact the School District's Registration Department for further information)
   Evidence of completion of Required Immunizations
   Evidence of a recent Physical Examination - Must be submitted within 30 days of registration

PROOF OF DOMICILE

Student Name: _____
(Please print)

Dear Parent/Guardian:

The Cherry Hill Board of Education has policies and procedures related to "Proof of Domicile" for students who attend our schools. The District shall only provide a free education to those students who are domiciled within the District or who otherwise qualify for a free education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 *et seq*. and N.J.A.C. 6A:22-1.1 *et seq*. A student shall be domiciled in the District "when he or she is living with a parent or legal guardian whose permanent home is located within the District." N.J.A.C. 6A:22-3.1. The home is permanent if "the parent or guardian intends to return to it when absent and has no present intent of moving from it…." *Id*. If the District discovers that a student is attending school whose parents are not domiciled within the District and who is not otherwise eligible for a free education, the District may apply for the student's removal and seek tuition reimbursement for the period of ineligible attendance in accordance with the provisions of N.J.S.A.18A:38-1(b) (2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense. N.J.S.A. 18A:38-1 (c). If the applicant is convicted of such an offense, the applicant may be fined up to $1,000.00 and/or be imprisoned for up to 6 months.

Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C:43-3. If convicted for such a crime, the applicant may be punished by a fine of $10,000.00 and/or be imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understood the contents of this notification.

_____ _____
Signature of Parent or Guardian Date

_____
Printed Name of Parent or Guardian

Cherry Hill
PUBLIC SCHOOLS

ESL Program Office
45 Ranoldo Terrace, P.O. Box 5015
Cherry Hill, NJ 08034-0391
(856) 429-5600, ext. 4333 Fax (856) 429-7948

CHERRY HILL HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: M □ F □

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

1. What language is spoken by you and your family most of the time at home? _____

2. If available, in what language would you prefer to receive communication from the school?

   English □ Other _____

3. Is your child's first-learned language English? Yes □ No □
   Is your child's home language English? Yes □ No □

   If you responded "NO" to questions in number 3 above, please answer the following questions:

   a. What language did your child learn when he/she first began to talk? _____
   b. What language does your child most frequently speak at home? _____
   c. What language does your child speak with friends? _____
   d. What language does your child most frequently speak at home with family members?
   mother_____father_____siblings_____

4. What language do you most frequently speak to your child? (Father) _____
   (Mother) _____

5. If your child currently speaks English, at what age did he or she begin speaking English? _____

6. Does your child write or read your home language? Yes □ No □

7. Has your child received ESL services at a previous school? Yes □ No □, if you checked yes, was the child exited from the program? Yes □ No □, if yes, how long ago was the child exited?_____

Parent/Guardian's Signature: _____ Date: _____

School Office Use Only: Student ID# _____ Date Distributed _____ Date School Received _____

IMMUNIZATION REQUIREMENTS

ALL REQUIRED IMMUNIZATIONS MUST APPEAR ON A RECORD SIGNED BY A PHYSICIAN FOR REGISTRATION TO BE CONSIDERED COMPLETED.

Effective participation in control measures will help to prevent the spread of communicable diseases among our school children and in the community. Coordinated efforts between the school and health department exist to protect and improve the health of young people. Mandatory measures have been developed by the health department to help maintain a high degree of protection against communicable disease. In accordance with New Jersey State Sanitary Code Chapter 14 Regulations, pupils are required to show evidence of the following immunizations prior to entering school:

Varicella Vaccine (Chicken Pox)

The Department of Health and Senior Services has initiated the administrative rulemaking process to require receipt of varicella vaccine on or after the first birthday or proof of immunity for children 19 months of age and older attending child care centers and those children entering Kindergarten who are born on or after January 1, 1998.

Diphtheria, Tetanus, and Pertussis

Every pupil shall have received a minimum of four doses of DTP, with one dose given on or after the fourth birthday or have received five or more doses of DTP. Pediatric DT shall be accepted in lieu of DTP for pupils under age 7 with a written statement from a physician indicating medical contraindication to pertussis. Adult Td is acceptable for pupils 7 years of age or older who have not completed the DTP requirement. Any appropriately spaced combination of three doses of Td or a Combination of DTP, DTaP, and Td to equal three doses in pupils over age seven is acceptable.

Polio Virus Vaccine

Every pupil shall have received at least three doses of IPV or OPV, one dose given on or after the fourth birthday or any four doses. For pupils 7 years of age or older, 3 doses of IPV or OPV is acceptable.

Measles Vaccine (Rubella)

Every pupil born on or after 1/1/1990 shall have received two doses of measles containing vaccine administered on or after their first birthday or document laboratory evidence of immunity. For pupils 7 years of age or older, 1 dose if born before 1/1/90 and 2 doses if born on or after 1/1/90. Pupils receiving the measles vaccine before their first birthday require reimmunization. Laboratory evidence of immunity is also acceptable. Intervals between the 1st and 2nd Measles / MR / MMR doses cannot be less than one month.

IMMUNIZATION REQUIREMENTS (Continued)

Mumps Vaccine

Every pupil shall have received one dose of mumps vaccine, or any vaccine combination containing mumps vaccine administered on or after the first birthday. Pupils with a history of mumps disease shall not be required to receive mumps vaccine, provided they present written certification from the diagnosing physician or documented laboratory evidence of the mumps immunity.

Rubella Vaccine

Every pupil shall have received one dose of rubella virus vaccine, or any vaccine combination containing rubella virus vaccine administered on or after the first birthday or laboratory evidence of immunity.

Hepatitis – B Vaccine

Every pupil entering Kindergarten/Grade1 on or after September 2001 shall have received the three dose hepatitis B series. Pupils entering Grade 6 on or after September 2001 shall have received the three dose hepatitis B series or a two dose hepatitis B vaccine series. This two-dose regimen only applies to pupils between 11-15 years of age who start and complete the hepatitis B vaccine series with one specific vaccine product known as Recombivax HB 1.0ml by Merck. The Department has also initiated rulemaking to implement the hepatitis B vaccine requirement for pupils in Grades 9-12 passed by the New Jersey Legislature and signed into law on August 3, 2002. School health and administration officials are urged during this school year to advise the parents of those affected unvaccinated children of these actions and that the final rules will be enforced beginning September 1, 2004.

Exemptions

The only pupils who may be exempted from immunization requirements are:

1. Pupils with a written statement from a physician that a specific immunization is medically contraindicated for a period of time specified and reasons for medical contraindication.

2. A written statement signed by parent or guardian explaining how the administration of immunizing agents conflicts with the pupil's exercise of bonafide religious tenets or practices. General philosophical or moral objection to immunization shall not be sufficient for exemption.

3. A valid health care provider notice with the date of a pending appointment to complete required immunizations.

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.

SCHOOL NURSE HEALTH RECORD UPDATE

Student's Name_____ Date of Birth_____

Grade_____ Homeroom Teacher_____ Date_____

1. Does your child take medication(s) on a regular basis (at home or school)? Yes_____ No_____
   If yes, please list medication(s) and reason(s) for medication(s):
   _____
2. Has your child had any accidents, injuries or operations over the past year? Yes_____ No_____
   If yes, please explain:
   _____
3. Has your child had any serious illnesses or allergies in the past year? Yes_____ No_____
   If yes, please explain:
   _____
4. Has your child had any vaccinations in the past year? Yes_____ No_____
   If yes, please list the vaccinations and provide documentation from your child's doctor or advanced practice nurse, so that this information may be entered onto your child's health records:
   _____
5. Have there been any other changes in your child's health status? Yes_____ No_____
   If yes, please explain:
   _____
6. Name and phone number of student's primary health care provider:
   _____
7. Name and phone number of student's dentist:
   _____
8. Preferred Hospital (transport squad determines the hospital):
   _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card 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.

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

Yes_____ If Yes, Name of Insurance company _____

No _____ NJ FamilyCare provided 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.

If No: You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Yes _____ No _____

Signature: _____ Printed Name _____

Date: _____

SCHOOL HEALTH SERVICE - HEALTH HISTORY

School:_____

Grade:_____

Dear Parents/Guardians:

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it at Registration to the School Nurse. Thank you.

Child's Name_____ Nickname _____ Sex _____

Address _____

Names of Parents/Guardians _____ Phone_____

List all members of household:

Name	Relationship	Age of Children
_____	_____	_____
_____	_____	_____
_____	_____	_____

If Parents/Guardians are working, who cares for child when not in school? _____

Parents/Guardians are:

Married ____ Separated ____ Divorced ____ Widowed ____ Unmarried/Living Together _____

During the pregnancy with this child, did the mother have any medical problems (e.g., high blood pressure or kidney infection, exposure to other infections)? _____

_____

Were there any problems during labor and delivery? _____ If yes, please explain _____

_____

Did the child leave the hospital when his/her mother left? _____ If no, please explain: _____

_____

CHILD'S MEDICAL HISTORY

At what age has the child had any of the following diseases?

Chicken Pox_____ Mumps_____ Rheumatic Fever_____ Measles_____ Strep_____ Scarlet Fever_____

German Measles_____ Hepatitis_____ Other_____

At what age has the child had any of the following operations?

Tonsillectomy_____ Hernia Repair_____ Appendectomy _____

Other (Please Explain) _____

Does the child have any medical history of the following?

Yes	No	Allergies
Yes	No	Convulsive Disorder
Yes	No	Diabetes
Yes	No	Physical Disability
Yes	No	Kidney Disorder
Yes	No	Heart Disorder
Yes	No	Fainting
Yes	No	Asthma
Yes	No	Frequent Headaches
Yes	No	Frequent Colds
Yes	No	Frequent Urinary Infections
Yes	No	Frequent Sore Throat
Yes	No	Poisoning
Yes	No	Serious Burns
Yes	No	Cuts Needing a Doctor
Yes	No	Physical Abnormality
Yes	No	Persistent Mouth Breathing
Yes	No	Frequent Digestive Disturbance
Yes	No	Frequent Pain: Joints_____ Muscular_____ Other_____

If yes to any of the above, please give details:_____

_____

Has the child been hospitalized for any reason since birth? _____ If yes, please explain _____

_____

SCHOOL HEALTH SERVICE - HEALTH SURVEY

Child's Patterns

This section contains additional information that may be of help to your child's teacher. Please take a few minutes to answer the questions that apply.

Yes No Was he/she a baby that required a great deal of attention or care?
Yes No Does the child presently have enuresis (bed wetting)?
Yes No Does the child have urinary accidents during the day?
Yes No Does the child have bowel movement accidents during the day?
Yes No Is the child a selective eater?
Yes No Is another language spoken in the home? Indicate_____

At what age did the child start to walk?_____ talk? _____

Yes No Does the child go to bed willingly? At what time?_____
Yes No Does the child have nightmares?
Yes No Does the child walk in his/her sleep?
Yes No Does the child have any difficulty hearing?
Yes No Can you leave your child with a babysitter?
Yes No Does the child bite his/her fingernails?
Yes No Does the child suck his/her thumb?
Yes No Has the child attended nursery or church/synagogue related schools, etc.?
Yes No Is the child bothered by noisy environment or loud noise?
Yes No Does the child forget what has been said after a few minutes?
Yes No Does the child have difficulty understanding many words?
Yes No Has the child ever had vision examined professionally?
Yes No Has the child ever had an eye injury?
Yes No Has the child ever had vision questioned in preschool screening?
Yes No Has the child ever had hearing examined professionally?
Yes No Did the child have frequent ear infections during the first five years?
If so, how was it treated? Tubes in ears _____ Medication_____ Both _____
Yes No Has your child ever had a professional dental examination?

Is your child presently taking any medication? If so, please specify reason and type_____

_____

Is your child under medical treatment at present? If so, please specify:_____

_____

SCHOOL HEALTH SERVICE - HEALTH SURVEY (Continued)

Please indicate any physical condition you feel the school should be aware of: _____

_____

What responsibilities does your child have at home?_____

_____

What pets are in the family?_____

_____

What terminology does your child use for bowel movements?_____

_____

What terminology does your child use for urination?_____

_____

What information do you feel would be of benefit to your child's teacher?_____

_____

Is there anything more about your child's health that you think is important for school personnel (teacher, nurse, etc.) to know?_____

_____

Thank you for taking the time to complete this form. Please feel free to call the school nurse with any questions or concerns.

_____
Parent/Guardian Signature

_____
Date