GARWOOD PUBLIC SCHOOL

www.garwoodschools.org

- An **original** and a copy of child's birth certificate and current immunization records are required for registration.

- The following are required proofs which may be used to establish residency and/or domicile in Garwood:
  1. Mortgage, lease or rental agreement with Garwood address; **AND**
  2. Two or more of the following:
     a) Utility bill in your name with a Garwood address
     b) Credit card bill in your name at a Garwood address
     c) Voter Registration Card in your name with a Garwood address
     d) Driver's License in your name with a Garwood address
     e) Vehicle Registration in your name with a Garwood address
     f) Bank Account in your name with a Garwood address
     g) Federal or State Income Tax Returns indicating domicile in Garwood
     h) Child Custody Order placing the child with a Garwood resident

  You will NOT be asked for any information or documents protected from disclosure by law, or pertaining to criteria that are not legitimate bases for determining eligibility to attend school.
  If living in a residency where there is no established rental agreement, i.e., living with a relative or under an oral lease,
  - the most recent tax bill and notarized letter of domicile from the person whose name appears on the tax bill; or
  - a notarized statement from your landlord indicating his/her name, address & telephone number and affirming that you live at the Garwood address on a month-to-month basis under an oral lease.

  The Garwood Board of Education reserves the right to make a bona fide request for additional and/or alternative documentation of residency on a case by case basis.

- Proof of Immunization (most recent record) as per NJ State Administrative Code 8:57-4
  Diphtheria, Pertussis and Tetanus vaccine (DPT Series) – 4 doses with 1 dose given on or after the fourth birthday, or any total of 5 doses.
  Poliomyelitis vaccine – 3 doses of oral poliovirus vaccine (OPV) or enhanced inactivated polio vaccine (IPV), with 1 dose given on or after the fourth birthday, or any 4 doses spaced by a minimum of 1 month.
  Rubeola (Measles) vaccine – 2 doses given on or after the first birthday separated by at least a month, or laboratory documentation of immunity.
  Rubella (German Measles) vaccine – 1 dose given on or after the first birthday or laboratory documentation of immunity.
  Mumps vaccine – 1 dose given on or after the first birthday, or laboratory documentation of immunity.
  Hepatitis B vaccine – 3 doses or laboratory documentation of immunity.
  Varicella vaccine - one dose of varicella vaccine on or after the first birthday or proof of disease or immunity is required for children 19 months of age or older who attend a child care center, or are entering Kindergarten or Grade 1.

Please note: State law will not permit any child to be admitted to a public school unless immunizations have been completed and documented by an M.D., D.O., or Nurse Practitioner, specifically indicating a day, month and year administered.

- The totality of information and documentation you offer will be considered in evaluating an application, and, unless expressly required by law, the student will not be denied enrollment based on your inability to provide certain form(s) of documentation where other acceptable evidence is presented.

PUPIL REGISTRATION FORM REGISTRATION DATE__________
START DATE ___________________

GARWOOD PUBLIC SCHOOLS GRADUATION YEAR ___________
GARWOOD, NEW JERSEY 07027 GRADE ________________________

Pupil's Name: ____

Pupil's DOB: _____/_____/_____ Verified: _____BC _____Passport/Visa _____Other

Birth city/state/country:____

Pupil's address/telephone: ____ ______________________________

(Number and Street) (Home Phone)

cell phone __________________________ e-mail address ____

Residency proof: See attached list ____

School pupil last attended: ____

Address: ____

PARENT/GUARDIAN INFORMATION

Parent/Guardian: ____

Highest level of education: ____
Occupation: ____
Business address: ____
Business telephone: ____
Parent/Guardian: ____
Highest level of education: ____
Occupation: ____
Business address: ____
Business telephone: ____
Pupil's brothers (names, DOB): ____
Pupil's sisters (names, DOB): ____

ETHNIC GROUP (please circle appropriate box):

White Non-Hispanic	Black Non-Hispanic	Hispanic	American Indian	Asian	Hawaiian native/other Pacific Islander
02-M 03-F	04-M 05-F	06-M 07-F	08-M 09-F	10-M 11-F	12-M 13-F

Language spoken in home: ________________________ Native language: _____________________

Marital Status of Parents:

_____Married/living together _____Separated _____Divorced _____Widowed _____Remarried

Has the child been receiving Special Services? Please check appropriate box(es):

____Speech/Language _____OT _____PT _____Other

Is there an IEP in place? _____ Yes _____No

Other information:____

CUSTODY: Is there an issue of child custody (court decree or other)?

_____ yes If yes, state the custodial parent _______________________________
_____ no

If your answer above was "yes", please fill in the information below:

Court decree: Have you brought the original court decree to the main office this school year so that the school may photocopy it to place in the pupil's folder _____ yes _____ no

Affidavit: If child has been given informal custody to a responsible adult, perhaps due to illness or domestic issue, you should have filed an affidavit to that effect this school year so that it may be placed in the pupil's folder. Is this applicable? _____ yes _____ no

In the absence of one of the above forms, either parent will have the right to receive school correspondence regarding the child, to pick up the child, and to authorize emergency actions.

I hereby grant permission to the school district regarding my child in the following areas:

1. to exchange student information with the student's high school district prior to and after graduation;
2. to participate in school screenings performed by the School Nurse;
3. to have my child appear in school publicity items including press releases, school website, photographs, and videotaping.

I AFFIRM THAT TO THE BEST OF MY KNOWLEDGE ALL INFORMATION CONTAINED ABOVE IS ACCURATE. I AM AWARE THAT DELIBERATELY FALSIFYING A PUBLIC DOCUMENT MAKES ME LIABLE FOR PROSECUTION (cf. N.J.S. 2 C:24-4 and N.J.S. 2 C:20-8). I FURTHER UNDERSTAND THAT MY CHILD'S REGISTRATION WILL NOT BE AUTHORIZED UNTIL I RETURN THE COMPLETED PUPIL MEDICAL FORM. I AUTHORIZE THE GARWOOD PUBLIC SCHOOLS TO TAKE PRUDENT ACTION IN AN EMERGENCY. MY SIGNATURE ALSO VERIFIES THAT I HAVE RECEIVED THE PUPIL/PARENT HANDBOOK, REVIEWED IT WITH MY CHILD AND WILL SEE THAT THE GUIDELINES ARE FOLLOWED.

_______________________________________ _______________________

Signature of parent/guardian Date

Reviewed by Building Principal _______________________ _______________________
Signature Date

Revised: 06/01/2022

Comments:____
____

GARWOOD PUBLIC SCHOOLS
Garwood New Jersey 07027

Pupil Medical Form for Entering Garwood Schools

Name :______________________________ Date of Birth: ______________

Address: ____

Current Immunizations: Mandated by New Jersey State Law and/or required by the Garwood Board of Education. Please provide written documentation on separate paper.

Has your child had any known developmental delays? ______________________

Has your child ever had a learning disability? ______________________

Is there a family history of a learning disability? ______________________

HEALTH HISTORY

Familial Diseases (indicate relationship):

Heart Disease ______________________________

Diabetes ______________________________

Asthma, Allergies ______________________________

Mental Illness ______________________________

Metabolic/Chemical Dependence ______________________________

Other ______________________________

Parent Signature: ______________________ Date: ______________

NEW STUDENT HEALTH AND PHYSICAL EXAM FORM

HEALTH HISTORY (to be filled out by PARENT/GUARDIAN)

Student's Name: ________________________________ Birth Date: __________________ Sex ____M ____F

Grade: ________________ Languages Spoken at home: ____

Parent / Guardian Name: ____

HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

____
____
____
____
____

Operations or Serious Hospitalizations:

____
____
____

Current Medications (Name, Dose, Frequency and Reason used):

____
____
____

Allergies: (Name, reaction to exposure)
Drug: ____
Food: ____
Environmental: ____

Any Other Additional comments or information that you would like to provide:

____
____
____

Student's Name: ______________________________ Exam Date: ________________

PHYSICAL EXAM

Height:	**Weight:**	**Pulse:**	**B/P:**
Vision:	**Uncorrected**	**Right:**	**Left:**
Vision:	**Corrected**	**Right:**	**Left:**
Hearing Screen:		Right:	Left:

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

____

____

____

Any Limitation of Activity or other Recommendations? No Yes (Please define):

____

____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: ______________________________ Date: ____________________

Name and Address Stamp:

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

Medical Provider Name:______________________________

Completed Cardiac Assessment Professional Development Module? ____Yes____No

Address Stamp:

Date of Exam:______________________

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician, APN, PA ______________________________

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HE0503
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71 Revised Green Brook Family Medicine May 2014
9-2681/0410

Garwood Public School
Emergency Notification Sheet

In the event of an emergency, the Garwood Public Schools need to have the following information for each student. Please fill out as thoroughly as possible.
Emergency calls will be made in the order these names are listed unless otherwise stated.

Child's Last Name: ______________________________ Child's First Name: ___________________________ Primary Phone#___________________________
e-mail address _______________________________

Parent/ _________________________________ _________________________________ ____________________ _______________________
Guardian (Last name) (First) (Employer/place of work) (Work phone-extension) (cell phone)

Parent/ _______________________________ ________________________________ ____________________ ________________________
Guardian (Last name) (First) (Employer/place of work) (Work phone-extension) (cell phone)

Names and relationship of 2 other adults if the above cannot be contacted for illness or emergency

_______________________________ ______________________________________ __________________________
(Last Name/Relationship) (First) (Phone)

_______________________________ ______________________________________ ___________________________
(Last Name/Relationship) (First) (Phone)

Does child have Health Insurance?
Yes ______ If yes, name of insurance company ____
No ______ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ Family Care Program to contact me about health insurance. Written consent required pursuant to 20 U.S.C. 1232g(b)(1) and 34 C.F.R. 99.30(b).
Signature: ____________________________________ Printed Name __________________________________ Date:__________________

Family Doctor ____ Dentist ____________________________________
(Name) (Phone) (Name) (Phone)

Wears eyeglasses: ___yes ___no Wears contact lenses ___yes ___no

Allergies/medication needs/medical restrictions____

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.
AUTHORIZATION IS GRANTED FOR THE GARWOOD PUBLIC SCHOOLS TO TAKE PRUDENT ACTION IN AN EMERGENCY.
Our Pupil/Parent Handbook is on the school website, www.garwoodschools.org. If you would like a hard copy, please let the office know. My signature below verifies that I have reviewed the Pupil/Parent Handbook with my child and will see that the guidelines are followed.

Parent/guardian signature____ Date____________________________

Revised: 06/01/2022