ENGLEWOOD ON THE PALISADES CHARTER SCHOOL

Mr. Anthony Barckett, Director **Dr. Shirl Burns, Principal**

Dear Parent/Guardian:

Welcome to the Englewood on the Palisades Charter!

Attached you will find the following forms. Please complete each form and return them to the Main Office.

- **Emergency Contact Form**
- **Emergency Procedure Form**
- **Student Enrollment Form**
- **Permission Form for Class Trips**
- **Record Release Form**
- **Family Input Sheet**
- **Policy on Medication**
- **Permission for use of photograph**
- **Universal Child Health Record (Pediatrician must complete)**

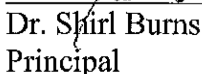
Copies of the following items must also be submitted:

- **Proof of Age (Copy of Birth Certificate or Passport)**
  - **If using Passport, provide City, State and Country of Birth**
- **2 Forms of Proof of Residency (utility bill, phone bill, driver's license, etc.)**
- **Report Card(s)**
- **Individual Evaluation Plan (IEP) by Child Study Team (If applicable)**
- **Proof of Immunization**
- **LETTER OF VERIFICATION from your Resident School District (proving your child is registered with them...your child cannot be enrolled until this is received)**

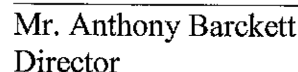
If you cannot submit copies of the required documents, please come to the office with original documents and we will make the copies.

If you have any questions or need help filling out these forms, please contact the Administrative Office at (201) 569-9765.

Sincerely,



Dr. Shirl Burns
Principal



Mr. Anthony Barckett
Director

Revised 2/2/2018

ENGLEWOOD ON THE PALIDSADES CHARTER SCHOOL
65 WEST DEMAREST AVENUE
ENGLEWOOD, NJ 07631

PHONE: (201) 569-9765 **FAX: (201) 568-9576**

Emergency Contact Form

Student's Name: ______________________ **Date of Birth: (MM/DD/YY)** ________
First **Last**

Address: ______________________________ **Apt #:** ____

City: ______________ **State:** ____ **Zip Code:** ________ ______________
Primary Phone

To Parent/Guardian: To serve your child in case of an accident or sudden illness, it is necessary for you to give the following information for EMERGENCY CALLS:

Parent/Legal Guardian: ______________________ **Relationship to Student:** ____________

Phone Numbers: Home: ____________ Cell: ______________ Work: ____________

Email: ______________________ ☐ I would like to receive School Reach notifications

Address (If different from Student): ______________________________

Parent/Legal Guardian: ______________________ **Relationship to Student:** ____________

Phone Numbers: Home: ____________ Cell: ______________ Work: ____________

Email: ______________________ ☐ I would like to receive School Reach notifications

Address (If different from Student): ______________________________

*** If you are the legal guardian, please submit legal documentation with this application.**

Please list two neighbors or relatives who will assume temporary care of your child(ren) if you cannot be reached:

Name: ______________________ **Relationship to Student:** ______________

Address: ______________________________

Phone Numbers: Home: ____________ Cell: ______________ Work: ____________

Name: ______________________ **Relationship to Student:** ______________

Address: ______________________________

Phone Numbers: Home: ____________ Cell: ______________ Work: ____________

Emergency Procedure Form

STUDENT(S) WILL NOT BE RELEASED FROM SCHOOL UNLESS ACCOMPANIED BY AN ADULT DESIGNATED BY THE PARENT OR PERMISSION HAS BEEN GIVEN FOR THE STUDENT(S) TO WALK HOME.

I give permission for the following people to pick up my child if I am unavailable or incapable. Please list contacts in the order in which they should be contacted.

1. Name: ______________________ Relationship to Student: __________
   Phone: ______________________ Phone: ______________________
2. Name: ______________________ Relationship to Student: __________
   Phone: ______________________ Phone: ______________________
3. Name: ______________________ Relationship to Student: __________
   Phone: ______________________ Phone: ______________________
4. Name: ______________________ Relationship to Student: __________
   Phone: ______________________ Phone: ______________________

Although the above recommendation of the parent/guardian will be respected if possible, I understand that in the final disposition of an emergency case the judgment of the school authorities will prevail. Anytime the above information must be changed, I will notify the office in writing.

Hospital______________________ Phone______________________

Doctor______________________ Phone______________________

Allergies____

Medications____

Other Health Alerts____

Does your child have any physical restrictions? YES NO

Does your child require medication during school hours? YES NO

If YES is circled, written order from your physician and/or school medical form must be on file with the school before medications is given.

IMMUNIZATION RECORD MUST BE ON FILE PER STATE LAW. DO WE HAVE AN UPDATED VERSION?

I authorize the physician and/or hospital listed to treat my child in the event of serious illness or accident, when I or the other persons listed on this form cannot be reached. Any obligation for medical expense resulting from treatment in such a case is my responsibility. Permission to transport my child in case of an emergency is also given.

Signature of Parent/Guardian: ______________________________ Date: ______________

Student Enrollment Form

Please complete the questions below. The information obtained from this survey will be used for the sole purpose of completing the New Jersey Department Education Student Database System.

Name of last School Attended: ______________________________

Address: ______________________________

____
City **State** **Zip Code**

Reason for leaving: ______________________________

Number of years attended: ______________________________

Ethnicity: (Please check one) ☐ Hispanic ☐ Non-Hispanic

Race: (Please check all that apply)

☐ Asian
☐ Pacific Islander
☐ White
☐ American Indian
☐ Black or African American
☐ Other: ______________

Place of Child's Birth: City: __________ **State:** __________ **Country:** __________

Does your child have health coverage? (Please circle one) A. YES B. NO
If you answered yes, please write the complete name of your health insurance coverage provider:

____

Has your child been referred to a Child Study Team? Yes ______ No ______
Does your child have an IEP (Individual Education Plan)? Yes ______ No ______
If yes, please submit the IEP with this application. Failure to submit documentation might jeopardize your child's acceptance into the school.

Has your child ever been referred for Speech Services? Yes ______ No ______
Does your child have an Individual Speech Plan? Yes ______ No ______
If yes, please submit the Individual Speech Plan with this application.

Has your child ever been referred for Occupational Therapy? Yes ______ No ______
Does your child presently have an Occupational Therapy? Yes ______ No ______
If yes, please submit the OT Plan with this application.

Has your child ever been referred for Physical Therapy? Yes ______ No ______
Does your child presently have a Physical Therapy Plan? Yes ______ No ______
If yes, please submit the PT Plan with this application.

Has your child ever been referred for 504 Accommodations? Yes ______ No ______
Does your child presently have a 504 Plan? Yes ______ No ______
If yes, please submit the 504 Plan with this application.

I certify that the statements and information I am providing in this application are true, accurate and complete.

______________________________ ______________
Signature of Parent/Guardian Date

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Permission Form for Class Trips

Date: ____________________

I hereby give permission for my child to leave the school building during the school day for class trips that will be taken throughout the year. I am aware that some of school trips may require the students to walk to their destination and sometimes bus transportation will be needed.

I accept responsibility for my child adhering to his/her teacher's instructions and directions during transit and at the point of destination.

Child's Name: ______________________________________ Grade: ______________

____
Parent/Guardian Signature

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Record Release Form

Please release the following records to the Englewood on the Palisades Charter School.

______________________________ ______________________
Student's Name **Date of Birth**

Please provide the following Information:

- ☐ Academic Records
- ☐ Health Records
- ☐ Standardized Test Records
- ☐ Confidential Records: (Child Study Team Records of psychological, neurological, psychiatric, learning disabilities evaluations, social history, speech and 504 Accommodations).
- ☐ Student Identification Number ______________________

Please print the name and address of your child's previous/current school.

____
Name of School

____
School Address

____
City State Zip Code

I understand the need for these records to be transferred, and hereby grant permission for you to release all records concerning my child to the Englewood on the Palisades Charter School.

Thank you for your prompt consideration of this request.

Parent or Guardian Signature: ______________________________ __________
Name Date

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Family Input Sheet

Child's Name: ______________________________ Entering Grade (2018-2019): ________

Please take this opportunity to describe your child's interests, strengths, and needs.

Are there any special learning needs that you feel we should know about that would help us plan for your child's academic success?

Please describe your hopes for your child this school year. Do you have any specific goals for expectations you want to share with us?

Is English your child's first language? YES ______ NO _______
If NO, what is the primary language spoken in your home? ________________________

How did you hear about the Englewood on the Palisades Charter School? (Please check ALL that apply.)
☐ Family ☐ News Paper
☐ Referral ☐ Website ☐ Other

Is student's parent or guardian is on Active Duty, in the National Guard, or in the Reserve components of the United States military services? (Please Circle One)
1 = Not Active Military Connected – Student is not military-connected.
2 = Active Military Connected - Student is a dependent of a member of the Active Duty Forces (full-time) Army, Navy, Air Force, Marine Corps, or Coast Guard and/or Student is a dependent of a member of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard).

Please include a copy of your child's most recent report card from the past year and their most recent IEP if your child has one.

Parent/Guardian Signature: ____

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Policy on Medication

If possible we request that parents administer all medication at home.

In case of special circumstances such as chronic diseases, medical operations or specific disabilities, it may be necessary for children to receive medication during the school day.

In accordance with State regulations and guidelines for **THE ADMINISTERING OF MEDICATION, a physician's prescription AND written consent of parent or guardian** must accompany all medication, both **PRESCRIPTIONS AND NON-PRESCRIPTIONS** (over the counter).

PRESCRIPTION and **NON-PRESCRIPTION** medications must be brought to school unopened and in the original container, and with the original label. Medications will be kept locked in the Nurse's Office.

A written statement from the child's physician must be obtained each school year for those students who are on continuous daily medication or who require "as needed" medication for allergies, allergic reaction, chronic headaches, etc.

IMPORTANT!!!

MEDICATION WILL NOT BE ADMINISTERED WITHOUT THE WRITTEN PERMISSION OF BOTH THE PARENT/GUARDIAN AND THE PHYSICIAN.

Please indicate by signing that you understand the Policy on Medication.

Parent/Guardian signature: ____

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Dear Parent or Guardian,

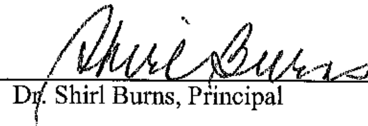
The use of photographs, and more recently digital images and video have become an integral part of many learning programs. They are used to record field trips, school assemblies and other special events occurring within the school. These images/names may be used to create a class display or be included as part of the school newsletter and/or website, to share with parents and relatives the many varied activities the children are involved in at school. Additional, these images may also be shared on social media or with the local newspapers.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site 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.

In an effort to respect parent and guardian wishes regarding the use of your child's image or work, we ask that you read the consent form below, indicate your preference, and sign and return this document.
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 school and such rescission will take effect upon receipt by the school.

Sincerely,

Anthony Barckett, Director



Dr. Shirl Burns, Principal

☐ I/We GRANT permission for this student's photo/image and name to be published on the school's public Internet site, electronic newsletter, social media and local newspapers, as well as, used in class displays.

☐ I/We DO NOT GRANT permission for photo/image that includes this student to be published on the school's public Internet site, electronic newsletter, social media and local newspapers, as well as, used in class displays.

Student's Name: (please print) ______________________ Student's Grade: _______

Print name of Parent/Guardian: (print) ______________________

Signature of Parent/Guardian: (sign) ______________________

Relation to Student: ______________________

Date: ______________

UNIVERSAL CHILD HEALTH RECORD

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

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

Condition		Comments
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	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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 and Senior Services, Immunization Program at 609-588-7512.
   - 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.state.nj.us/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.