ISLAND HEIGHTS SCHOOL DISTRICT
115 Summit Avenue, P.O. Box 329
Island Heights, NJ 08732
Tel. (732) 929-1222
Fax (732) 929-9563
www.islandheights.k12.nj.us

TIMOTHY J. REHM
Superintendent/Principal

FRANK FRAZEE
Business Administrator

LIL BRENDEL
Board Secretary

Sea Devils

REGISTRATION REQUIREMENTS
ONLY THE NATURAL PARENT OR GUARDIAN MAY REGISTER A STUDENT!

1. **Proof of Residency (necessary before beginning any registration);**

   - **Two (2) Proofs of Residency must be presented indicating the student lives in the sending district.**

   Acceptable examples of such proof are:

   a. **Tax bill or Deed**
   b. **Contract of Sale or Closing Statement**
   c. **Copy of Lease or rental receipt with address of property**
   d. **Utility bill or Digital Driver's License (acceptable as second proof only)**

   - **In the event the student and parent are residing with a third party, the third party must provide two (2) Proofs of Residency, as listed above. In addition, the third party must provide notarized letter stating the parent and student are residing at their address. One proof of residency for the registering party is also required.**

   - **In the event the student is not residing with the parent/guardian, or does not have a court order indicating placement, then the registering party must apply for an Affidavit of Guardianship/Residency agreement.**

2. **Health Records (Immunizations)**

3. **Original Birth Certificate with raised seal (Bureau of Vital Statistics)**

4. **Transfer Card from Previous School**

5. **Latest Report Card**

Provisional registration approvals will grant a party 30 days to provide any listed missing information. Failure to comply may result in exclusion from school until proper documentation is provided.

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To Whom It May Concern,

The following pupil has been enrolled in the Island Heights Grade School for the current school year.

_____

Date of Registration: _____

Please forward the following information and records to the Island Heights Grade School as soon as possible so that proper placement can be made for this pupil.

_____ **Cumulative Records**

_____ **Basic Skills/Chapter I Records**

_____ **Medical Records/Health Card**

_____ **Confidential Records/Child Study Team Reports**

_____ **Other Records of Importance**

Thank you for your prompt attention to our request.

Sincerely,

Timothy J. Rehm
Superintendent/Principal

I give my permission for the _____ **to release records as**
(Name of School)
indicated above for my child.

_____ _____
(Parent's/Guardian's Signature) **(Date)**

ISLAND HEIGHTS SCHOOL DISTRICT

EMERGENCY DATA FORM FOR PUPILS

Emergencies such as sudden illness and injury tend to arise during the course of the school day and school year. It is for the welfare of the children attending the Island Heights Grade School to be able, at all times, to contact an adult member of the family, or a responsible neighbor, who will assist when these emergencies arise. Therefore, we ask your cooperation by completing the "Emergency Data" information below.

Thank you,

Timothy J. Rehm
Superintendent/Principal

Pupil's Name: _____
(Last Name) (First Name) (Middle Initial or Name)

Address: _____

P. O. Box #: _____ Present Grade Level: _____ Mom's Cell Phone #_____

Home Telephone #: _____ Dad's Cell Phone # _____

Pupil's Date of Birth:_____Is your child _____Left Handed? _____Right Handed?

Please List Your Child's Allergies or Handicaps: _____

Please List Languages Spoken At Home If Other Than English: _____

Mother's Name: _____ Address: (if different) _____

Father's Name: _____ Address: (if different) _____

Mother's Place of Employment and Phone Number: _____

Father's Place of Employment and Phone Number: _____

IN CASE OF THE SUDDEN ILLNESS OF YOUR CHLD WHEN NEITHER SPOUSE CAN BE CONTACTED, PLEASE LIST THE NAMES AND PHONE NUMBERS OF TWO INDIVIDUALS WHO WILL ASSUME RESPONSIBILITY FOR YOUR CHILD UNTIL YOU BECOME AVAILABLE:

Name&Relationship _____ Phone Number: _____

Name&Relationship _____ Phone Number: _____

IF YOU WOULD PREFER THAT YOUR PERSONAL PHYSICIAL BE CONTACTED IN CASES OF EXTREME EMERGENCY, PLEASE STATE YOUR PERSONAL PHYSICIAN'S NAME AND PHONE NUMBER BELOW:

Name: _____ Phone Number: _____

_____ _____
Parent's/Guardian's Signature) (Date)

ISLAND HEIGHTS SCHOOL DISTRICT
ISLAND HEIGHTS, NJ 08732

TIMOTHY J. REHM, SUPERINTENDENT/PRINCIPAL

NEW PUPIL INFORMATION

Name: _____ Date of Birth: _____

Residence: _____ Birthplace: _____
Box : _____

Proof of Birth Date: BC _____

Cell Phone #_____
Phone: _____ Former School: _____

Age: _____ Address: _____

PARENT/GUARDIAN INFORMATION

Father: _____ Mother: _____

Birthplace: _____ Birthplace: _____

Occupation: _____ Occupation: _____

Where Employed: _____ Where Employed: _____

Phone: _____ Phone: _____

Former Residence: _____ Cell Phone #_____

Date moved into Island Heights: _____

EMERGENCY INFORMATION

Illness Alternate: Name: _____ Phone: _____

Name: _____ Phone: _____

All other children of school age: Name: _____ Birthday: _____

All children under school age: Name: _____ Birthday: _____

IMMUNIZATION RECORD: (DATES)

D. P. T. : _____ Polio: _____
Measles: _____ TB Tine: _____
Mumps: _____ Rubella: _____

ASSIGNMENT TO:

Teacher: _____ Grade: _____ Date:_____

Parent's/Guardian's Signature: _____ Date: _____

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Board Secretary

Date:

Dear Parents and Guardians,

Throughout the school year, pupils will walk to the Island Heights Library to participate in the school's library program. The pupils will go as a class with their classroom teacher at least once a week. This program is part of their curriculum and we ask that you be aware of this important learning experience.

It is important that the children learn to be responsible for the return of books and materials they borrow from the library. These books must be returned in good condition and on time. We ask your support as parents in this part of our library skills program.

Also, throughout the school year, there will be walking trips to points of interest within the town of Island Heights. The classes will always be accompanied by your child's teacher and by other responsible adults who have volunteered to be chaperones.

Please sign the form below and return it to school, as soon as possible, so that we know you are informed of these particular activities which will take place during the school day of the current school year.

Sincerely,

Timothy J. Rehm
Superintendent/Principal

Dear Mr. Rehm,

Please be advised that I am aware that my child _____ will be visiting the Island Heights Library with his/her class on walking trips and may also be taking walking trips to other points of interest within Island Heights on various occasions throughout the school year.

_____ _____
Parent's/Guardian's Signature **Date**

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Sea Devils

Date:

TO: **Parents & Guardians of Island Heights Grade School Pupils**

FROM: **Mr. Timothy Legendre, Physical Education Instructor**

RE: **Physical Education Program**

Please complete the information below and return this memo, with your signature, to the Island Heights Grade School.

Mr. Legendre

Dear Mr. Legendre,

Please be advised that I am aware that my child _____

will participate in the physical education program at the Island Heights Grade School.

--- To the best of my knowledge, my child is in good physical health. _____

--- To the best of my knowledge, my child is not in good physical health. _____

--- To the best of my knowledge, my child has the following abnormalities and/or health problems about which you should be aware for the benefit of both you and my child.

_____

_____

_____ _____

(Parent's/Guardian's Signature) **(Date)**

ISLAND HEIGHTS GRADE SCHOOL DISTRICT

PART A
HOME SURVEY

1. Student's Name _____ 5. Telephone _____
2. Date of Birth _____ 6. Place of Birth _____
3. Address _____
4. Parent's/Guardian's Name _____

PART B
LANGUAGE INFORMATION

1. What language did your child speak first?	English ____ Spanish ____ Other ____ (language)
2. What language do you speak most often to your child at home?	English ____ Spanish ____ Other ____ (language)
3. What language does your child most often use when speaking to you at home?	English ____ Spanish ____ Other ____ (language)
4. What language does your child most often use when speaking to: brothers and sisters?	English ____ Spanish ____ Other ____ (language)
5. What language does your child speak most often with other family members?	English ____ Spanish ____ Other ____ (language)

PART C
STUDENT RACE/ETHNICITY INFORMATION

Circle Yes or No to each of the following about your child:

Hispanic or Latino	Yes	No
American Indian	Yes	No
Asian	Yes	No
Black/African American	Yes	No
Pacific Islander/Hawaiian	Yes	No
White	Yes	No

_____ _____

Parent's/Guardian's Signature Date

Island Heights Grade School

REGULATIONS REGARDING ADMINISTRATION OF MEDICATION TO PUPILS IN SCHOOL

If your child is to receive medication during school hours, please be aware of the following requirements:

1. **All medications, whether prescription or over-the –counter, must be ordered in writing, by a physician or certified nurse practitioner.**
2. The parent/guardian must provide a written request for the administration of medication.
3. Written orders must be provided by the private physician or certified nurse practitioner detailing the type of illness, name of the prescribed medication, dosage, time of administration and duration of the order. **All orders must be renewed annually.** Orders may be faxed, but must be followed up by a hard copy.
4. Medication must be provided by the parent in the original container and labeled by the pharmacy or physician. Medication will be kept in the Health Office. **Children are NOT allowed to carry medications on their person in school. (See below regarding exceptions of epi-pen and inhalers)**
5. Records and documentation of administration will be maintained by the school nurse
6. The school nurse or the parent will be the only persons permitted to administer medication to pupils during school and on school trips. ***Teachers are not permitted to administer medications.***

Please be aware that the school nurse is not always available to administer medications during a school trip. *Parents of children receiving medication are advised to make an effort to accompany their child on field trips so they may administer medication to their child.*

In cases of life-threatening illnesses, a condition wherein if the medication is not received, the individual's life is threatened (i.e. documented sever allergic reaction, asthma), children may be allowed to carry and self-medicate if the following criteria are met:

1. Written authorization by the parent that the child may self-medicate
2. Written certification from a doctor/certified nurse practitioner that:
    A. The child has been diagnosed with a life threatening condition
    B. The child has received instruction and is capable of performing the appropriate self-medication.
    C. The child demonstrates to the school nurse his/her ability to self-medicate correctly and understands the conditions for such.
3. The Board of education will inform the parent that the District, its employees and/or agents shall not be liable for any injury resulting from self-medication and the parent will sign a statement acknowledging such.
4. The child will report tot the school nurse whenever he/she has self-medication so the nurse may be aware of such and take appropriate action as needed.
5. The criteria will be met annually

The NJ State laws and local school policies are designed to protect the health of children by insuring uniform practice and procedure. This helps to promote pupil health and safety which is always our primary concern. Please contact the School Health Office with any questions.

Judith Mekles, RN

Island Heights Grade School
Island Heights, New Jersey
School Health Office
Judith Mekles, RN
Phone: 732-929-1222 Ext. 4
Fax: 732-929-9563
Email: jmekles@islandheights.k12.nj.us

Health History

Child's Name:_____ **Date:**_____

Please complete the following health history.
Does your child have a history of:

	YES	NO	
Lyme Disease	_____	_____	**If yes: Date:**_____ **Treatment:**_____
Neuro/Muscular Disorders	_____	_____	**Type:**_____
Asthma:	_____	_____	**Triggers:**_____ **Treatment:**_____
Chicken Pox	_____	_____	**Disease Date:**_____ **Immunization Date:**_____
Convulsions/ Seizures:	_____	_____	**Age of onset:**_____ **Type:**_____ **Treatment:**_____
Diabetes	_____	_____	**Type:**_____ **Onset:**_____ **Treatment:**_____
Heart Disease	_____	_____	**Explain:**_____
Heart Murmur	_____	_____	**Explain:**_____
Middle Ear Infections:	_____	_____	
Strep Infections	_____	_____	
Rheumatic Fever:	_____	_____	
Mononucleosis:	_____	_____	**Date:**_____
Surgery:	_____	_____	**Explanation with Dates:**_____
Injury:	_____	_____	**Explanation:**_____
Congenital Defects:	_____	_____	**Explanation:**_____

_____
Signature of Parent/Guardian

ISLAND HEIGHTS GRADE SCHOOL
SCHOOL HEALTH OFFICE
JUDITH MEKLES, RN
SCHOOL NURSE
School Year:

September 2020

Dear Parent/Guardian:

In order to provide the best possible health services for your child, I need to know your child's health history and current status. Your response to this letter will allow me to update your child's school health file. Please indicate below ***any changes*** in your child's health status or general health history. If there have been ***no changes*** please check **"none of the above"** and return to school.

_____ Asthma Treatment:_____

_____ Allergies Type:_____
Treatment:_____

_____ Any Hospitalizations: Reasons and Dates:_____

_____ Injuries: Describe:_____

_____ Surgery Type and Date:_____

_____ Ear Infections

_____ Current Medications: Name and Dosage:
_____

_____ Other health conditions(s) or concerns
Describe:_____

_____ **NONE OF THE ABOVE**

Please circle yes or no:

Has your child been diagnosed with COVID-19?	YES	NO	If yes, Date:_____
If diagnosed, was your child symptomatic?	YES	NO	
If diagnosed, was your child hospitalized?	YES	NO	
Has any member of your household been diagnosed With COVID-19?	YES	NO	

My child ***(will)*** ***(will not)*** participate in the school health screenings program.
CIRCLE ONE

If your child ***will not*** be participating in any portion of the health screenings program, please state which screening you do not wish your child to receive. If you wish, you may cite your reasoning. A form will be sent home for completion by your private healthcare provider for any screenings you do not wish your child to receive.

Please check the appropriate response below **(GRADE 5 ONLY):**

I wish to be present during my child's scoliosis screening. _____

I **DO NOT** wish to be present during my child's scoliosis screening. _____

Please return these forms as soon as possible.

Child's Name:_____ **Grade:**_____

Parent/Guardian Signature:_____ **Date:**_____

Island Heights School District
115 SUMMIT AVENUE
P.O. BOX 329
ISLAND HEIGHTS, NEW JERSEY 08732
732-929-1222

To: The School Health Office
Island Heights Grade School
Island Heights, New Jersey
School Year:

I hereby give my permission for the school nurse to forward information concerning my child's health (i.e. allergies, asthma, other chronic conditions) to those school staff members who may need to know. I recognize that sharing this information is important to my child's safety and well being while attending school.

_____ _____
Child's Name Signature of Parent/Guardian

_____ _____
Grade Attending Date

Cc: Individual Health File
Jm/08

Island Heights Grade School
Island Heights, New Jersey
School Health Office
Judith Mekles, RN
Phone: 732-929-1222 ext. 4
Fax: 732-929-9563

Dear Parent/Guardian,

Your child requires a report of a physical examination performed within the last year. Please have your physician or certified nurse practitioner complete and sign the attached school physical form prior to your child's admission. If you have any questions, please contact the school nurse at the school health office.

Thank you

Sincerely,

J Mekles

Judith Mekles, RN
School Nurse

Island Heights Grade School
115 Summit Avenue Box 329
Island Heights, New Jersey 08732
(732) 929-1222 Ext. 4
Fax: (732) 929-9563

TO BE COMPLETED BY PHYSICIAN OR CERTIFIED NURSE PRACTITIONER

SCHOOL PHYSICAL

Child's Name:_____ Child's Birth Date:_____

Weight: _____ Height: _____

Vital Signs: T:_____ P: _____ R: _____ B/P: _____

Allergies: Insect Bites: _____ Food: _____

Medications: _____ Other: _____
(If allergies require restrictions, alterations in diet or treatment, a signed physician's order is required.)

Eyes/Vision: _____ Ears/Hearing: _____

Hair/Scalp: _____ Nose/Throat: _____

Teeth/Gums: _____ Skin: _____

Lungs: _____ Heart: _____

Abdomen: _____ Speech: _____

Musculo/Skeletal: _____ Nutrition: _____

Current prescribed Medications: _____

_____

Any Significant Diagnosis or Chronic Condition: _____

_____

Do you have any recommendations for the school to follow concerning the health status of this child?

_____

Please include a copy of current immunizations. If the child is exempt for medical or religious reasons, proper documentation must accompany this form.

_____ _____
Physician's Signature Date of Examination

Printed name and address of Physician: _____

_____

_____

jm 3/02