SPRINGFIELD TOWNSHIP ELEMENTARY SCHOOL
2146 Jacksonville Jobstown Road
Jobstown, NJ 08041
Telephone (609) 723-2479
Facsimile (609) 723-8213

CRAIG VAUGHN
Superintendent / Principal

Preschool Program
2019-2020 School Year

This integrated program is comprised of children with special needs as well as typically developing preschool children. A general preschool curriculum is followed for all students. The annual cost, without transportation, has not yet been set and approved by the Board of Education; however, this fee is historically lower than area private preschool programs and is comparable with the tuition rates charged by surrounding districts.

All preschool sessions are two and one-half hour classes, Monday through Friday. The 3 year-old program runs in the morning from 9:00 a.m. through 11:30 a.m. The 4 year-old program runs in the afternoon from 12:30 p.m. through 3:00p.m. Early dismissal days for the 3 year-old program runs from 9:00 a.m. through 10:30 am and for the 4 year-old program from 11:30 a.m. through 1:00 p.m.

Regular education students must submit an application to be eligible for the program. Eligibility is on a first come, first served basis. To start the program in September applicants must be 3 years of age on or before September 30, 2019, and **fully toilet-trained** as of the start of school.

Applications will be available in our main office and on our website at www.springfieldschool.org.

To obtain more detailed information about this exciting program, please call the main office at 609-723-2479 ext.100 or visit our website at www.springfieldschool.org.

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Preschool Program Requirements

Dear Parents,

Please submit the following with your application:

1. Child's Birth Certificate
2. Completed Preschool Program Application
3. NJ State Demographic and Emergency Information
4. Completed Questionnaire
5. Universal Child Health Record which should be completed by your child's physician.
6. Records of Immunizations for the following:
    a. 4 doses DTP or DtaP (if a DT is given, a MD note is needed)
    b. 3 doses of Polio
    c. 1 MMR given on or after the first birthday
    d. 1 HIB given after the first birthday
    e. 1 Varicella (chicken pox vaccine) given after the first birthday
    f. Pneumococcal conjugate vaccine (PCV) (at least one dose given on or after the first birthday)
    g. Influenza Vaccine **

    ***For all children 6 months through 59 months of age, at least one dose of influenza vaccine between September 1st and December 31st **<u>of each year</u>** is required to prevent exclusion from school in January.*

If you have any questions please call the main office at 609-723-2479 ext.100.

Sincerely,

JoAnn Ricciani, RN, BSN, NJ-CSN

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Preschool Program Application
2019-2020 School Year

Child's Name ______________________________ **Boy** ____ **Girl** ____ **DOB** ____/____/____
(Students must be 3/4 years old by September 30, 2019)

Street Address ______________________________

City ______________________________ **Zip** ______________

Parent/Guardian's Name ______________________________

Parent/Guardian's Name ______________________________

Home Phone ______________________ **Cell Phone** ______________________

Email Address ______________________________

Class signing up for: 3 Year: ________ **4/5 Year:** ________

Each program will be held 5 days/week for 2.5 hours. The annual cost, without transportation, has not yet been set and approved by the Board of Education. There is a ***non-refundable*** deposit of $45.00, required to be made payable to Springfield Township School District, to secure enrollment. Enrollment will be based on a first come, first served basis. In the event that there is an oversubscription of this program you will be notified and your name will be placed on a waiting list. At that time your deposit will be returned. The first monthly tuition installment must be received prior to August 1, 2019. If you do not submit the first tuition installment by August 1, 2019, you will lose your spot and we will take the next person on the waiting list.

Before your child can begin the program, you must provide a copy of his/her current physical examination and immunization records and the completed registration.

Parent Signature ______________________________ Date ______________________

Please return this application and $45.00 non-refundable deposit, made payable to Springfield Township School District, ASAP to:

Springfield Township School District
2146 Jacksonville Jobstown Road
Jobstown, NJ 08041
Preschool Application

Springfield Township Elementary School

2146 Jacksonville Jobstown Road
Jobstown, NJ 08041
Telephone (609) 723-2479
Facsimile (609) 723-8213

CRAIG VAUGHN
Superintendent / Principal

Springfield Township School District
NJ State Demographic and Emergency Information

Student's Name ____
Last Name First Name Middle Name

Date of Birth ______________________ **Gender** ______ **Male** ______ **Female**

City of Birth ______________________ **State of Birth** ______________________

Country of Birth ______________________

Ethnicity : ( ) White ( ) American Indian/Alaskan ( ) Multi ______________
( ) Black ( ) Hawaiian Native/Pacific Islander
( ) Hispanic ( ) Asian

Primary Language ______________________ **Language Spoken at Home** ______________________

Address Where Child Resides ____

____

Child Lives with: ( ) Both Parents ( ) Mother ( ) Father
( ) Step-Father ( ) Step-Mother ( ) Other ______________

Mother's Name ____

Address ____

Home Phone ______________ **Cell #** ______________ **Work #** ______________

Email Address ____

Father's Name ____

Address ____

Home Phone ______________ **Cell #** ______________ **Work #** ______________

Email Address ____

Please list two neighbors or nearby relatives who are at home during the day and would be willing to pick up your child at school and/or assume temporary care of your child if you cannot be reached during an emergency. *PLEASE LIST TWO.*

Name ______________________ **Name** ______________________

Address ______________________ **Address** ______________________

Relationship ______________________ **Relationship** ______________________

Phone # ______________________ **Phone #** ______________________

Signature of Parent/Guardian ______________________________ **Date** ______________

SPRINGFIELD TOWNSHIP SCHOOL
Jostown, New Jersey

School Year ____________

NAME: ____ **DATE:** ______________________________

This questionnaire will help the doctor and school nurse to find out if your child is in the best of health for school. The questionnaire will become part of your child's personal health record and is confidential. Take the questionnaire to your family doctor when he examines your child, as your answers will help him too.
Please write down any special questions you have regarding your child's health. The doctor or school nurse will help you with any questions you might have with parts of this questionnaire.

PLEASE CIRCLE THE CORRECT ANSWER. EXPLAIN IF ANSWER IS YES.

1.	Has your child had Headaches or Dizzy Spells?	**No**	**Yes**
2.	Convulsions or other seizures?	**No**	**Yes**
3.	Trouble with eyes or with seeing?	**No**	**Yes**
4.	Trouble with ears or with hearing?	**No**	**Yes**
5.	Nose bleeds, constant colds, sore throats, or sinus?	**No**	**Yes**
6.	Frequent swollen glands?	**No**	**Yes**
7.	Asthma, wheezing, cough, bronchitis, pneumonia? If YES – medication for the above	**No**	**Yes**
8.	Heart trouble?	**No**	**Yes**
9.	Frequent upset stomach or bowel trouble?	**No**	**Yes**
10.	Trouble with urination or making water?	**No**	**Yes**
11.	Kidney or bladder infection?	**No**	**Yes**
12.	Any exposure to Tuberculosis?	**No**	**Yes**
13.	Any previous illness at any age?	**No**	**Yes**
14.	Special doctoring at any age?	**No**	**Yes**
15.	Diabetes?	**No**	**Yes**
16.	Mumps, Measles, Chicken Pox, Whooping Cough or German Measles? **(Circle)**	**No**	**Yes**
17.	Any stays in a hospital? (If YES, explain) Why: ______________________________ When:	**No**	**Yes**
18.	Any operations? Date: What Kind:	**No**	**Yes**
19.	Any bad accidents or broken bones?	**No**	**Yes**
20.	Hay Fever, Hives or Eczema?	**No**	**Yes**
21.	Allergies? ______________________________ Medication for above:	**No**	**Yes**
22.	Tires easily, loss of vigor, or trouble fighting-off infections?	**No**	**Yes**
23.	Any trouble sleeping or nightmares?	**No**	**Yes**
24.	Bed wetting or day wetting?	**No**	**Yes**
25.	Thumb sucking, nail biting, stammering, stuttering?	**No**	**Yes**
26.	Other speech problems?	**No**	**Yes**
27.	Nervous habits, high-strung, easily upset, temper tantrums?	**No**	**Yes**
28.	Shy, glum, sulky or feelings easily hurt?	**No**	**Yes**
29.	Wanting too much attention – disobedient?	**No**	**Yes**

Please answer these questions about the history of pregnancy, birth and early life:

1.	Was there a sickness or complication during pregnancy? **(Optional)**	**No**	**Yes**
2.	Did you have any infections or viruses during pregnancy? **(Optional)**	**No**	**Yes**
3.	Did you have high blood pressure or extra water retention during pregnancy**? (Optional)**	**No**	**Yes**
4.	Did you take medication during pregnancy? **(Optional)**	**No**	**Yes**
5.	Was there trouble with the labor and/or delivery? **(Optional)**	**No**	**Yes**
6.	Was the baby abnormal at birth or was there a birth defect?	**No**	**Yes**
7.	Did the baby do well for the first few months?	**No**	**Yes**
8.	Was there any problem with colic, crying, vomiting, sleeping, or settling the baby?	**No**	**Yes**

9.	At what hospital was the baby born? Birth weight: Address:
10.	Who is your child's family physician? Address:
11.	How many times has your child seen a doctor in the last year?
12.	When was your child's last check-up?

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 <u>that is being used to complete the form</u>. 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 and Senior Services, Immunization Program at 609-588-7512.
   - 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 <u>www.state.nj.us/health/forms/ch-15.dot</u> 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 <u>should</u> 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.

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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

Condition		
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	