WHAT TO BRING TO YOUR REGISTRATION

Parents and guardians, please bring the following documents to the school or office to ensure a smooth and complete registration process:

- ☐ An ***original birth certificate with raised seal*** for the students
- ☐ ***Acceptance Letter from Charter School*** (transferring)
- ☐ Student's ***School Records*** **or** ***Record Release Form*** (from previously attended school)
- ☐ Custodial Parent/Guardian Documentation (if Applicable):
- ☐ ***Transfer Card*** or Clearance Form (from previously attended school)
- ☐ Health/Immunization Record
- ☐ ***Proof of Residency – parent/guardian will be asked to complete the eligibility for registration form and must provide the following:***

TYPE	PRIMARY (ONE of the following)	AND	SECONDARY (TWO of the following)
Own	Original Deed **OR** Property Tax Bill **OR** Closing Statement **OR** Agreement of Sale		Documents with address accepted: Any Utility Bill (from current month of registration date) Any Insurance Documents Pay Stub Car Registration Monthly Benefits Statement
Rent	Official Lease with Expiration Date		Secondary Documents listed above may be provided by a renter and/or landlord
Other Alternate/Temporary Living Arrangements	Notarized Affidavit of residence (living with family/friend or homeless) Host families are required to provide a notarized letter along with two proofs of residency in the homeowner's name.		

**Please note any bill must be for the current month of registration date (within the last 30 Days).

Once registration is completed, the registration forms will be maintained at the school. Please be sure to bring ALL health forms, school records, and transcripts with you to Achievers ECP.

QUE DEBEN DE TRAER PARA LA MATRICULA

Para empezar a matricular a un estudiante en la escuela, los padres o tutores tienen que traer los siguientes documentos:

- ☐ ***El Certificado de nacimiento original del estudiante con sello de relieve***
- ☐ ***La Carta de Aceptación de la Escuela Chárter*** (siesta transfiriéndose)
- ☐ ***El Expediente de la Escuela o el Formulario para Facilitar la Entrega del Expediente del estudiante de la escuela a donde asistió anteriormente*** (ej. Libreta de Calificaciones, IEP, 504, etc.)
- ☐ Documentación de custodia de padres (si corresponde)
- ☐ ***La Tarjeta de Traslado o el Formulario de Despacho*** (de la escuela done asistió previamente)
- ☐ El Record de Vacunas del estudiante
- ☐ ***Prueba de Domicilio - padre/tutor tienen que traer los siguientes con fecha actual:***

TIPO	PRINCIPAL (UNO DE LOS SIGUIENTES)	Y SECUNDARIO (DOS DE LOS SIGUIENTES)
Propietario	Titulo Original del Hogar **O** Contribución territorial (Impuestos)**O** Declaración de la hipoteca **O** Contrato de Venta	Pruebas de domicilio que serán aceptadas: Cuentas de Servicio Público Pólizas de Seguros Talonario de pago Registro del Automóvil Declaración de Beneficios Mensual
Inquilino	Actual Contrato de Alquiler (con fecha)	Documento secundarios mencionados anteriormente pueden ser proporcionados por el inquilino y/o el propietario
Otro Arreglos alternativos o Temporales de vivienda	Una Declaración Jurada de residencia (viven con familiares o amigos o personas sin hogar). Se requiere que el dueño del hogar provea una carta firmada ante un notario y acompañada de dos pruebas de residencia a nombre del dueño.	

**Tome nota que cualquier factura tiene que corresponder al mes vigente o a la fecha de matrícula.

Cuando se complete el proceso de registración, los datos permanecerán en la escuela donde asistirá el estudiante. Por favor asegúrese de llevar TODOS los records médicos, expedientes escolares y de traslado de escuela.

ACHIEVERS EARLY COLLEGE PREP DATE:_____NJSID #:_____Trenton Student ID#:_____

STUDENT REGISTRATION FORM GRADES 6-8

	Forms of ID	Birth Certificate: ☐ Yes ☐ No	☐ Special Education ☐ 504 Accommodations ☐ Bilingual ☐ Transportation	☐ Grades 6-8 *Present Grade*_____

STUDENT INFORMATION / INFORMACION DE ESTUDIANTE

Last Name *Apellido*	**First Name** *Nombre*	**Middle** *Segundo Nombre*	**Sex** ☐ Male/*Masculino* *Sexo* ☐ Female/*Femenino*

Date of Birth (MM/DD/YY) *Fecha de Nacimiento*	**City of Birth** *Ciudad de Nacimiento*	**State** *Estado*	**Country** *País*	**Age as of October 1** *Edad a partir de Octubre 1*

Current Address (Street/Apt No.) *Dirección Actual (Calle/Numero de Apartamento)*	**City** *Ciudad*	**Zip** *Código Postal*

Home Phone Number *Numero del Hogar*	**Who has legal residential custody of this student? (List person or agency):** *¿Quién tiene custodia residencial legal de este estudiante? (Escriba el nombre de la persona o agencia):*

Check if the Student/Custodial Parent Currently Homeless? ☐ **¿El Estudiante / Padre Custodial actualmente está sin hogar?** (Homeless means lacking a fixed, regular and adequate residence pursuant to N.J.S.A. 18A:7B-12 and N.J.A.C. 6A:17). *(Sin hogar significa falta de una residencia fija, regular y adecuada de acuerdo con N.J.S.A. 18A: 7B-12 y N.J.A.C. 6A: 17).*	**If homeless, what was the student's last fixed, permanent address?** *Si no tiene hogar, ¿cuál fue la última dirección fija y permanente del estudiante?*

Race: *La Raza del Niño*: ☐ **White** *Anglosajón* ☐ **Black** *Afroamericano* ☐ **Hispanic** *Hispano* ☐ **Asian/Pacific Islander** *Asiático* ☐ **Native American** *Nativo Americano*

For Multi-Racial—Check all that Apply *Multirracial por favor marque lo que corresponda.*

MUST COMPLETE IF BORN OUTSIDE THE US OR US TERRITORIES / ESTO DEBE SER COMPLETADO SI NACIDO FUERA DE LOS TERRITORIOS DE LOS EEUU O DE LOS EEUU.

Date entered US: *Fecha de entrada en los EEUU:*	**Date FIRST entered ANY US school:** *Fecha en que entró por primera vez en cualquier escuela en los EEUU:*

MILITARY CONNECTED STUDENT / ESTUDIANTE MILITAR CONECTADO

Is the student a dependent of:
(Please check any that apply.)
¿Es el estudiante un dependiente de:
Por favor marque lo que corresponda.

☐ **On Active Duty (full-time) in the Army, Navy, Air Force, Marine Corps or Coast Guard?** *Están empleados a tiempo completo en Servicio Activo, en el Ejército, Fuerza Naval, Fuerza Aérea, Cuerpo de Marines o Guardia Costera?*

☐ **Member(s) of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps or Coast Guard)?** *Son miembros de la Guardia Nacional o Reservas (Ejército, Fuerza Naval, Fuerza Aérea, Cuerpo de Marines o Guardia Costera)?*

LIST ALL SCHOOLS PREVIOUSLY ATTENDED (INCLUDING ALL TRENTON SCHOOLS) / LISTA DE TODAS LAS ESCUELAS PREVIAMENTE ASISTIDAS (INCLUIDAS LAS ESCUELAS DE TRENTON)

Years Attended (ex. 9/1999—7/2006) *Años de Estudio (ej. 9/1999—7/2006)*	**State or Country (ex. Ohio or Guatemala)** *Estado o País (ej. Ohio o Guatemala)*	**School Name (ex. John Smith Elementary)** *Nombre de la escuela (Escuela de John Smith)*	**Grade Levels Attended (ex. K-3)** *Grado atendidas (ej. K-3)*

ACHIEVERS EARLY COLLEGE PREP **STUDENT REGISTRATION FORM GRADES 6-8**

PARENT/LEGAL GUARDIAN CONTACT INFORMATION / INFORMACIÓN DE CONTACTO DEL PADRE / GUARDIÁN LEGAL:

	Contact #1	Contact #2
Relationship To Student: *Relación con el estudiante:* **(Mother, Father, Legal Guardian)** *(Madre, Padre, Guardián Legal)*		
Name: *Nombre:*		
Current Address: *Dirección Actual:*		
Home Phone: *Tel. Hogar:* **609-555-1212**		
Cell Phone: *Tel. Celular:*		
Place of Birth: *Ciudad de Nacimiento:*		
Place of Employment: *Lugar de empleo:*		
Work Phone: *Numero del Trabajo:*		
E-mail:		

PLEASE LIST EMERGENCY CONTACTS IN CASE WE ARE UNABLE TO REACH YOU. CONTACTS WILL NEED TO PROVIDE IDENTIFICATION.
Por favor escriba el nombre y numero de teléfono de un pariente de confianza, amigo, o vecino en caso de emergencia. Necesita ran proporcionar identificación.
Additional contacts if necessary can be provided to the main office. *Contactos adicionales si es necesario se pueden proporcionar a la oficina principal.*

	Emergency Contact #1 *Contacto de emergencia #1*	Emergency Contact #2 *Contacto de emergencia #2*	Emergency Contact #3 *Contacto de emergencia #*
Name: *Nombre:*			
Home Phone: *Tel. Hogar:*			
Cell Phone: *Tel. Celular:*			
Work Phone: *Numero del Trabajo:*			
E-mail:			
Relationship to Child: *Relación con el estudiante:*			

LIST ALL CHILDREN IN FAMILY (OLDEST FIRST) Hermanos/as del estudiante en orden de nacimiento.

Last Name *Apellido*	**First Name** *Nombre*	**Gender** *Sexo*	**Date of Birth** *Fecha de Nacimiento*	**Name of School Attending** *Nombre de Escuala*

►► **Parent/Legal Guardian Signature** ►► **Date**
Firma de Padre/Guardián Legal ***Fecha***

ELIGIBILITY FOR REGISTRATION

Public schools are required to provide a free education to all persons over age 5 and under age 20 who are domiciled in the district. Domiciled means that the student is living with a parent or guardian whose permanent home is located within the boundaries of the district.

- A home is permanent when the person intends to return to it when absent and has no present plan to move from it, even though he/she has existence of homes or residences elsewhere.

- Residency requires bodily presence as an occupant in a given district.

If at any time, you or your child changes domicile or residence, you must report this information immediately to the school building secretary.

It is the policy of the board that should the district discover that a child is not a legal resident of the district and is illegally attending Trenton Public Schools, the district will assess the parents the full costs of the tuition for such attendance. Any additional costs for special education services will be added to the regular education costs.

Parent/Guardian of: _____

School:_____Grade:_____

By my signature, I am indicating that I have read the information above, understand it, and affirm that my child(ren) and I are legal residents of and are domiciled in the Trenton Public School District.

Signed:_____Date:_____

PLEASE RETURN THIS FORM TO THE MAIN OFFICE.
THIS COPY IS TO BE MAINTAINED IN THE STUDENT'S FILE.

ELEGIBILIDAD PARA MATRICULACIÓN

Las escuelas públicas tienen la obligación de proveer educación gratuita a todas las personas mayores de 5 años y menores de 20 años cuyo domicilio está dentro del distrito. Domicilio significa que el estudiante está residiendo con su padre o tutor cuyo hogar permanente está situado dentro de los límites del distrito.

- Un hogar es permanente cuando la intención de la persona es de regresar ahí cuando no está presente y no tiene ningún plan de mudarse de ahí en la actualidad, a pesar de que él/ella tienen otras casas o residencias en otro lugar.

- Residencia requiere la presencia corporal de un ocupante en un distrito dado .

Si en algún memento, usted o su hijo(a) cambia de domicilio o residencia, usted tiene que reportar esta información a la secretaria de la escuela inmediatamente.

Es la norma de la junta que si el distrito descubre que un niño(a) está asistiendo a las Escuelas Públicas de Trenton ilegalmente, el distrito le cobrará a los padres el coste complete de la cuota de asistencia. Cualquier coste adicional por servicios de educaci6n especial se le aumentara al coste regular de la educación.

Padre/Tutor de: _____

Escuela: _____ Grado: _____

Con mi firma, Yo estoy indicando que he leído la información anterior, la comprendo, y afirmo que mi hijo(s) y yo somas residentes legales de y que nuestro domicilio está dentro del Trenton.

Firmado: _____ Fecha: _____

POR FAVOR DEVUELVA ESTE FORMULARIO AL OFICINA ESTA COPIA DEBE DE MANTENERSE EN EL ARCHIVO CUMULATIVO DEL ESTUDIANTE.

Special Education Medicaid Initiative

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

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

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

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

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

Child's Name: _____

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

Parent/Guardian: _____ Date: ____ / ____ / ____

I give consent to bill for SEMI:

☐ Yes
☐ No

This consent can be revoked at any time by contacting the administrators at Achievers.

HOME LANGUAGE SURVEY-Encuesta del Idioma del Hogar

PART A:

School Name: _____
Nombre de la Escuela

Student's Name: _____ Date of Birth: _____

Nombre del Estudiante *Fecha de Nacimiento*

Place of Birth: _____ School: _____
Lugar de Nacimiento *Escuela*

Parent/Guardian: _____ Phone #: _____
Padre/Guardian *#Teléfono*

Address: _____ City/State/Zip: _____
Dirección *Ciudad/Estado/Código Postal*

School: _____ Teacher: _____ Grade: _____

Escuela *Profesor/a* *Curso*

PART B: Language Information-Información del Idioma

1. What language did your child speak first? *¿Qué idioma habló su hijo/a primero?*
   O English O Spanish O Other _____

2. What language do **you** speak most often to your child at home? *¿Que idioma habla usted más a menudo en su casa?*
   O English O Spanish O Other _____

3. What language does **your child** most often speak at home? *¿Qué idioma habla su hijo/a mas a menudo en casa?*
   O English O Spanish O Other _____

4. What language does **your child** use when speaking to his/her brother or sister? *¿Qué idioma habla su hijo/a cuando habla con su hermano/a?*
   O English O Spanish O Other _____

5. What language does your child most often speak with other family members? *¿Qué idioma habla su hijo/a más frecuentemente con otros miembros de la familia?*
   O English O Spanish O Other _____

PART C: Language Selection- Selección de Idioma

Which language would you prefer the school use to send correspondence to you? (Please indicate below)-
¿En qué idioma prefiere que la esculea le envie mensajes? *(Por favor indique debajo)*

_____ _____ _____

Language- *Idioma* Parent/Guardian Signature-*Firma* Date-*Fecha*

STUDENT HEALTH HISTORY

Pupil's Name_____School_____Grade _____

Birthdate_____Sex _____

Address_____Telephone #_____

Parent/Guardian's Name_____Work #_____

Usual Care Provider: (check): Private Physician_____HMO_____H.J. Austin Health Center_____Clinic _____

Doctor's Name_____Telephone # _____

Health History and Development

1. Length of pregnancy_____months Delivery (circle one) Normal, Caesarian, Premature Birth
   weight_____lbs_____oz
   Problems at birth or delay sending newborn home. If Yes, explain _____
   _____
2. Birth sequence of above child 1st_____2nd_____3rd_____4th_____Other _____
3. What age did your child walk_____talk_____toilet-train _____
4. Does your child have any of the following problems?
   Vision_____Hearing_____Speech _____
5. Does your child take medications? Yes_____No_____If Yes, explain _____
   _____
6. Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes_____No_____If Yes, explain _____
   _____
7. Has your child had a serious injury? Yes_____Year_____No _____
8. Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization? Yes_
   Year_____No_____If Yes, explain _____
   _____
9. Has your child been tested for lead poisoning? Yes_____No_____Results _____

Disease History (Age)

Measles	_____	German Measles	_____	Mumps	_____
Scarlet Fever	_____	Whooping cough	_____	Asthma	_____
Pneumonia	_____	Ear Infections	_____	Tuberculosis	_____
Convulsions	_____	Tubes in ears	_____	Chicken Pox	_____
Polio	_____				
Heart Disease	_____	Sickle Cell	_____		
Anemia	_____	Fractures	_____	Frequent sore throats	_____
Frequent headaches	_____	Liver Disease	_____	Diabetes	_____
Frequent nosebleeds	_____	Lyme Disease	_____	Tonsillitis	_____

Any restrictions or limitations to physical activity? _____
Is there anything about your child's health not mentioned above that we should know? _____
_____

Date_____ Signature of Parent/Guardian

CONFIDENTIAL INFORMATION

STUDENT HEALTH HISTORY

Nombre del estudiante_____ Grade _____

Fecha de nacimiento_____ Sexo _____

Dirección_____ Teléfono # _____

Nombre del padre o encargado_____ Numero de trabajo _____

Cuidado medico: Doctor privado _____ HMO _____ Centro de Salud _____

Nombre del doctor_____ Teléfono # _____

Historial de Salud y desarrollo

1. Meses de embarazo _____ Parto: (circule uno) Normal, Cesarea, Prematuro
   Peso_____lbs_____oz

   Problemsas al nacer o estadia en el hospital. No_____Sí _____
   Explicación _____
2. Total de embarazo_____Estudiante es el numero _____
3. A que edad el nino (a) camino? _____ Hablo? _____ uso el inodoro? _____
4. Tiene su hijo (a) problema con lo siguiente? _____
   Vision_____Oir_____Hablar _____
5. Tomas u hijo (a) algun medicamento? No_____Sí _____
6. Tiene su hijo alguna laergia a alguna comida, plantas, animals, insectos u otro? No_____Sí _____
   Explicación _____
7. Ha tenido su hijo (a) alguma lesion o golpe serio? No_____Sí _____
   Cuando? Explicación _____
8. Tiene el nino (a) alguna operacion o procedimiento medico que haya requerido hospitalización o servicios de paciente externo hospitalization? No _____ Sí_____
9. Le han hecho la prueba del plomo a su nino (a) No _____ Sí _____ resultado _

Enfermedades (edad)

Sarampion	____	Sarampion aleman	____	Paperas	____
Fiebre escarlata	____	Tosferina	____	Asma	____
Pulmonia	____	Infecciones del oido	____	Tuberculosis	____
Convulsioness	____	Tubos en los oidos	____	Varicelas	____
Polio	____			Epilepsia	____
Carazon	____	Sickle Cell	____	Dolar de garganta	____
Anemia	____	Fracturas	____	Frequent sore throats	____
Frecuente dolor de cabeza	___	Higado	____		
Amigdalitis	____				
Frecuente sangra por a nariz	____	Lyme Disease	____		

Hay alguna restriccion o limitacion par la actividad fisica? _____
Tiene alguna informacion acerca de la salud de su hijo que no se ha mencionado? _____

Fecha_____ Firma del padre o encargado_____

INFORMACION CONFIDENCIAL

ACHIEVERS EARLY COLLEGE PREP

STUDENT EMERGENCY MEDICAL INFORMATION CARD

(Tarjeta de información de emergencia médica del estudiante

Last Name_____ **First**_____ **Initial**____ **Date of Birth (Mo/Day/Year)**_____
(Apellido) (Nombre) (Inicial) Fecha de nacimiento:Mes/Día/Año)

Address_____ **School** _____
(Dirección) (Escuela)

City_____ **State**_____ **Zip**_____ **Grade** _____
(Ciudas) (Estado) (Apartado) (Grado)

HomeTelephone(_____)_____ **Teacher H.R.** _____
(Teléfonodelacasa) (Maestro/a de SalónHogar)

To parent/ guardian: To serve your child in case of accident or sudden illness, it is necessary that you furnish the following information for emergency calls:
(A los padres o encargados: Par asistír a su hijo/a en caso de accidente o enfermedad súbita, es necesario que nos provea la siguiente información par liamades de emergencia)

	Name (Nombre)	**Address** (Dirección)	**Telephone** (Teléfono)
Mother/Guardian (Madre/Encarada)		**Home** (Hogar)	
		Work (Trabajo)	
Father/Guardian (Padre/Encargado)		**Home** (Hogar)	
		Work (Trabajo)	

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:
(Enlishe dos vecinos o familiars que asumirán cuidado temporeno de su hijo/a sí usted no puede ser contactado)

Name _____
(Nombre)
Home/Address _____
(Hogar/Dirección)
Telephone: Home_____ **Work** _____
(Teléfonos: Hogar) (Trabajo)
Relationship _____
(Relación)

Name_____
(Nombre)
Home/Address_____
(Hogar/Direción)
Telephone: Home_____ **Work**_____
(Teléfonos: Hogar) (Trabajo)
Relationship_____
(Relación)

Please list other children attending Trenton Public Schools (Name, School)
(Favor de Enlistar Otos Niños Asistiendo a las Escuelas Públicas de Trenton: Nombre, Escuela)

_____ _____

_____ _____

_____ _____

Does your child have health insurance? ¿Tíene su hijo/a seguro medico? **Yes** (Sí) _____ **If Yes, name of insurance company**_____
(De ser cierto, el nombre de la compania)
No (No)_____

NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. You may release my name and address to the NJ Family Care Program to contact me about health insurance. NJ Family Care proveseguro de salud gratis o de bajo costo para los niños que no tienen seguro medico y para ciurtos padres que tiensen bajos ingresos. Authorizo a que óé mi nombre y dirección al Programa de Nj Family Care para qu3 me contracten acerca del seguro de salud)

Signature:_____ **Print Name**_____ **Date** _____
(Firma) (Nombre Impreso) (Fecha)
Doctor_____ **Telephone**_____
(Doctor) (Teléfono)
Hospital_____ **Address**_____ **Telephone**_____
(Hospital) (Dirección) (Teléfono)

I, the undersigned, do hereby authorize officials of Trenton Public Schools to contact directly the persons named on this card and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. (Yo, quien firma esta tarjeta, asuthorizo a los oficiales de las Esuelas Públicas de Trenton a contactar directamente a las personas nombradas en testa tarjeta y authorize al medico nombrado a render tal tratamiento que estime necesario em um emergencia, por el bienestar del estudiante nombrado

In the event that physician, other persons named on this card, or parent cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child. (En caso de que el medico; otras personas nombradas en esta tarjets, o los padres no puectan ser contractados, los oficiales de la escuela testán autorizados a tomar cusalquier acción que en su juicío estimen necesaria, por la salud del estudiante aquí nomtrado)

I will not hold the school district financially responsible for the emergency care and/or transportation for said child (No hare responsible financeramente al distnto escotar por el cuidado de emergencia y/o la transportación par dicho estudiante)

Pupil's Last Name (Apelido del Estudiante)	**First** (Nombre)	**Initial** (Incical)	**Signature of Parent(s)/Guardian(s)** (Firma de Padre(s) / Encargado (s)	**Date** (Fecha)

c

Dear Parent/Guardian:

The Department of Education collaborated with the American Academy of Pediatrics and reviewed the New Jersey Administrative Code 6A:16-2.2. regarding school and athletic physicals. The new code supports the concept of accessible, continuous, comprehensive, and family centered care for all our students.

As a result of the new regulation, medical examinations must now be conducted in the "medical home" of the student with a full report sent to the school. "Medical home" means a private or clinic health care provider (physician, nurse practitioner/clinical nurse specialist or physician's assistant) chosen by the student's parent or guardian for the provision of health care. **The cost of the medical examination is the responsibility of the parent/guardian.**

Therefore, ALL SCHOOL ENTRY PHYSICALS MUST BE DONE BY THE STUDENT'S OWN PHYSICIAN OR HEALTH CARE PROVIDER. Physical exams are required at the time of school entry into the district. **This examination must be done no more than 365 days prior to entry.**

Students who do not have a health care provider due to lack of insurance may be eligible for medical services either free or low cost up to age nineteen through NJ Family Care. For information about NJ Family Care, eligibility, or to enroll, you may call **l-800-701-0710**. Multilingual operators are available.

In order to determine how many students have a medical home, it is necessary for you to complete the attached **Medical Home Information Form**. Please return the form to the school. If you have any questions or concerns, please contact us.

-Achievers Early College Prep Charter School

School Health Services

Estimados Padres/Encargados:

El Departamento de Educación colaboró con La Asociación Americana de Pediatría y revisó el Código Administrativo de New Jersey 6A: 16-2.2. en relación a los examenes físicos en la escuela y atléticos. El Nuevo código sostiene el concepto del cuidado accesible, continuo, comprensivo, y centralizado en la familia para todos nuestros estudiantes.

Como resultado de la nueva regulación, los examenes médicos ahora se tienen que llevar a cabo en el "hogar médico" del estudiante con un reporte completo enviado a la escuela. "Hogar médico" significa la clínica o proveedor de cuidado de salud privado (medico, enfermera práctica/enfermera clínica especialista o médico asistente) seleccionado por los padres o encargados del estudiante para proveer el cuidado de salud. **El costo del examen médico es responsabilidad de los padres/encargados.**

Por lo tanto, TODOS LOS EXAMENES FISICOS DE ENTRADA DEBEN DE SER REALIZADOS POR EL MEDICO 0 PROVEEDOR DE CUIDADO DE SALUD DEL ESTUDIANTE. Adjunto se encuentra la forma de Examen Físico que el médico tiene que llenar. Favor de devolver la forma llenada a la enfermera escolar.

Examenes físicos son requeridos en el momento de entrada a la escuela en el distrito. **Este examen debe de llevarse a cabo no más de 365 días antes de entrar.**

Para los estudiantes que no tienen un proveedor de cuidado de salud debido a carencia de seguro médico, puede que sean elegibles para servicios médicos ya sea grátis o a bajo costa hasta la edad de diecinueve años a través del NJ Family Care. Para información sobre NJ Family Care, elegibilidad, o inscripción, puede llamar al **l-800-701-0710.** Recepcionistas que hablan diferentes idiomas están disponibles.

Para determinar cuántos estudiantes tienen hogar médico, es necesario que llene la forma de **Información del Hogar Médico** adjunta. Favor de devolver la forma a la enfermera escolar. Si tiene alguna pregunta o inquietud, puede ponerse en contacto con la enfermera de la escuela.

-Achievers Early College Prep Charter School

MEDICAL HOME INFORMATION FORM

Dear Parent / Guardian:

In order to determine how many students have a medical home, it is necessary for you to complete the Medical Home Information Form. Please return the form to the school nurse.

Name of Student _____ School_____

Address _____ Grade_____

_____

Phone Number _____

Name of Health Care Provider _____
(Doctor's Name or Clinic)

Address _____

_____

Phone Number _____

Does your child have health insurance? Yes____ No_____

If yes, name of insurance company_____

Parent/ **Guardian** Signature_____Date_____

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STUDENT RECORDS RELEASE FORM

To Whom It May Concern:

I hereby authorize the following school to release health records and other pertinent information regarding my child to Trenton Public Schools for the purpose of registration.

_____ _____
(Student Name) (Date of Birth)

Sending School:

_____
(School Name)

_____
(Address)

_____
(City, State, Zip Code)

Please forward records to:

_____
(School Name)

_____
(Address)

_____
(City, State, Zip Code)

Attention: School Nurse

_____
(Parent Signature)

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AUTORIZACION DE RELEVO DE EXPEDIENTE DEL ESTUDIANTE

A Quien Pueda Interesar:

Por la presente autorizo a la siguiente escuela compartir historiales médicos y otra información pertinente con respecto a mi hijo/a al Trenton Public School District para efectos de registro.

_____ _____
(Nombre del Estudiante) (Fecha de nacimiento)

El envío de la escuela:

_____
(Nombre de la escuela)

_____
(Dirección)

_____
(Ciudad, estado, código postal)

Enviar los registros a:

_____
(Nombre de la escuela)

_____
(dirección)

_____
(Ciudad, estado, código postal)

Atención: enfermera de la escuela

_____
(Firma de los padres)

UNIVERSAL
CHILD HEALTH RECORD

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

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐Male ☐Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐Immunization Record Attached ☐Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐None ☐Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐None ☐Special Care Plan Attached ☐	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐None ☐Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐None ☐Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐None ☐Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐None ☐Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐None ☐Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐None Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct ☐ ☐			Hearing		
Lead: Capillary Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

      Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

STUDENT RECORDS RELEASE FORM

I hereby authorize the following school district to request records from the schools/facility my child previously attended.

Parent/Guardian (PRINT) Parent/Guardian (Signature) Date

Name of Student: _ _ _ _ _ _ _ _ _ _ _ Date of Birth __/__/__

Sending School:
(Last School Attended) (Address)

_ Last Grade Completed:
City State Zip Code

Phone: ( ) _____ Fax: ( ) _____

(For School Use Only)

Information to be sent to the attention of: _

Receiving School: _
(Name of School Student is Enrolling) (Address)

_ Phone: ( ) _____ Fax: ( ) _____

Please include all items below that apply to the students.

o Transfer Card
o Academic Record (Report Card/Transcript)
o Attendance Record
o Standardized Test Scores
o Child Study Records
o Health Records
o Discipline Records

Thank you for your cooperation in this regard. It is greatly appreciated.

PERMISO PARA ENTREGA DE DOCUMENTOS DE ESTUDIANTE

Aqui autorizo al distrito escolar el permiso para que manden lost record de mi hijo/a de la escuela que asistio anteriormente.

Padre/o Guardian (Favor letra de imprenta) Parent/Guardian (Signature) Fecha

Nombre del Estudiante: _ _ _ _ _ _ _ _ _ _ _ Fecha de Nacimiento: __I__I__

Escuela que asisti6: _

(Direcci6n)

_____ _____ _____ Ultimo grado que completo:
Ciudad Estado Codig6 Postal

Phone: ( ) _ _ _ _ _ _ _ _ Fax: ( ) _____

(Solamente para use de la Escue/a)

A que persona le enviamos los documentos: _____ _____

Escuela donde va asistir: _

(Escuela donde el estudiante va asistir) (Direcci6n)

_____ Telefono: ( ) _____ Fax: ( ) _____
(Ciudad/Estado/C6digo Postal)

Favor de marcar abajo mencionado lo que es applicable al estudiante.

o Tarjeta de cambio
o Registro academico
o Regstro de asistencia
o Resultados de los Examenes
o Registro de Estudio del estudiante
o Registro de Salud
o Registro de Disciplina

Muchas gracias por su cooperaci6n. Estamos muy agradecidos.

500 Smith Street, Trenton, NJ 08611

www.achieversearlycollegeprep.org

Parent Commitment Pledge

As an Achievers Parent,

I will show respect for the school by assuring that my student and I:

1. Arrive on time and remain at school for the full length of the school day _____
2. Comply with the school calendar for vacations _____
3. Adhere to all guidelines presented in the Achievers' Student Handbook Enhance learning. I will:

    A. Read with my child thirty minutes daily and sign planner. _____

    B. Monitor my child's progress through conferences and communication with the teachers and via the parent portal. _____

    C. Monitor completion of homework projects, and classwork. _____

    D. Attend Parent Nights, Open Houses, and other events. _____

    E. Model attitudes and behaviors that show support for Achievers. _____

4. Speak positively with my child and others about the school and staff. _____
5. Address concerns at school in an appropriate manner with staff. _____
6. Promote Achievers in a positive manner at the school and in public. _____

_____ _____

Print Full Name Signature Date