LITTLE SILVER SCHOOLS
Little Silver, NJ

Name__________________________

Health Questionnaire and Developmental History

Does your child have any of the following health conditions now or in the past?

	Yes	No	Explain
Asthma			
Cardiac problems			
Car sickness			
Chronic ear infections			
Chicken pox			
Concussion			
Congenital condition (Specify)			
Diabetes			
Environmental allergies			
Fractured bones			
✯ Wears orthopedic device (splint, etc.)			
Frequent headaches			
Head injury			
Hearing problem			
✯ Wears hearing aid			
Hives			
Lyme disease			
Migraine headaches			
Seizure disorder			
Sinus infections			
Speech problem/concern			
Strep throat			
Urinary/bowel problems			
Vision problem			
✯ Wears glasses or contact lenses (Circle one)			
Other			

1. Does your child have a **life-threatening allergy** (requires an Epipen) to the following:

	Yes	No	If yes, which one(s)?
Foods			
Insects			
Other			

2. Does your child have any other allergies? Yes No
If yes, please specify type of allergy and reaction (hives, etc.):
____
____
____

3. Does your child take any medications either daily or as needed? Yes No
If yes, please list name of medication, reason for use and how often child takes the medication:
____
____

(OVER)

4. Has your child had any serious illness, injury or surgery? Yes No
If yes, please give details and date(s) of illness, injury, hospitalization or surgery:
____
____

5. **Birth Data** Full-term ______ Premature ______ (weeks)
Birth weight ______ Apgar score (if known) ______
Please indicate any difficulties during pregnancy or birth: ___________________________
____

6. **Developmental Data**: Please give approximate ages that your child accomplished the following:
Sat up ______ Walked ______ Talked ______
Toilet trained ______
Left or right handed? ______ Established when? ______

7. Check any of the following patterns that you have observed in your child:
Easily frustrated ______ Completes tasks slowly ______
Exhibits aggressive behavior ______ Shyness ______
Talks a lot ______ Temper tantrums ______ Moody _____
Short attention span ______ Overly active ______
Difficulty communicating needs and wants ______
Other (please specify) ____________________________________

8. Has your child ever qualified or been enrolled in a specialized program? Please check all that apply:
Early intervention (please specify) ___________________________
Pre-School ______ Speech ______ Second Language ______
Gifted and Talented ______ Other (please specify) ____________

9. Has your child ever had an IEP ______ or 504 Plan __________?

10. Has your child ever received any private therapies? If so, please specify:
____
____

11. Do you have any concerns about your child's developmental behavior or emotional well-being that the school should be aware of? ____________________________________
____
____

12. Do you have any other concerns that you would like to share with us? ____________
____
____

Student Release Authorization:

In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed below:

____ ________________________________
Name and Relationship to Child Home and Cell Phone Numbers

____ ________________________________
Name and Relationship to Child Home and Cell Phone Numbers

Parent/Guardian Signature _______________________________ Date _________________

Sharing of Information:
I acknowledge that the information noted above may be shared with school staff members on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _______________________________ Date _____________

LITTLE SILVER SCHOOLS

New Student Information Form

Pupil's Name____ **Grade** __________
Last **First** **Middle**

RESIDENT STATUS AND EMERGENCY CONTACT INFO

Please select ONE: a. Owns a Home:_____ b. Rents/Leases: _____ (You must provide a current lease agreement each year prior to school starting.) c. Eligible for domicile waver - Lives with ____________________________ (must complete Domicile Waiver)

Student resides with (please circle): Both Parents Guardian #1 Guardian #2 Other (please specify)________________________

Emergency Contact Name :_________________________ Relation:_______________________ Cell Phone: ____________________
(Not a Parent)

CUSTODY INFORMATION (Please complete this section if student does NOT reside with both parents)

Legal, court awarded custody/guardianship is held by: _____both parents jointly ____Parent 1 ____Parent 2 ____Guardian(s)

Name: ____ Relationship: ______________________________________

Unless denied by court order, both parents are entitled by law to receive school mailings. If applicable, please indicate the name/address to which duplicate mailings are to be sent:

Name: ____ Address: ____

City: ____ State: ______________________________ Zip:_________________________

IMPORTANT: **You will be asked to provide a copy of your custody agreement prior to your child starting school in the fall.**

SPECIAL CIRCUMSTANCES

Please describe any custody or residential circumstances that may exist. Please provide appropriate documentation for these circumstances prior to student attendance.

The **Education Foundation of Little Silver and the Little Silver PTO** are our parent organizations that support the schools in a variety of ways such as purchasing technology, providing cultural arts assemblies, providing teacher grants, assisting the district with the cleaning protocols necessary due to COVID, to name just a few. Normally, representatives from these groups would be with us today to collect your email address for future events, however, again, due to COVID they are not able to join us. Please complete the form below if you are willing to give us permission to share your email address with them.

I give Point Road School permission to share my email address(es) with the EFLS and LSPTO.
Signature: ______________________________________ Date: _________________________

Form Completed by (PLEASE PRINT)_______________________________________

Signature: ____

Little Silver Schools
Little Silver, NJ

NEW STUDENT PHYSICIAN'S EXAMINATION FORM

Incoming students must have evidence of a physical examination upon entry into a NJ Public School District. The exam must state what, if any, modifications are required for full participation in the school program. Please return this completed form to the Point Road (or Markham Place if in Grades 5-8) School office by **July 1**.

Child's Name____ Date of Birth_____________________

Address ____ Phone: _______________________

History and date of serious illness, injury, surgery, etc. ____

Does child require any of the following (please check all that apply): glasses ________ hearing aid ______
Corrective shoes ______ other____

Is child presently taking any prescribed medication? If so, please explain: ___________________________

Physical examination: WT _______ HT _______ BP ________ Heart ________ Lungs _________
Eyes ______________ Ears ___________ Nose ______________ Throat _________ Skin ___________
Orthopedic __________ Abdomen ____________ Speech _____________ Lymph nodes _____________
General appearance ____

History (give dates where applicable): Asthma _________ Allergies (type) _________________________
Chicken Pox _________ Drug allergies ____________________________ Hernia ____________________
Lyme disease ___________ Meningitis ____________ Mononucleosis __________Pneumonia__________
Seizure disorder _______________ Strep ________________Other ________________________________

The following vaccines are REQUIRED. Please supply **month, day, and year.** (A copy of immunization record may be attached)
DPT: (1) ___________ (2) ___________ (3) ___________ (4) ___________ (5) ______________
(Minimum 4 doses of DPT required-one must be given after age 4)

OPV or IPV (indicate which)**:** (1) __________ (2) __________ (3) __________ (4) __________
(Any 4 doses or 3 doses if one is given after age 4)

MMR (Measles, Mumps, Rubella)**:** _________________ ____________________
(2 doses after age 1) (1) (2)

Hepatitis B: ______________ ______________ ______________
(1) (2) (3)

HIB: (one dose after first birthday) (1) ________ (2) ________ (3) __________ (4) __________

Varicella: (one dose after age 1 or proof of disease immunity) ________________

OPTIONAL:

Hepatitis A: (1) __________________ (2) __________________

Mantoux Tuberculin test: Date: __________________ Result: ______________

DATE OF EXAMINATION: ____

SIGNATURE OF PHYSICIAN/CNP: ____

PRINTED NAME OF PHYSICIAN/CNP: ____