BERGENFIELD PUBLIC SCHOOLS
Registration Form

School Entering:
Franklin Hoover
Jefferson Lincoln
Washington RWB BHS
Assigned Grade/HR: _____
ID #:

Student Information

Name: ________________________________ **Date of Birth:** ____/ ____/ _______

Home Address: ____________________________ **Gender:** _____ Male _____ Female

________________________________ **City, State of birth:** ______________________

Home Phone #: ____________________________ **Language Spoken at Home:** _______________

Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White Other: ____________________

International Students:

Birth Country: __________________________

Birth City: __________________________

Date Entered U.S: ____/ ____/ _______

Date Entered 1st U.S School: ____/ ___/ _______

Date Entered NJ State School: ____/___/_______

Check all that applies: ___ IEP ___ 504 ___ ISP ___ health concerns ___ ESL

Student's Former School

Name: ______________________________

Address: ____________________________

U.S. Military Status: ____Not military ____ Active duty ____ National Guard/Reserve

Guardian/Household Information

Parent/Legal Guardian: ____________________ **Parent/Legal Guardian:** ____________________

Email: ______________________________ **Email:** ______________________________

Cell#: ______________________________ **Cell #:** ______________________________

Work#: ______________________________ **Work #:** ______________________________

Lives in household: ___Yes ___No **Lives in household:** ____Yes ____No

Relationship to student: ________________ **Relationship to student:** ________________

Emergency Contacts Other Than Household Members

Name: ______________________________ **Gender:** _____ Male _____Female

Relationship to Student: ________________ **Cell Phone #:** ________________________

Home/Work Phone #: ____________________

Name: ______________________________ **Gender:** _____ Male _____Female

Relationship to Student: ________________ **Cell Phone #:** ________________________

Home/Work Phone #: ____________________

Insurance Information

Is your child covered by health insurance:__Yes __No **Name of Insurance Co:** ____________________

Doctor's Name & Address: ____

Doctor's Telephone #: ____________________

NJ FamilyCare 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. The Bergenfield Board of Education may release my name and address to the NJ FamilyCare Program to contact me about health insurance. _____ Yes _____ No

Signature of Parent/Guardian: ______________________ **Date:** __________________________

ALL OTHER CHILDREN IN THE HOUSEHOLD

1. **Name:** ___________________________________ **Date of Birth:** ____/ ____/ _______
   Name of Former School: _________________ **Gender:** _____ **Male** _____ **Female**
   ____ **City, State of birth:** __________________
   Address of Former School: _______________ **Country of birth:** __________________
   ____ **Relationship to Student:** ______________

2. **Student Name:** ____________________________ **Date of Birth:** ____/ ____/ _______
   Name of Former School: _________________ **Gender:** _____ **Male** _____ **Female**
   ____ **City, State of birth:** __________________
   Address of Former School:_________________ **Country of birth:** __________________
   ____ **Relationship to Student:** ______________

3. **Student Name:** ____________________________ **Date of Birth:** ____/ ____/ _______
   Name of Former School: _________________ **Gender:** _____ **Male** _____ **Female**
   ____ **City, State of birth:** __________________
   Address of Former School:_________________ **Country of birth:** __________________
   ____ **Relationship to Student:** ______________

4. **Student Name:** ____________________________ **Date of Birth:** ____/ ____/ _______
   Name of Former School: _________________ **Gender:** _____ **Male** _____ **Female**
   ____ **City, State of birth:** __________________
   Address of Former School:_________________ **Country of birth:** __________________
   ____ **Relationship to Student:** ______________

5. **Student Name:** ____________________________ **Date of Birth:** ____/ ____/ _______
   Name of Former School: _________________ **Gender:** _____ **Male** _____ **Female**
   ____ **City, State of birth:** __________________
   Address of Former School:_________________ **Country of birth:** __________________
   ____ **Relationship to Student:** ______________

Comments/additional information you would like us to know:

____

____

____

____

SWORN STATEMENT OF LANDLORD

I, ____own the property located
(Name of Owner/Leasing Agency)

at ____ which is presently
(Address of Rental Property)

rented to ____.
(Tenant's Name)

The only tenants who are permitted to reside in this rental unit are:
(list each and every tenant including all children)

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

The term of this lease is from __________________ to ____________________.

The amount of rent being paid is ______________________________________.

This family has lived in this rental unit since ___________________________.

I have attached a true copy of this lease if it is in written form. If it is not in written form please check here (   ).

____
Signature of Owner/Leasing Agent

Sworn and subscribed to
before me this ____day
of _____________, 20______

____
Print Name (Owner/Leasing Agent)

____
Notary Public

Stamp & Seal required:

BERGENFIELD PUBLIC SCHOOL DISTRICT
100 South Prospect Avenue
Bergenfield, New Jersey 07621
201-385-8202

This is a LEGAL DOCUMENT. The information which you will provide will be used by the Bergenfield Public School District to determine whether the pupil is entitled to a free education in this school district. Please answer each question.

This affidavit is made in compliance with provisions of NJSA 18A:38-1 as amended and is being executed and delivered to the Superintendent of Schools of the Bergenfield Public School District for the specific purpose of inducing the District to permit the pupil named herein to obtain a free education in the public schools of the Bergenfield Public School District. I understand that the Bergenfield School System will rely on the truth of the statements made in this document. I also understand that I may be required to produce documents and/or records to demonstrate the truth of the statements I will make in this document.

I also understand that false execution of this affidavit is an offense punishable by civil and/or criminal law, and that if I provide false information, I could be held liable for payment of tuition at a cost of $ _______________ annually for the full period of Illegal attendance by this pupil.

PARENT AFFIDAVIT OF LEGAL RESIDENCE AND PUPIL DOMICILE

STATE OF NEW JERSEY)
: ss.
COUNTY OF BERGEN)

______________________________, of full age, being sworn upon his/her oath according to law, deposes and says:
[Parent's Name]

1. I am executing this affidavit for the specific purpose of inducing the Bergenfield Public School District to provide a free education to my son/daughter whose name is: ______________________ and whose date of birth is _____________________.

2. I reside at the following address and affirm that I am not an occasional resident there:
House Number & Street Name: ____
City/Town/Boro: ___________________________ County: ________________ State: ____________
Telephone #: ______________________________

3. Check either a or b below:
_____ a. I own that residence, and I have attached a true copy of the Deed.
_____ b. I rent or lease that residence, and I have attached a true copy of the lease. If I do not have a lease, I have attached a notarized statement from the owner of this residence which confirms that I am renting or leasing this residence for my domicile.
_____ c. Other (Please explain below):
____
____
____
____
____
____

4. My son/daughter who is named above resides at the following address, is not an occasional resident there, and is not being domiciled there for the sole purpose of obtaining a free education from the Bergenfield Public School District.
House Number & Street Name: ____
City/Town/Boro: _____________________ County: _____________ State: __________
Telephone #: _________________________

5. My son/daughter who is named above:
_______ a. will live with me at this address during the school year. Phone # ____________
_______ b. will live with me at another address during the school year. (If you checked this item, write the other address below):
____
____
____
_______ c. will live with me at this address during the summer.
_______ d. will live with me at another address during the summer. (If you checked this item, write the other address below.)

This student has successfully completed grade ______________. (Transcript is required)

6. SCHOOL ATTENDANCE INFORMATION
This student, in whose behalf I am filling this official affidavit, last attended:
a. Name of School: ____________________________________ Grade: _________
b. Address of School: ____
c. City: ________________ Town: ______________ State: ________ Zip: _______
d. Country: ____

7. SIGNATURE OF PARENT COMPLETING THIS AFFIDAVIT.
I am making this affidavit pursuant to SA 18A38-1(b), to induce the Bergenfield Public School District to provide a free education for the pupil who is named in this affidavit.

I understand that if any of the information provided in this affidavit is changed for any reason, it is my responsibility to immediately notify the Superintendent of Schools of the Bergenfield Public School District.

The above statements and supporting attachments are true and complete to the best of my knowledge. I know that if they are willfully false, I will be subject to punishment prescribed by statue and will be assessed tuition for the full period of illegal attendance.

____
(Signature of Parent or LEGAL Guardian)

Sworn to and subscribed
before me this _______ day
of ___________ 20_____.

____
Notary Public

BERGENFIELD BOARD OF EDUCATION
225 WEST CLINTON AVENUE
BERGENFIELD, NJ 07621

REGISTRATION QUESTIONNAIRE

Student Name: ____
PRINT

Guardian Name: ____
PRINT

Has your child ever been referred for a special education evaluation? YES NO

Has your child ever been evaluated by a special education child study team? YES NO

Has your child ever been classified for special education and related services or for speech services? YES NO

Has your child ever had an IEP or ISP? YES NO

Do you have any reason to suspect that your child may have a learning, emotional or physical issue? YES NO

Has your child ever had a 504 plan? YES NO

Guardian Signature: _______________________________________

Date: ___________________________________

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: ____Date of Birth (YYYYMMDD): _________

Current Address: ____

Survey Questions:

1.) List all languages used in the student's home.

____

2.) Was the first language used by the student a language other than English?

______ **No** _____**Yes**

3.) Does the student speak or understand a language other than English?

______ **No** _____**Yes**

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

______ **No** _____**Yes**

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

______ **No** _____**Yes**

BERGENFIELD PUBLIC SCHOOL DISTRICT
Photograph / Image Consent Form

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personally identifiable information to be published on the district and/or school's website.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a website since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, email address, telephone numbers and locations and times of class trips.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

Check one of the following choices:

- ☐ I/We GRANT permission for a photo/image that includes this student without any other personal identifiers to be published on the school and/or district's public Internet site.
- ☐ I/We GRANT permission for this student's photo/image and name to be published on the school and/or district's public Internet site.
- ☐ I/We GRANT permission for this student's photo/image and all other personal identifiers listed above to be published on the school and/or district's public Internet site.
- ☐ I/We DO NOT GRANT permission for a photo/image that includes this student to be published on the school and/or district's public Internet site.

Student's Name (please print): ______________________________ Grade: ____________

Parent/Guardian's Name (print): ____________________________

Relationship to Student: __________________________________

Signature of Parent/Guardian: ______________________________ Date: ___ /___ /_____

Bergenfield Board of Education
Internet & Electronic Information
Access Agreement/Student Agreement

Dear Student and Parents/Guardians:
Bergenfield Public School District's goal in providing access to the Internet and/or other sources of electronic information includes (1) providing a rich and interesting educational experience; (2) developing academic growth and excellence; and (3) developing skills related to research, use of computers, applications, software, and computer etiquette, responsibility, and accountability.

Any use of unapproved software or applications, including but not limited to Virtual Private Networks ("VPNs"), Proxy servers or sites, or copyrighted software, to bypass security measures on the Bergenfield School District network is forbidden. Please be advised that any unapproved software, applications, or resources used by a student puts the student's personal and private information at risk to parties who may impose harm. **All Internet use and communications must be related to research and educational objectives only.** Any violation of the Bergenfield Board of Education Policy 2361 (Acceptable Use Policy) and the Google Apps for Education Edition Agreement and Privacy Policy may result in immediate termination of access to the network. Other disciplinary actions may also be taken in proportion to the severity of the violation.

STUDENT AGREEMENT

As a condition of using Bergenfield School District's computers and devices, applications, software, and computer networks to access programs and/or information including, but not limited to, the Internet, Google G Suite for Education, such as Gmail, and related networks, I have read and agree to abide by the Bergenfield Board of Education Policy 2361 (Acceptable Use Policy) and the Google Apps for Education Edition Agreement and Privacy Policy. I understand that any violation of these guidelines or any inappropriate conduct related to computer usage may result in administrative action, including, but not limited to, revocation of my computer use and access, detention, suspension, expulsion, or legal prosecution. I understand and am fully responsible for my actions.

Google Apps for Education Edition Agreement and Privacy Policy:
https://gsuite.google.com/intl/en/terms/education_terms.html

Student's Name ____ **(Please Print)**

Student's ID Number __________________________ Grade ___________

Student's Signature ____________________________ Date ____________

PARENT/GUARDIAN CONSENT AND AGREEMENT

I have read and discussed with _______________________ (Student's Name) the above agreement and the Board of Education Policy 2361 (Acceptable Use Policy) and the Google Apps for Education Edition Agreement and Privacy Policy. I understand that access to the Internet and related networks as well as to computer software, Google G Suite for Education including Gmail, and applications on school computers and devices are for **educational use only.**

Parents/Guardian's Name _______________________ **(Please Print)**

Parent/Guardian's Signature _____________________ Date _________

The Board of Education recognizes as new technologies shift the manner in which information is accessed, communicated, and transferred; these changes will alter the nature of teaching and learning. Access to technology will allow pupils to explore databases, libraries, Internet sites, and bulletin boards while exchanging information with individuals throughout the world. The Board supports access by pupils to these information sources but reserves the right to limit in-school use to materials appropriate for educational purposes. The Board directs the Superintendent to effect training of teaching staff members in skills appropriate to analyzing and evaluating such resources as to appropriateness for educational purposes.

The Board also recognizes technology allows pupils access to information sources that have not been pre-screened by educators using Board approved standards. The Board therefore adopts the following standards of conduct for the use of computer networks and declares unethical, unacceptable, or illegal behavior as just cause for taking disciplinary action, limiting or revoking network access privileges, and/or instituting legal action.

The Board provides access to computer networks/computers for educational purposes only. The Board retains the right to restrict or terminate pupil access to computer networks/computers at any time, for any reason. School district personnel will monitor networks and online activity to maintain the integrity of the networks, ensure their proper use, and ensure compliance with Federal and State laws that regulate Internet safety.

Standards for Use of Computer Networks
Any individual engaging in the following actions when using computer networks/computers shall be subject to discipline or legal action:

A. Using the computer network/computers for illegal, inappropriate or obscene purposes, or in support of such activities. Illegal activities are defined as activities that violate Federal, State, local laws and regulations. Inappropriate activities are defined as those that violate the intended use of the networks. Obscene activities shall be defined as a violation of generally accepted social standards for use of publicly owned and operated communication vehicles.

B. Using the computer network/computers to violate copyrights, institutional or third party copyrights, license agreements or other contracts.

C. Using the computer network in a manner that:

1. Intentionally disrupts network traffic or crashes the network;
2. Degrades or disrupts equipment or system performance;
3. Uses the computing resources of the school district for commercial purposes, financial gain, or fraud;
4. Steals data or other intellectual property;
5. Gains or seeks unauthorized access to the files of others or vandalizes the data of another person;
6. Gains or seeks unauthorized access to resources or entities;
7. Forges electronic mail messages or uses an account owned by others;
8. Invades privacy of others;
9. Posts anonymous messages;
10. Possesses any data which is a violation of this Policy; and/or
11. Engages in other activities that do not advance the educational purposes for which computer networks/computers are provided.

Internet Safety Protection
As a condition for receipt of certain Federal funding, the school district shall be in compliance with the Children's Internet Protection Act, the Neighborhood Children's Internet Protection Act, and has installed technology protection measures for all computers in the school district, including computers in media centers/libraries. The technology protection must block and/or filter material and visual depictions that are obscene as defined in Section 1460 of Title 18, United States Code; child pornography, as defined in Section 2256 of Title 18, United States Code; are harmful to minors including any pictures, images, graphic image file or other material or visual depiction that taken as a whole and with respect to minors, appeals to a prurient interest in nudity, sex, or excretion; or depicts, describes, or represents in a patently offensive way, with respect to what is suitable for minors, sexual acts or conduct; or taken as a whole, lacks serious literary, artistic, political, or scientific value as to minors.

This Policy also establishes Internet safety policy and procedures in the district as required in the Neighborhood Children's Internet Protection Act. Policy 2361 addresses access by minors to inappropriate matter on the Internet and world wide web; the safety and security of minors when using electronic mail, chat rooms, and other forms of direct electronic communications; unauthorized access, including "hacking" and other unlawful activities by minors online; unauthorized disclosures, use, and dissemination of personal identification information regarding minors; and measures designed to restrict minors' access to materials harmful to minors.

Notwithstanding blocking and/or filtering the material and visual depictions prohibited in the Children's Internet Protection Act and the Neighborhood Children's Internet Protection Act, the Board shall determine other Internet material that is inappropriate for minors.

In accordance with the provisions of the Children's Internet Protection Act, the Superintendent of Schools or designee will develop and ensure education is provided to every pupil regarding appropriate online behavior, including pupils interacting with other individuals on social networking sites and/or chat rooms, and cyberbullying awareness and response.

The Board will provide reasonable public notice and will hold one annual public hearing during a regular monthly Board meeting or during a designated special Board meeting to address and receive public community input on the Internet safety policy - Policy and Regulation 2361. Any changes in Policy and Regulation 2361 since the previous year's annual public hearing will also be discussed at a meeting following the annual public hearing.

The school district will certify on an annual basis, that the schools, including media centers/libraries in the district, are in compliance with the Children's Internet Protection Act and the Neighborhood Children's Internet Protection Act and the school district enforces the requirements of these Acts and this Policy.

Consent Requirement

No pupil shall be allowed to use the school districts' computer networks/computers and the Internet unless they have filed with the main office a consent form signed by the pupil and his/her parent(s) or legal guardian(s).

Violations

Individuals violating this Policy shall be subject to the consequences as indicated in Regulation 2361 and other appropriate discipline, which includes but are not limited to:

1. Use of the network only under direct supervision;
2. Suspension of network privileges;
3. Revocation of network privileges;
4. Suspension of computer privileges;
5. Revocation of computer privileges;
6. Suspension from school;
7. Expulsion from school; and/or
8. Legal action and prosecution by the authorities.

N.J.S.A. 2A:38A-3

Federal Communications Commission: Children's Internet Protection Act
Federal Communications Commission: Neighborhood Children's Internet Protection Act

STUDENT REGISTRATION REQUIREMENTS AND AGREEMENT

PLEASE READ THIS INFORMATION BEFORE YOU START THE REGISTRATION PROCESS.

1. School age children whose Parent(s) or LEGAL Guardian(s) are able to document that they are LEGAL RESIDENTS of BERGENFIELD and are able to document residence, legal guardianship, and full financial responsibility for the child's support may be enrolled on a resident non-tuition basis.

2. A student is **NOT** a legal resident of Bergenfield simply because she/he is living in Bergenfield with an aunt or uncle or other relative UNLESS the SURROGATE COURT of BERGEN COUNTY HAS GRANTED COMPLETE CUSTODY TO THAT RELATIVE WHO IS A RESIDENT OF BERGENFIELD. It will be the sole responsibility of that relative to prove (a) that she/he is a legal resident of Bergenfield, (b) that Surrogate Court has granted custody to that relative, and (c) that said relative is paying in full for the entire cost of the student's support.

3. NON-RESIDENTS of Bergenfield **MAY** be accepted for registration, on a space-available basis, only after full payment by bank check of the full tuition for the time remaining in the academic year at the time of registration.

4. **<u>Information for Persons Who Have Recently Purchased a Home in Bergenfield</u>**:

   A. You are **NOT** a Bergenfield resident until **AFTER** title to the Bergenfield residence has passed to you at closing and you actually live in your Bergenfield house.
   B. School District Policy does **NOT** allow exceptions to this definition of "legal resident".
   C. If you need to enroll your child(ren) in the Bergenfield Public Schools BEFORE you close title on your Bergenfield residence, you can do so AS A NON-RESIDENT. To enroll, you must present, at the time of registration, a cashier's check for the amount of tuition due up to and including the last day of the month of your scheduled closing.
   D. If the closing of title is postponed, the "not-yet-resident" student may continue to attend the Bergenfield Public Schools only if you pay tuition one month in advance by cashier's check by the 30th of each month until the closing takes place and you are living in your Bergenfield residence.
   E. If the purchase transaction does not occur, the parent or legal guardian must do one of the following:
      1. Pay tuition, by cashier's check, in advance for the remainder of the school year; or
      2. Withdraw the student from the Bergenfield Public School in which she/he was registered and return to the school in the community in which she/he is a legal resident.

STUDENT REGISTRATION
REQUIREMENTS AND AGREEMENT

F. If a parent or legal guardian fails to comply with section "E" above, there will be no requirement that the Board of Education conduct a hearing to remove the non-resident student. The student's registration will be canceled and the student will be refused admission to any and all classes in the Bergenfield Public School System. In addition, the parents or legal guardians of such student shall be held responsible for payment of back tuition, if any, at the rate of one-tenth the annual tuition rate per month plus interest at nine per cent per annum, plus all costs of collection and enforcement.

G. In the event that parents or legal guardians default with regard to their obligations to pay tuition as described in this document, the Board of Education will proceed as though the parents or legal guardians had consented to the ex parte entry of judgment against them for their obligations under the terms herein set forth.

5. **Information for Persons Who Live in a Rented Residence in the Borough of Bergenfield**:

A. You are **NOT** a Bergenfield resident for tuition-free school registration purposes unless you can furnish written proof that as the student's parents or legal guardians (as declared by Surrogate Court of Bergen County) you are the **legal renters** of the Bergenfield premises claimed as a residence and, upon further investigation, can prove that you (and they) **DO**, in fact, **LIVE THERE**.

B. School District Policy does **NOT** allow exceptions to this definition of "legal resident" and does not allow for tuition-free enrollment of non-resident students UNDER ANY CIRCUMSTANCES.

C. **RENTERS ARE CAUTIONED TO ASK THAT YOUR LANDLORD FURNISH YOU WITH PROOF THAT THE APARTMENT OR THE HOUSE YOU ARE RENTING COMPLIES WITH ALL BOROUGH REQUIREMENTS TO QUALIFY AS A LEGAL RENTAL PROPERTY IN THE BOROUGH OF BERGENFIELD**. We **WILL** check your rental premises against the official records of the Borough of Bergenfield to verify that you are living in a property that has been approved by the Borough for use as a rental property or a property in which occupancy by other that the owner(s) has been approved by the borough. ***THIS CAUTION IS FOR YOUR PROTECTION AND TO ENSURE THAT BERGENFIELD'S TAXPAYERS DO NOT PAY THE BILL FOR STUDENTS WHOSE PARENTS HAVE RENTED A RESIDENCE WHICH THE BOROUGH HAS NOT APPROVED FOR THAT USE.***

D. If there is pressing need for a student to be registered in the Bergenfield Public Schools before his/her parent(s) or legal guardian(s) can furnish **ALL** of the required proofs, the student will be accepted ONLY AS A TUITION-PAYING NON- RESIDENT STUDENT, AND only after payment-in-advance by cashier's check of tuition for 2 months, at a rate of one-tenth per month of the state-established tuition rate, for that student's grade level and level of programming.

STUDENT REGISTRATION
REQUIREMENTS AND AGREEMENT

E. If a parent or guardian fails to comply with the procedures for documenting residency, custody, and full financial responsibility that are described herein, and on the Affidavit of Residence which **MUST** be completed by the parent(s) and/or “host residents”, the student will be **DENIED** tuition-free admission. The student will then be admitted **ONLY** after payment-in-advance by cashier’s check of full tuition due for the remainder of the current school year, pro-rated at the rate of one tenth the state-established annual tuition rate, for that student’s grade level and level of special programming.

6. Should further investigation provide evidence that a student has been granted admission as a resident non-tuition-paying student on the basis of false, inaccurate, or otherwise misleading information which was provided as an inducement for the school system to grant tuition-free status, the student will be removed without need for a hearing conducted by the Board of Education. The persons who have furnished false information shall be prosecuted to the fullest extent of the law and shall be responsible for payment of back tuition, if any, at the rate of one tenth the annual state-established tuition rate for month plus interest at the rate of nine per cent per annum, plus all costs of collection and enforcement. The Board of Education shall proceed as though the parent(s) or the legal guardian(s) had consented to the ex parte entry of judgment against them for their obligations under the terms set forth herein and in the affidavit materials which were completed as part of the registration process.

TUITION RATE APPROVED BY NJ DEPARTMENT OF EDUCATION FOR THE BERGENFIELD PUBLIC SCHOOLS 2020-2021

Preschool/Kindergarten	$14,052 per year*
Grades 1-5	$14,156 per year*
Grades 6-8	$13,770 per year*
Grades 9-12	$14,859 per year*
Learning and/or Lang. Disability	$13,555 per year*
Emot. Reg. Imp. (BD)	$48,764 per year*
Autism	$83,472 per year*
Multiple Disability	$26,156 per year*
Preschool Disability - FT	$13,160 per year*

*The school calendar from September 1 through the following June 30.

STUDENT REGISTRATION
REQUIREMENTS AND AGREEMENT

AGREEMENT

I have read the publication entitled STUDENT REGISTRATION REQUIREMENTS AND AGREEMENT which was furnished to me by a representative of the Bergenfield Public School System. This will confirm my agreement to provide full and accurate information as requested by the Bergenfield Public School District and that I agree and understand that if these conditions are not met, then:

a. I will be responsible for full tuition payment as of the student's first day of attendance in the Bergenfield Public School System as well as for the costs of collection and interest at the rate of nine percent per annum, and for payment of tuition for the remainder of the current school year;
b. the student will be removed from attendance, with no need for a Hearing before the Board of Education, until and unless all financial obligations and arrears shall have been paid in full with interest and collection costs as they are described in this publication;
c. the person(s) who have provided false, incomplete, or misleading information to the Bergenfield Public School System as an inducement for the school system to grant tuition-free resident status to the student will be subject to prosecution to the fullest extent of the law, and
d. the Board of Education will proceed as though the parents or legal guardians had consented to the ex parte entry of judgment against them for their obligations under the terms set forth in this publication.

____________________________________	____________________________________
Signature of Parent/Legal Guardian	School Official's Signature, Title
Date ______________________________	Date: ______________________________

BERGENFIELD PUBLIC SCHOOL DISTRICT
Where Children Come First
80 South Prospect Avenue • Bergenfield, NJ 07621 • (201) 385-8600 x1609
Alice M. Nieves
District Registrar

Release of Records Request

____
Student's Last Name First Name Birth Date Grade

__________________________________ (_____)___________ (_____)____________
Previous School Phone Fax

____
Town/City State

The above named student has registered in our school district. Please send us the student's mandated records. Please make sure you send the following:

1. Attendance records
2. Test scores (NJASK, HSPA, ACCESS, MAC, etc.)
3. Grades (transcript including courses in progress)
4. All health records
5. Child Study Team records
6. Discipline records
7. And, all records required by the State Board of Education

Parent signature serves as notice to the parent that we are requesting such records. According to stature, you do not need parent consent to send the records. We need to provide them notice of request for such records.

_________________________________ ______________________
Parent/Guardian Signature Date

PLEASE SEND RECORDS TO:

☐ ROY W. BROWN MIDDLE SCHOOL
Guidance Department
130 South Washington Avenue
Bergenfield, NJ 07621
Fax: 201-385-0219
Tel: 201-385-8847

☐ BERGENFIELD HIGH SCHOOL
Guidance Department
80 South Prospect Avenue
Bergenfield, NJ 07621
Fax: 201-385-9412
Tel: 201-385-8600

BERGENFIELD PUBLIC SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
Roy W Brown Middle School / Bergenfield High School

Name of Student: ________________________________ M ____ F ____ Grade _____
Last First

Address: ______________________________ Date of Birth: ____/ ____/ ____
______________________________ Mo. Day Year
____

1. Has your child ever attended a Bergenfield School? School Name _______________
2. Has your child ever attended a school in New Jersey? Yes ____ No ____
3. Name and address of school transferring from ______________________________
____
____
4. Grade transferred out ______
5. Please check any medical conditions that may pertain to your child.

_____ None
_____ Diabetes
_____ Seizures
_____ Asthma
_____ Heart Condition
_____ Gastrointestinal Disorder(s)
_____ Orthopedic Conditions
_____ Other - Please List
____
____

Please explain ____
____
____

6. Does your child require daily medication? Yes _____ No _____
If so, what medication? ________________________________
7. Please note any measures that should be taken should an emergency arise from any of the noted medical conditions ____
____
____

8. I hereby give permission for the school to take necessary action in any extreme emergency. (I am aware that every effort will be made to contact the child's parent/guardian.) In the event of an emergency requiring an ambulance, the Bergenfield Ambulance Corp. will transport your child to Englewood, Hackensack Medical Center, or Holy Name Hospital.

Hospital Desired: Englewood _____ Hackensack Medical Center _____
Holy Name _____ Nearest Hospital _____

Name of Parent/Guardian (please print) ______________________________________
Signature of Parent/Guardian ___________________________ Date _____________

Please update this information, at any time, by notifying the School Nurse in writing.

12/2013

BERGENFIELD PUBLIC SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
Roy W Brown Middle School / Bergenfield High School

STUDENT RECORD OF DISCLOSURE & RELEASE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses of their protected health information (PHI). The individuals also provided the right to request confidential communications or that a communication of PHI be made by the alternative means, such as correspondence to the Individual's office instead of the individual's home.

NAME OF CHILD: ____
Last name First Name

DATE OF BIRTH: ___________________________

NAME OF TRANSFERRING SCHOOL: _________________________

ADDRESS: ________________________________

GRADE COMPLETED: ________________

I GRANT MY PERMISSION TO RELEASE MY CHILD'S HEALTH RECORDS TO THE FOLLOWING:

SCHOOL ADDRESS:

_____ Roy W Brown Middle School
130 South Washington Avenue
Bergenfield, NJ 07621
Attn: A.M. Murphy, RN, MA,CSN

_____ Bergenfield High School
80 South Prospect Avenue
Bergenfield, NJ 07621
Attn: Loretta Borrows, RN, BA, CSN

PARENT/GUARDIAN SIGNATURE: ____

DATE: _________________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to authorization requested by the Individual Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

DATE	DISCLOSED (To Whom/ Address/ Fax #)	DESCRIPTION (Of Disclosure/Purpose)	BY WHOM DISCLOSED	DATE RECEIVED

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)					
Tdap					
POLIO - INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

	Date:	Titer:
Hepatitis B		
Varicella		
Measles		
Mumps		
Rubella		

☐ Provisional admission attached-Date Granted: _______________ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISORDER		AUTISM SPECTRUM DISORDERS	
ASTHMA		HEART DISEASE		CHRONIC OTITIS MEDIA		HEMATOLOGICAL DISORDERS	
CONGENITAL DISORDER		HEPATITIS		AUTO IMMUNE DISORDERS		**OPERATIONS OR INJURIES**	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

****MANTOUX - Date Planted: ____________________ Date Read: ______________________ Results: ____**

****REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required**

VA-16 AUG. 75 **FY-09**

NEW JERSEY STATE DEPARTMENT OF HEALTH
NOTICE TO PARENTS/GUARDIANS REGARDING
IMMUNIZATION DEFICIENCIES

To the Parents/Guardians of ____

Your child's health record shows that immunization requirements for school attendance are incomplete. The boxes circled below indicate the immunization(s) that are missing.

If you have records which show that these immunizations have been received, please present them at your earliest convenience and have the information transcribed to the school's health record. The immunization regulations permit provisional or temporary attendance at school upon filing of a request for provisional admittance. If your child requires more than one doctor visit to complete these requirements, have your physician or local health officer complete the attached form. Failure to comply with the State's immunization requirements will prevent your child from attending school.

___________________________ ___________________________ ___________________________

Date **School Nurse** **Phone Number**

Check if you need either of these forms: Medical Contraindication __________ **Religious Exemption** __________

DO NOT DETACH
PROVISIONAL ADMITTANCE REQUEST

I request to have my child provisionally admitted to school pending the completion of the minimum immunization requirements. I affirm that the immunizations required will be completed as soon as possible and in accordance with the appointment schedule provided by our family physician or local health department.

Expiration of Provisional Admittance ____

___________________________ ___________________________ ___________________________

Date **School Nurse** **Phone Number**

The above pupil's immunization series has been initiated and he/she is in the process of complying with all the immunization requirements. I have arranged an appointment schedule and agree to provide the remaining immunizations. All immunization requirements should be met by ___________________________

___________________________ ___________________________ ___________________________

Signature of Physician/Date **Name/Address Physician Clinic** **Phone Number**

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 keepa 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 ____________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

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

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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 ____________________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

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 of exam ____________

Address ______________________________ Phone ______________

Signature of physician, APN, PA ______________________________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

HE0503　　9-2681/0410

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

Preparticipation Physical Evaluation
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age ____________ Date of birth ____________

☐ 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 ______________________________

____

____

____

____

____

EMERGENCY INFORMATION

Allergies ______________________________

____

____

____

____

____

Other information ______________________________

____

____

____

____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ______________________________
(Date)

Approved ______ Not Approved ______

Signature: ______________________________

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, the 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) ______________________________ Date ____________

Address ______________________________ Phone ____________

Signature of physician, APN, PA ______________________________

Completed Cardiac Assessment Professional Development Module

Date____________ Signature______________________________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact	
Phone	Phone	Phone	

HEALTHY (Green Zone)

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above __________

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take____________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:___________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to______

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_______________

And/or Peak flow below _________

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❏ Colds/flu
- ❏ Exercise
- ❏ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❏ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❏ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❏ Foods:
  - ❍ ____________
  - ❍ ____________
  - ❍ ____________
- ❏ Other:
  - ❍ ____________
  - ❍ ____________
  - ❍ ____________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Disclaimers: The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

REVISED MAY 2017

Permission to reproduce blank form • www.pacnj.org

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_________________________ DATE__________

Physician's Orders

PARENT/GUARDIAN SIGNATURE_________________________

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

______________________________	______________	__________
Parent/Guardian Signature	Phone	Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication ______________________ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

______________________________	______________	__________
Parent/Guardian Signature	Phone	Date

PACNJ
Pediatric/Adult Asthma Coalition

Disclaimers: The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Sponsored by
AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

BERGENFIELD PUBLIC SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Required Physical Exams

To: Parents/Guardians:

In compliance with School Law Title 18A:40-4 and School Board Policy 5141, a physical examination is required for your child. The exam may be done by the School Physician or by the private physician of your choice which would be at your own expense. The school nurse will issue the medical exam form should you choose to go to your private physician. The deadline for private physicals is in accordance with School Board Policy 5141 "within 60 days of entrance" for the school year.

Complete school physical examinations including a review of the body systems such as skin, cardio-respiratory, musculoskeletal, etc. are performed by the school doctor/pediatrician with the assistance of the school nurse. Urine testing for sugar and protein will not be part of this exam.

If an abnormality is detected in any area of the physical assessment, it will be reported to you. Should you receive such a notice, it is expected you will take your child to his/her own doctor for follow up care. If you do not receive a notice, this indicates that your child was in good physical health at the time of the examination.

Kindly check below indicating your preference, sign and complete this form and return promptly to the school nurse:

Student Name (please print) ____ Grade ________ HR ________
Last First

I would prefer that my child have a:

_________ Private physical at my expense

_________ School Physical

____ ____________________
Signature of Parent / Guardian Date

If your child has had a recent physical exam (within 1 year) please provide information to the school nurse.

BERGENFIELD PUBLIC SCHOOLS
21-22 ONE-TIME STUDENT HEALTH SCREENER PAPER FORM
STUDENT NAME: ____

I certify I will not send my child, to any school programs if he/she meet any of the following criteria:
-Tested positive for COIVD-19 in the past week.
-Has been in close contact with someone who has tested positive for COVID-19 in the past week AND is not fully vaccinated
-Has any of the following symptoms: shortness of breath, cough difficulty breathing, olfactory disorder, loss or change in ability to taste
-Has two or more of the following systems: runny/stuffy nose, fever (greater than 100.0 F), chills shivers, sore throat, muscle aches, headache, tired/fatigued, nausea vomiting, diarrhea
-Has taken fever-reducing medication for the purpose of reducing a fever
-Has taken fever-reducing medication for the purpose of reducing a fever
-Has traveled out of the country or been in contact with someone who has been in the past 14 days AND is not fully vaccinated
-Has traveled to a state other than NY, CT, PA or DE or been in contact with someone who has been in 14 days and is not fully vaccinated.

By printing and signing your name below serves as your signature and certification of this form.

Print name

Signature

*** Please return the form to the main office.**

BERGENFIELD PUBLIC SCHOOLS
21-22 SOLO UNA VEZ FORMULARIO DE EVALUACIÓN DE SALUD DEL ESTUDIANTE
NOMBRE DEL EL ESTUDIANTE: ____

Certifico que no enviaré a mi hijo/hija a ningún programa de la escuela si cumple con alguno de los siguientes criterios:

-Dio positivo para COVID-19 la semana pasada
-Ha estado en contacto cercano con alguien que dio positivo en la prueba de COVID-19 en la última semana Y no está completamente vacunado
-Tiene CUALQUIERA de los siguientes síntomas: dificultad para respirar, tos, dificultad para respirar, trastorno olfativo, pérdida o cambio en la capacidad para saborear
-Tiene dos o más de los siguientes síntomas: secreción / nariz tapada, fiebre (más de 100.0 f), escalofríos, escalofríos, dolor de garganta, dolores musculares, dolor de cabeza, cansado / fatigado, náuseas / vómitos, diarrea
-Ha tomado medicamentos para reducir la fiebre con el fin de reducir la fiebre.
-Ha viajado fuera del país o ha estado en contacto con alguien que ha estado en los últimos 14 días Y no está completamente vacunado.
-Ha viajado a un estado que no sea NY, CT, PA o DE o ha estado en contacto con alguien que ha estado en los últimos 14 días Y no está completamente vacunado.

Al imprimir y firmar su nombre a continuación, sirve como su firma y certificación de este formulario.

Imprimir nombre

Firma

*** Devuelva el formulario a la oficina principal.**