EAST NEWARK PUBLIC SCHOOL

PRE-REGISTRATION

East Newark Public School

Richard R. Corbett, Ed.D.
501-11 North Third Street
East Newark, N.J. 07029
(973) 481-6800

RESIDENCY

The following are required for the registration in East Newark Public School:

Renters/ Tenants Form "A" and a certificate of Continued Occupancy is required for all person who rent. Form A must be signed and notarized by the landlord.
Home Owners: Home a deed or a tax bill from the Borough of East Newark or mortgage paper for that property is required.
All applicants must supply one (1) original of at least three (3) of the following:

- Current PSE&G bill
- Current Telephone bill
- Paycheck stub with current address
- Bank Statement with current address

Additional requirements for all applicants:

- Parent's Identification (Driver's license, alien registration card, passport, welfare card, or some forms of government identification).
- Student's birth certificate or some identification showing that the student is son/daughter of parent.
- Custody papers (If parents are divorced or person is not parent, but has legal custody of student.
- Health/ medical records of student.
- Transfer card/unofficial transcript from where the student was previously enrolled, if applicable.

East Newark Public School
East Newark, New Jersey
Owner/Landlord Affidavit

Please Print

LANDLORD INFORMATION	TENANT INFORMATION
Name of Landlord:	Family Name:
Street Address:	Street Address:
City State Zip Telephone Number: ( ) -	City State Zip Telephone Number: ( ) -

BUILDING INFORMATION

Please specify the type of building in which the apartment is located:

Single Family Home
Two Family Home
Three Family Home
Multi-Dwelling, No. of Apartments
Other ____________________

LEASING INFORMATION

Please specify the terms of the lease.

When did the tenant(s) move in? ______/_______/______ Relation to renter: No Relation

When does the agreement expire? ______/_______/______ Family Member(s)

Month to Month Year to Year

LIST THE NAMES OF ALL PERSONS LIVING IN THE APARTMENT/HOME (IF 1 FAMILY)

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SEND INFORMATION TO:
East Newark Board of Education
Attention: Residency Office
501-511 North Third Street
East Newark, New Jersey 07029

OFFICE USE ONLY:
Date Received: ____________________
Received by: ____________________

TENANT ATTESTATION:
I attest that the above information is true and correct, and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.

____
Signature of Tenant/Parent/Guardian

Sworn and subscribed before me this

__________day of ____________

____
Notary Public of New Jersey

____
Date

LANDLORD ATTESTATION:
I attest that the above information is true and correct, and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.

____
Signature of Landlord

Sworn and subscribed before me this

__________day of ____________

____
Notary Public of New Jersey

____
Date

EAST NEWARK BOARD OF EDUCATION
RESIDENCY REQUIREMENTS

You will be required to supply the following documents to prove residency:

1. An original deed, mortgage statement, lease or property tax bill
   If a lease is used for proof of residency, a Landlord Affidavit and cancelled check or receipt showing payment or rent for a current period and a lease termination date clearly indicated on the agreement are required.

2. FOUR of the following statements showing family name and Borough of East Newark address:

   - Recent Water Bill
   - Recent Unemployment Claim
   - Television Bill
   - Telephone Bill
   - Recent Electric/Gas Bill
   - Voter's Registration Card
   - Insurance claim/payment or benefit statement
   - Auto Insurance Card
   - Recent Court Order
   - Current Bank Statement
   - Document Pertaining to Military Status and Assignment
   - New Jersey Driver's License
   - New Jersey Non-Driver's License Card
   - Consulate ID with East Newark Address
   - Driver's Permit
   - New Jersey Vehicle Registration showing East Newark Address and family name. If the vehicle is leased and the address displayed is that of the bank, then the vehicle lease invoice showing the East Newark address may be used in addition to the registration.

SECOND READING/PUBLIC HEARING

ORDINANCE

BOROUGH OF EAST NEWARK
COUNTY OF HUDSON, STATE OF NEW JERSEY

AN ORDINANCE TO PREVENT THE UNLAWFUL ENROLLMENT OF SCHOOL CHILDREN IN THE BOROUGH OF EAST NEWARK PUBLIC SCHOOL SYSTEM AND TO PROVIDE PENALTIES THEREFORE.

BE IT ORDAINED, by the Mayor and Council of the Borough of East Newark in the County of Hudson and State of New Jersey that the Code of the Borough of East Newark is hereby amended, revised and supplemented to create a New Chapter to Be Entitled "Miscellaneous" as follows:

SECTION 1: Chapter 36, Miscellaneous

Section 36-1. Ineligible student enrollment prohibition; penalties.

(a) Purpose. A section to prohibit and penalize: (i) any parent or other person enrolling a student in the Borough of East Newark School District, or (ii) any parent or other person enrolling a student in the Harrison High School claiming that his or her child is a resident of East Newark, seeking free of charge education when such student is ineligible for free of charge education.

(b) Prohibited conduct. It shall be unlawful for any person who is 18 years old and older to:

(1) Knowingly register or enroll a student in the Borough of East Newark School District, or Harrison High School District, seeking free-of-charge education or maintain the enrollment of a student receiving free of charge education when the student is ineligible for free of charge education pursuant to N.J.S.A. Title 18A; or

(2) Knowingly assist, aid, or permit a student to register or enroll in the Borough of East Newark School District or Harrison High School District seeking free of charge education when the student is ineligible to attend free of charge pursuant to N.J.S.A. Title 18A; or

(3) Knowingly permit his or her name, address or other residence designating documentation to be utilized in the registration or enrollment of any student seeking free of charge education in the Borough of East Newark School District or Harrison High School District when the student is ineligible to attend free of charge pursuant to N.J.S.A. Title 18A; or

(4) Does not notify or inform the Borough of East Newark School District or Harrison High School District when a student is no longer a resident in the household of that person who had previously/knowingly permitted his or her name, address or other residence designating documentation to be utilized in the registration or enrollment of the student in the Borough of East Newark School District or Harrison High School District.

(c) Requirements. Upon the request of the Borough of East Newark School District or Harrison High School District, the parent or guardian of a student registered in the Borough of East Newark School District or the Harrison High School District shall be required to complete documentation intended to determine the student's eligibility to attend school in the Borough of East Newark School District or the Harrison High School District free of charge in accordance with N.J.S.A. Title 18A. All residents hosting other families, with a student enrolled in the Borough of East Newark School District or the

EAST NEWARK
PUBLIC SCHOOL

REGISTRATION

EAST NEWARK SCHOOL DISTRICT
EAST NEWARK NEW JERSEY
REGISTRATION FORM

Name: ____ Sex: Male/Female
Last First Middle

Home Address: ______________ ______ ______ _ ______, NJ 07029
Street Address Flr. Apt. City
Home Telephone: ______________ Birth Date: ______________

Place of Birth ______________ ______________ ______________
City State Country
For purpose of English as Second Language Reporting, please provide; (optional)

Date of entry into the United States: ______________________________

Child's Ethnic Background: White/ Hispanic/ African American/ Asian Native American/ Pacific Islander

School transferring from: ______________________________

First School Date in USA: ______________ ______________
School Address Relationship to Child

Person Registering the Child: ______________ ______________
Name Relationship to Child

Marital Status of Parents: Married/ Separated/ Divorced/ Widowed/Remarried/Single

With whom does the child live? ______________ ______________

Name Relationship
Number of Brothers and Sisters: Brothers: ________ Sisters:_______

Name: ______________ Age: ______ School Presently Attending: ______________

Name: ______________ Age:______ School Presently Attending: ______________

Name: ______________ Age: _____ School Presently Attending: ______________

Military Connected Student Indication: Please check the number that applies to you

1. _______ Not Military

_______Active Duty – Student is a dependent of a member of the Active duty Forces (Full Time) Branch: US Army. Us Navy, Us Air Force, US Marines Corp, or Coast Guard

2. ______ National Guard or Reserve- Student is a dependent of a member of the National Guard or Reserve Forces Branch: US Army, US Navy, US Air Force, US Marine Corp, or Coast Guard

3. ______ Unknown- It is whether or not the student is Military-connected

PEASE IDENTIFY ANY MEDICAL PROBLEMS OR HANDICAP OR WHICH THE SCHOOL SHOULD BE AWARE

QUICK REFERENCE EMERGENCY INFORMATION FORM

Student Name: ______________________________ Age: ____________

Mother's Name: ______________________________ Work #: __________

Father's Name: ______________________________ Work #: __________

Home Telephone #: ___________________________ Cell #:____________

If parent cannot be reached, please give the name and telephone number of another contact.

NAME	REALTIONSHIP	TELEPHONE#

PHYSICIAN'S INFORMATION

Please indicate if your child has any allergies or if there has been any recent changes in your child's medical history.

____

____

____

East Newark Public School

Richard R. Corbett, Ed.D.
501-11 North Third Street
East Newark, N.J. 07029
(973) 481-6800

RELEASE OF INFORMATION

I, the undersigned parent or legal guardian of:

____

herby authorize the

____

to release the pupil records of my child to the:
East Newark Public School at the following address:

EAST NEWARK PUBLIC SCHOLL
501-11 NORTH THTIRD STREET
EAST NEWARK, NJ 07029

The following records are to be released:

All mandated records and permitted records as specified by the Federal and State regulations up to including Special Education records.

____
Parent or Guardian

____
Date

THE EAST NEWARK SCHOOL DISTRICT – AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EMPLOYER

East Newark Registration

Home/ Native Language Survey

STUDENT'S NAME: ____

GRADE: ________

ENGLISH

1. What is your child's native language?

2. What language is most spoken at home? (write only one)

SPANISH

1. Cual es la lenguaje principal de su hijio en la casa?

2. Cual es el idioma que mas se utiliza en la casa?

PORTUGUESE

1. Qual a lingua native do seu filho?

2. Qual a lingua mais falada em casa? (Escreva somente uma?)

EAST NEWARK PUBLIC SCHOOLDISTRICT
EAST NEWARK, NEW JERSEY
PARENT/ GUARDIAN INFORMATION

Father's Name: ____________ ____________ ________ Living: YES/NO
Last First Middle

Home Address: ____________ ________ ______ ________ _____ _______
Street Address Floor Apt. # City State Zip Code

Name of Employer: ______________________________

Address: ______________ ________ ________ ________
Street Address City State Zip Code

Telephone Number: ____________ Occupation: ____________________

Mother's Name: ____________ ____________ ________ Living: YES/NO
Last First Middle

Home Address: ______________ ________ ________ ________
Street Address City State Zip Code

Name of Employer: ______________________________

Address: ______________ ________ ________ ________
Street Address City State Zip Code

Telephone Number: ____________ Occupation: ____________________

If child is living with Stepparent or Guardian, please fill out the information below:

Name of Stepparent/Guardian: ____________ ____________ ________
Last First Middle

Home Address: ______________ ________ ________ ________
Street Address City State Zip Code

Home Telephone: ____________ Cell/Emergency Telephone Number: ____________

Name of Employer: ______________

Address: ______________ ________ ________ ________

Telephone Number: ____________ Occupation ____________

EAST NEWARK PUBLIC SCHOOLDISTRICT
EAST NEWARK, NEW JERSEY
BAACKGROUND INFORMATION

GRADE: ___________ DATE REGISTERED: ____________
DATE ENTERED: ________________

____________ ____________ ________ Masculine: ______/ Female: ______
Last Name Middle

____________ ____________ ____________
Address City Telephone

____________ ____________ Citizen? YES_____ No_____
Place of Birth (City-State) Date of Birth

Language spoken at home: ____

If foreign when did you arrive to the USA? ______________________________

Upon entering the USA did you have any knowledge of English language? ______________

Marital Status:

Presently: Married: _____ Seperated: _____ Widow: _____ Remarried: _____

____________ ____________ Is father living? _____ Yes / _____NO
Father's Name Ethnic Background

____________ ____________ Is mother living? _____ YES/ _____NO
Mother Name Ethnic Background

____________ ____________ Is he/she living? _____YES/_____NO
Name of Stepparent/ Guardian Ethnic Background

____________ ____________ ____________
Father's Occupation Employer's Address Telephone #

____________ ____________ ____________
Mother's Occupation Employer's Address Telelpone #

Do you live with your mother and father? __________ Yes __________NO

If NO, whom do you live with? ____________________ ____________________
Name Relationship

Does the student have siblings: ______ YES ______NO If yes, How many?

____________ ____________
Older Minor

____
Former School Location

____
Former home address if transferring from another school.

______________________________ ______________________________
Signature of Parent/ Guardian Date

EAST NEWARK PUBLIC SCHOOL

HEALTH PACKET

East Newark Public School

Richard Corbett, Ed.D.
Superintendent/Principal

501-11 North Third Street
East Newark, NJ 07029
(973) 481-6800
Fax# (973) 485-1344

2018-2019 School Year

Dear Parents/Guardians:

To complete the Health Office portion of the preschool requirements, certain mandatory information must be met **BEFORE** entrance into school.

Compliance with the New Jersey Department of Health and Senior Services immunization requirements for pupils in schools must be completed.

A physician's documentation of:

- Recent physical examination by a physician
- Three (3) Hepatitis B vaccines and four (4) DPT vaccines
- Three (3) polio vaccines (OPV) or enhanced IPV
- One (1) dose of MMR, given on or after the first birthday
- One (1) dose of Pneumococcal Conjugate vaccine. (Prevnar or PCV)
- One (1) dose of Influenza Vaccine by December 31 (yearly). Please note that if this vaccine is not received by this date, your child may not return to school until the vaccine is received.
- One (1) dose of HIB
- Lead screening every year up until age six (6).
- PPD if your child has entered the U.S. from another country (this depends on the country your child has come from, please discuss with your doctor).

Thank you for your cooperation in this matter, and please call me if you have any questions.

Sincerely yours,

Mary Ann Ciesla, BSN, RN, CSN
School Nurse

East Newark Public School

"Where every day learning is an exciting adventure!"

"¡Donde todos los dias el aprendizaje es una Aventura excitante!"

Dr. Richard Corbett, Ed. D.
Superintendent / Principal

501-11 North Third Street
East Newark, NJ 07029
(973) 481-6800
Fax #: (973) 485-1344

Año Escolar 2018-2019

Estimados padres / guardianes:

Para completar la parte de la Oficina de Salud de los requisitos preescolares, se debe cumplir cierta información obligatoria **ANTES** de ingresar a la escuela.

Se debe completar el cumplimiento de los requisitos de vacunación del Departamento de Salud y Servicios para Personas Mayores de Nueva Jersey para los alumnos en las escuelas.

La documentación de un médico de:

- Examen físico reciente por un médico
- Tres (3) vacunas contra la hepatitis B y cuatro (4) vacunas DPT
- Tres (3) vacunas contra la polio (OPV) o IPV mejorada
- Una (1) dosis de MMR, administrada en o después del primer cumpleaños
- Una (1) dosis de vacuna conjugada neumocócica. (Prevnar o PCV)
- Una (1) dosis de la vacuna contra la influenza antes del 31 de diciembre (anual). Por favor, tenga en cuenta si esta vacuna no se recibe antes de esta fecha, es posible que su hijo no regrese a la escuela hasta que se reciba la vacuna.
- Una (1) dosis de HIB
- Prueba de plomo cada año hasta los seis (6) años.
- PPD si su hijo ingresó a los EE. UU. Desde otro país (esto depende del país de donde proviene su hijo, por favor hable con su médico).

Gracias por su cooperación en este asunto, y llámeme si tiene alguna pregunta.

Sinceramente,

Mary Ann Ciesla, BSN, RN, CSN

Enfermera Escolar

East Newark Public School
HEALTH HISTORY QUESTIONNAIRE

Student's Name ______________________________ Date of Birth ________________

Mother / Guardian ____________________________ Daytime Phone # ______________

Child's Doctor ________________

Prenatal

When you were pregnant, were you sick during your pregnancy? ______ Yes ______ No

When you were pregnant, did you have to use medicine? ______ Yes ______ No

How long was your pregnancy? __________________________

What type of delivery did you have? ______________________

Neonatal

How much did your baby weigh at birth? ___________________

Was your baby sick in the first few days of life? ______ Yes ______ No

If yes, please explain ____

Health Problems

Has your child ever had any of the following illnesses?

	Yes	No		Yes	No
Heart Disease	_________	_________	Seizure, Convulsion	_______	________
Fainting	_________	_________	Diabetes	_______	________
Kidney Disease	_________	_________	Ear Infection	_______	________
Sickle Cell	_________	_________	Lung Disease	_______	________
Lead Poisoning	_________	_________	Chickenpox	_______	________

Has your child ever had Asthma? ________ Yes ________ No if your child has had asthma please answer the following questions.

At what age did your child have their first asthma attack? ____________________

How often does your child have asthma attacks? ________________________

How many asthma attacks has your child had? _________________________

When did your child have their last asthma attack? ______________________

Has your child been hospitalized for asthma? _____ Yes _____ No How often _________

When was your child's last hospitalization for asthma? ____________________

Has your child used asthma medicine in the past two years? _________________

If your child has asthma medicine, the school nurse will require a written order from your doctor, for your child, so that we can care for your child if your child has an asthma attack while they attend school.

East Newark Public School
HEALTH HISTORY QUESTIONNAIRE

Has your child ever been hospitalized for any reason? ______Yes ______No

Reason for hospitalization ____________________How many days? _____Year _____

Reason for hospitalization ____________________How many days? _____Year _____

Has your child ever had any broken bones? ______ Yes ______ No

If yes, please explain ____

Does your child have any allergies? ______ Yes ______ No

Does your child have any other health problems? ______ Yes ______ No

If yes, please explain ____

At what age did your child first walk? ____, talk in sentence _____, was fully toilet trained _____

Does your child have siblings? ______ Yes ______No

If yes, please write their name and the year they were born:

Name	Year

______________________________ ______________________

Parent / Guardian Signature Date

______________________________ ______________________

Signature of School Nurse Reviewing Health History Date

East Newark Public School

501-11 North Third Street
East Newark, NJ 07029
Ph: (973) 481-6800
Fax #: (973) 485-1344

School Nurse
(973) 481-6804

____
Student's Name

Physical Examinations are recommended by the New Jersey Department of Education and the Department of Health & Senior Services.

Your child will receive a physical examination this school year by our School Physician, Dr. P. Palmiery. This exam will not require your child to get undressed. If you will to be present during the physical exam, please notify the school in writing.

Your authorization will remain in place as long as your child remain a student in the District. If you would like to make a change in your decision, please notify the school nurse at (973) 481-6804.

Please check one:

______________Yes, I wish to have my child examined by the School Physician.

______________ No, I do not wish for my child to have a physical exam by the School Physician.

______________ ______________________
Date Parent / Guardian Signature

Enfermera Escolar
(973) 481-6804

____
Nombre del Alumno

Exámenes físicos son recomendados por el Departamento de Educación de Nueva Jersey y el Departamento de Salud.

Su hijo / a recibirá un examen físico durante este año escolar por el médico de la escuela, Dr. P. Palmiery. Este examen no requerirá que su hijo / a se desvista. Si usted desea estar presente durante el examen físico, notifique a la escuela por escrito.

Su autorización permanecerá vigente mientras su hijo permanezca como alumno en el Distrito. Si desea realizar un cambio en su decisión, notifique a la enfermera de la escuela al (973) 481-6804.

Por favor marque uno:

______________ Sí, deseo que el médico de la escuela examine a mi hijo / a.

______________ No, deseo que mi hijo tenga un examen físico por el médico de la escuela.

______________ ______________________
Fecha Firma de padre / guardián

East Newark Public School
East Newark, NJ 07029
STUDENT HEALTH AND PHYSICAL EXAM FORM

Student's Name: ______________________ Birth Date: ______________________

Sex: Male Female

DISEASE HISTORY	TYPE / YEAR	DISEASE HISTORY	TYPE / YEAR
Allergies		Diabetes	
Drug Sensitivities		Heart Disease	
Lyme Disease		Ear Infection	
Hepatitis		Rheumatic Fever	
Neuromuscular Disease		Strep Infections	
ADHD		Mononucleosis	
Chicken Pox		Sickle Cell	
Convulsive Disorder		Lead Poisoning	
Asthma (on medications at this time ___yes ___no)		Other:	

OPERATION / INJURIES (PLEASE SPECIFY):

Birth History:

Was the child full term:__________ , if not at what month __________

How much did the child weigh at birth: __________

What type of delivery: ______________________

Was the mother on any medication during pregnancy: ____________ if yes what and why:

____

Was the child sick the first few days of life: ____________ yes ______________ no

If yes, please explain ____

Developmental History: (at what age did child?)

Walk: _________ Talk: _________ Toilet trained: _________

IMMUNIZATIONS : (___reviewed ___translated (if not in English) ___copy attached)

VACCINE TYPE	DISEASE DATE	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
DTP/Tdap						
OPV/IPV						
MMR						
Hepatitis A						
Hepatitis B						
Varicella						
Meningococcal						
Pneumococul Conjugate						
HIB						
Rotavirus						
HPV						
Flu						

Mantoux (PPD)	Date administered:	Date Read and Results:

ALLERGIES: ____

Has child ever had anaphylaxis: ___Yes ___No

Has child ever been prescribed medication for allergic reaction: ____Yes ____No

If yes what? ____

Student's Name: ______________________ Exam Date: ______________________

Height:	Weight:	Pulse:	B / P:
Vision:	Uncorrected:	Right:	Left:
Vision:	Corrected:	Right:	Left:
Hearing:	Right:	Left:	

	Normal Exam	Abnormal Findings:
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Lead Screening: ____Capillary____Venous Date Performed: ____________ Recorded Value: ____________

Limitations of Activity: No Yes (Please define): ______________________

____

Medications: ____

Health Care Provider's Comments and Recommendations:

____

____

Health Care Providers Signature: ______________________ Date: ____________

Health Care Provider Name, Address and Telephone #: (Stamp)

____

____

____

I give consent to my Health Care Provider to discuss information with the School Nurse, and the release of medical information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent's Signature: ______________________ Date: ____________

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 keep a 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

____

____

____

____

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____

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 ____________

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HE0503 9-2681/0410

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

EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser rellenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen ____________________

Nombre ____________________ Fecha de nacimiento ____________________

Sexo ________ Edad ________ Grado ________ Escuela ____________________ Deporte(s) ________

Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbales y nutricionales) que estás tomando actualmente

____

____

____

Tienes alergias ☐ Sí ☐ No Si la respuesta es sí, por favor identifica abajo la alergia específica.
☐ Medicamentos ☐ Polen ☐ Comida ☐ Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

PREGUNTAS GENERALES	Sí	No
1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?		
2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo: ☐ Asma ☐ Anemia ☐ Diabetes ☐ Infecciones Otro: ________		
3. ¿Has sido ingresado alguna vez en el hospital?		
4. ¿Has tenido cirugía alguna vez?		
PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN	**Sí**	**No**
5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?		
7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?		
8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente ☐ Presión alta ☐ Un soplo en el corazón ☐ Nivel alto de colesterol ☐ Una infección en el corazón ☐ Enfermedad de Kawasaki ☐ Otro:		
9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EKG, ecocardiograma)		
10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?		
11. ¿Has tenido alguna vez una convulsión inexplicable?		
12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?		

PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA	Sí	No
13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)?		
14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?		
15. ¿Alguien en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en sucorazón?		
16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?		
PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	**Sí**	**No**
17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?		
18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?		
19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tablilla, un yeso, o muletas?		
20. ¿Has sufrido alguna vez una fractura por estrés?		
21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)		
22. ¿Usas regularmente una tablilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?		
23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?		
24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?		
25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?		

(Por favor, continúe)

PREGUNTAS MÉDICAS	Sí	No
26. ¿Toses, tienes silbidos o dificultad para respirar durante o después de hacer ejercicio?		
27. ¿Has usado alguna vez un inhalador o has tomado medicamento para el asma?		
28. ¿Hay alguien en tu familia que tenga asma?		
29. ¿Naciste sin o te falta un riñón, un ojo, un testículo (varones), el bazo, o algún otro órgano?		
30. ¿Tienes dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?		
31. ¿Has tenido mononucleosis (mono) infecciosa en el último mes?		
32. ¿Tienes algún sarpullido, llagas, u otros problemas en la piel?		
33. ¿Has tenido herpes o infección de SARM en la piel?		
34. ¿Has sufrido alguna vez una lesión o contusión en la cabeza?		
35. ¿Has sufrido alguna vez un golpe en la cabeza que te haya producido una confusión, dolor de cabeza prolongado, o problemas de memoria?		
36. ¿Tienes un historial de un trastorno de convulsiones?		
37. ¿Tienes dolores de cabeza cuando haces ejercicio?		
38. ¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?		
39. ¿Has sido alguna vez incapaz de mover los brazos o las piernas después de haber sufrido un golpe o haberte caído?		
40. ¿Te has enfermado alguna vez al hacer ejercicio cuando hace calor?		
41. ¿Tienes calambres frecuentes en los músculos cuando haces ejercicio?		
42. ¿Tienes tú o alguien en tu familia el rasgo depranocítico o la enfermedad drepanocítica?		
43. ¿Has tenido algún problema con los ojos o la vista?		
44. ¿Has sufrido alguna lesión o daño en los ojos?		
45. ¿Usas lentes o lentes de contacto?		
46. ¿Usas protección para los ojos, tal como lentes protectoras o un escudo facial?		
47. ¿Te preocupa tu peso?		
48. ¿Estás intentando aumentar o perder de peso o alguien te ha recomendado que lo hagas?		
49. ¿Estás siguiendo alguna dieta especial o evitas ciertos tipos de comida?		
50. ¿Has tenido alguna vez un trastorno alimenticio?		
51. ¿Tienes alguna preocupación de la que quieras hablar con el doctor?		

SÓLO PARA MUJERES	Sí	No
52. ¿Has tenido alguna vez el período menstrual?		
53. ¿Qué edad tenías cuando tuviste tu primer período menstrual?		
54. ¿Cuántos períodos has tenido en los últimos 12 meses?		

Explica aquí las preguntas a las que respondiste con un "sí"

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Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta ______________________________

Firma del padre/madre/tutor legal ______________________________

Fecha ______________________________

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

State of New Jersey
DEPARTMENT OF EDUCATION

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School ____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student ____________________________________ **Age**_____ **Grade** ______

Date of Last Physical Examination______________________ **Sport**______________________

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes____ No____
   If yes, describe in detail ____
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____
   If yes, explain in detail ____
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____
   If yes, describe in detail ____
4. Fainted or "blacked out?" Yes____ No____
   If yes, was this during or immediately after exercise?______________________
5. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____
   If yes, explain ____
6. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
7. Been hospitalized or had to go to the emergency room? Yes____ No____
   If yes, explain in detail ____
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____ No____
9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s)______________________________________

Date:____________________ **Signature of parent/guardian** ______________________________

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284

Name: ____________________
Grade: ____________________

INSURANCE FORM
EAST NEWARK PUBLIC SCHOOL
EAST NEWARK, NEW JERSEY

Does child have Health Insurance? __________
Yes __________ If Yes, name of insurance company ____________________
No __________ NJ Family Care 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.
You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature: ____________________ Print Name: ____________________ Date: __________
Written consent required pursuant to 20 U.S.C. & 1232g (b) 1; and 34 C.F.R. 99.30 (b)

List any medical / surgical care your child has received during the past year:

____

Dental Exam ____________________ ____________________
Date Braces

Eye Exam ____________________ ____________________
Date Contacts Glasses

Allergy ____________________ ____________________
Kind Medications

Allergic Reaction ____________________ ____________________
Date Medications

Immunizations / Tetanus ____________________ ____________________
Date Type

Restrictions ____
Type

Doctor ____________________ Telephone ____________________

Dentist ____________________ Telephone ____________________

Hospital ____________________ Address ____________________ Telephone __________

I, the undersigned, to hereby authorize officials of New Jersey Public School to contract directly the persons named on this card an do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card or parents cannot be contact, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and / or transportation for said child.

____
Signature of Parent (s) / Guardian (s) Date

Nombre: ____________________
Grado: ____________________

FORMULARIO DE SEGURO
EAST NEWARK PUBLIC SCHOOL
EAST NEWARK, NEW JERSEY

¿Tiene el niño / a seguro de salud? ____________________
Sí _______ En caso afirmativo, nombre de la compañía de seguro ______________________________
No_______ NJ Family Care ofrece seguro de salud gratuito o de bajo costo para niños no asegurados y ciertos padres de bajos ingresos.
Para obtener más información, llame al (800) 701-0710 o visite www.njfamilycare.org, a aplica online.
Puede divulgar mi nombre y dirección al Programa NJ Family Care para contactar yo sobre el seguro de salud.

Firma: ____________________Nombre impreso: ____________________________Fecha: ___________
Se requiere consentimiento por escrito de conformidad con 20 U.S.C. & 1232g (b) 1; y 34 C.F.R. 99.30 (b)

Enliste cualquier cuidado médico / cirugía que su hijo haya recibido durante el año pasado:

____

Examen Dental ____________________ ____________________
Date Frenos

Examen de la Vista ____________________ ____________________
Date Contactos Lentes

Alergia ____________________ ____________________
Tipo Medicamentos

reacción alérgica ____________________ ____________________
Date Medicamentos

Inmunizaciones / Tétanos ____________________ ____________________
Date Tipo

Restricciones ____
Tipo

Doctor ______________________________ Teléfono ________________

Dentista ______________________________ Teléfono ________________

Hospital __________________ Dirección __________________ Teléfono ______________

Yo, el abajo firmante, autorizo a los funcionarios de la Escuela Pública de Nueva Jersey a contratar directamente a las personas nombradas en esta tarjeta y autorizo a los médicos nombrados a prestar el tratamiento que se considere necesario en caso de emergencia para la salud de dicho niño.

En el caso de que los médicos, otras personas nombradas en esta tarjeta o los padres no puedan ser contactados, se autoriza a los funcionarios de la escuela a tomar cualquier medida que se considere necesaria a su juicio, para la salud de dicho niño.
No responsabilizaré económicamente al distrito escolar por la atención de emergencia y / o el transporte de dicho niño.

____
Firma del (los) padre (s) / guardián (es) Fecha

East Newark Public School
Medical Information Release Form

Child's Name: ____________________________________

Date of Birth: ____________________________________

School: ____________________________________

I consent to the release of medical information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent's Signature: ____________________________________

Date: ____________________________________

East Newark Public School
Formulario de Divulgación de Información Médica

El nombre del niño / a: ____________________________________

Fecha de nacimiento: ____________________________________

Escuela: ____________________________________

Doy mi consentimiento para la divulgación de información médica a todos los miembros del personal y otros adultos que tienen cuidado de custodia de mi hijo y que pueden necesitar esta información para mantener la salud y seguridad de mi hijo.

Firma de los padres: ____________________________________

Fecha: ____________________________________