POPE JOHN PAUL II REGIONAL SCHOOL

11 SOUTH SUNSET ROAD • WILLINGBORO • NEW JERSEY 08046
609-877-2144 • www.pjpiirs.com

School Year 2019-2020

Dear Pope John Paul II Regional School Family,

It is time to re-register your child at Pope John Paul II Regional School. Although it seems early to be thinking about the next school year, budgets must be prepared and decisions must be made long before the first day of school.

In an effort to plan efficiently for the growth of our regional school for the 2019-2020 school year, please complete and return your re-registration application to the main office before March 1, 2019. After March 1, 2019, we will start accepting applications for new students who are interested in becoming part of the Pope John Paul II Regional School family.

I have enclosed our re-registration application for the 2019-2020 school year with the tuition rates and fees for your convenience. **Your completed application should include: (do not return an incomplete re-registration packet as it will be returned to you unprocessed).**

- □ Re-Registration Application (**one per student**)
- □ Re-Registratration Fee (**$100.00 per family**) ***This fee may be added to your FACTS account.***
- □ Private School Survey (**one per student**)
- □ Individual Pupil Request for Loan of Textbooks (**one per student**)
- □ B6T Application for Private School Transportation (**one per student**) If transportation is not needed write "not needed" across the transportation form, sign, date and return with the packet.
- □ Tuition Payment Preference Form (**one per family**)
- □ PTA Agreement Form (**one per family**)
- □ Emergency and Release Authorization Form (**one per student**)

Thank you for sharing your child with us and for helping us to continue to grow as a regional school community.

Sincerely,

Mrs. Catherine Zagola
Principal

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RE-REGISTRATION 2019-2020

Completed re-registrations must include a check payable to Pope John Paul II Regional School for the non-refundable re-registration fee of $100.00 per family, not per student (this fee may be added to your FACTS account). All students must be re-registered in order to be placed on a class list for the upcoming school year and to be considered for financial aid. A separate application must be completed for financial aid consideration.

Please print neatly and provide all the information requested.

Student Information

Grade for the 2019-2020 school year _____ Gender: □ Male □ Female
Transportation Mode: □ Car □ Bus □ Walk

Name of Student: _____
Last First Middle

Address: _____
Street Address City/Town Zip Code

Home Phone: _____ Date of Birth: _____ Place of Birth: _____

Country of Citizenship: _____

Religion: _____ (Catholic, Protestant, Jewish, Other) Ethnicity: _____ (White, Black, Hispanic, Asian American Indian/Alaskan, Hawaiian Native/other Pacific Islander)

Family Parish/Church: _____

Language Spoken at Home: _____

Parish/Church Address: _____

Household Information

Family E-mail Address: _____

Applicant Resides with: □ Both Parents □ Mother □ Father □ Other (please specify) _____

Father's Full Name: _____ E-mail Address: _____

Father's Home Address: _____ City/Town State, Zip: _____
(If different from student)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Father's Title/Position: _____ Father's Employer: _____

Company Address: _____

Mother's Full Name: _____ E-mail Address: _____

Mother's Home Address: _____ City/Town State, Zip: _____
(If different from student)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mother's Title/Position: _____ Mother's Employer: _____

Company Address: _____

Emergency Information

List emergency names, in the order to be called, in the event a parent cannot be reached!

Name (First and Last) ***Phone Number*** ***Relationship***

1st: _____

2nd: _____

Family Information

Siblings attending Pope John Paul II Regional School

Name: _____ Grade in 2019: _____ DOB: _____

Name: _____ Grade in 2019: _____ DOB: _____

Siblings not attending Pope John Paul II Regional School

Name: _____ School Attending: _____ Grade in 2019: _____ DOB: _____

Name: _____ School Attending: _____ Grade in 2019: _____ DOB: _____

Grandparent information: The following information will be used for invitations to special school activities and for development purposes. □ Please check if you prefer they NOT be contacted.

Names of paternal grandparents: _____

Address: _____

Names of maternal grandparents: _____

Address: _____

Tuition Payment Preference

I/We understand that each parent/guardian of the child/children enrolled at Pope John Paul II Regional School must sign the Tuition Payment Preference Form on an annual basis and I/we are jointly and severally liable for my/our child/children's entire yearly tuition and fees to include PTA dues and Fundraising obligation.

Tuition and fees must be paid in full or up to date with monthly payments for the previous academic school year before the child/children may be registered for the following academic school year. Any questions please contact the business manager at 609-877-2144 option #2.

I understand and acknowledge that Pope John Paul II Regional School may terminate enrollment at any time if it determines that continued enrollment would be inconsistent with the mission of Pope John Paul II Regional School.

Signature of Parent/ Guardian: _____ Date: _____

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The Improving America's Schools Act of 1994 re-authorized federal legislation to continue to provide a variety of programs, materials and services to children and teachers in private schools similar to those provided to public school students and teachers. These activities are enhanced by additional federal funds provided for areas having families whose income falls below specific levels or who benefit from other federal assistance programs. In order for our children to benefit from these additional funds, it is very important for us to have this information.

Please review the enclosed survey and indicate Yes or No. This information is essential to insure our continued participation in the federal programs, such as Title I, currently serving children. Please sign and return this form with the registration materials. All information will be kept confidential.

PRIVATE SCHOOL SURVEY
(TITLE I)

1. Use chart on the reverse side: US Department of Agriculture
   Is your family income less than the amount in column 1 (Federal Poverty Guidelines)?
   Yes _____ No _____

   Is your family income less than the amount in column 2 (Reduced Prices Meals)?
   Yes _____ No _____

   Is your family income less than the amount in column 3 (Free Meals)?
   Yes _____ No _____

2. Are you receiving assistance under the Aid to Families with Dependent children program?
   Yes _____ No _____

3. Are any of your children eligible to receive medical assistance under the Medicaid program?
   Yes _____ No _____

Signature _____ Date _____

Name (please print) _____

Address _____

_____

Name of your District Board of Education _____

Child's Name _____ Grade in September 2019: _____

Authority: Section 9(b)(1) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(1)(A)).

INCOME ELIGIBILITY GUIDELINES
[Effective from July 1, 2018 to June 30, 2019]

Household size	Federal poverty guidelines	Reduced Price Meals—185%					Free Meals—130%				
	Annual	Annual	Monthly	Twice per month	Every two weeks	Weekly	Annual	Monthly	Twice per month	Every two weeks	Weekly
48 Contiguous States, District of Columbia, Guam, and Territories											
1	12,140	22,459	1,872	936	864	432	15,782	1,316	658	607	304
2	16,460	30,451	2,538	1,269	1,172	586	21,398	1,784	892	823	412
3	20,780	38,443	3,204	1,602	1,479	740	27,014	2,252	1,126	1,039	520
4	25,100	46,435	3,870	1,935	1,786	893	32,630	2,720	1,360	1,255	628
5	29,420	54,427	4,536	2,268	2,094	1,047	38,246	3,188	1,594	1,471	736
6	33,740	62,419	5,202	2,601	2,401	1,201	43,862	3,656	1,828	1,687	844
7	38,060	70,411	5,868	2,934	2,709	1,355	49,478	4,124	2,062	1,903	952
8	42,380	78,403	6,534	3,267	3,016	1,508	55,094	4,592	2,296	2,119	1,060
For each add'l family member, add	4,320	7,992	666	333	308	154	5,616	468	234	216	108
Alaska											
1	15,180	28,083	2,341	1,171	1,081	541	19,734	1,645	823	759	380
2	20,580	38,073	3,173	1,587	1,465	733	26,754	2,230	1,115	1,029	515
3	25,980	48,063	4,006	2,003	1,849	925	33,774	2,815	1,408	1,299	650
4	31,380	58,053	4,838	2,419	2,233	1,117	40,794	3,400	1,700	1,569	785
5	36,780	68,043	5,671	2,836	2,618	1,309	47,814	3,985	1,993	1,839	920
6	42,180	78,033	6,503	3,252	3,002	1,501	54,834	4,570	2,285	2,109	1,055
7	47,580	88,023	7,336	3,668	3,386	1,693	61,854	5,155	2,578	2,379	1,190
8	52,980	98,013	8,168	4,084	3,770	1,885	68,874	5,740	2,870	2,649	1,325
For each add'l family member, add	5,400	9,990	833	417	385	193	7,020	585	293	270	135
Hawaii											
1	13,960	25,826	2,153	1,077	994	497	18,148	1,513	757	698	349
2	18,930	35,021	2,919	1,460	1,347	674	24,609	2,051	1,026	947	474
3	23,900	44,215	3,685	1,843	1,701	851	31,070	2,590	1,295	1,195	598
4	28,870	53,410	4,451	2,226	2,055	1,028	37,531	3,128	1,564	1,444	722
5	33,840	62,604	5,217	2,609	2,408	1,204	43,992	3,666	1,833	1,692	846
6	38,810	71,799	5,984	2,992	2,762	1,381	50,453	4,205	2,103	1,941	971
7	43,780	80,993	6,750	3,375	3,116	1,558	56,914	4,743	2,372	2,189	1,095
8	48,750	90,188	7,516	3,758	3,469	1,735	63,375	5,282	2,641	2,438	1,219
For each add'l family member, add	4,970	9,195	767	384	354	177	6,461	539	270	249	125

Dated: April 18, 2018.

Brandon Lipps,

Administrator, Food and Nutrition Service.

[FR Doc. 2018–09679 Filed 5–7–18; 8:45 am]

BILLING CODE 3410–30–P

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

[Docket No. NRCS–2018–0002]

Lick Creek Watershed, Russell, Dickenson and Wise Counties, Virginia

AGENCY: Natural Resources Conservation Service, USDA.

ACTION: Notice of intent to deauthorize federal funding.

SUMMARY: Pursuant to the Watershed Protection and Flood Prevention Act of 1954 and the Natural Resources Conservation Service (NRCS) Guidelines, NRCS gives notice of the intent to deauthorize Federal funding for the Lick Creek Watershed project, Russell, Dickenson and Wise Counties, Virginia.

DATES: Interested persons are invited to submit comments within 60 days of this notice being published in the **Federal Register.**

ADDRESSES: Comments submitted in response to this notice should be sent to John Bricker, VA State Conservationist, 1606 Santa Rosa Road, Suite 209, Richmond, Virginia 23229. Telephone: (804) 287–1691 or email: *Jack.Bricker@va.usda.gov.*

FOR FURTHER INFORMATION CONTACT: For specific questions about this notice, please contact Wade Biddix, (804) 287–1675 or *Wade.Biddix@va.usda.gov.*

SUPPLEMENTARY INFORMATION: A determination has been made by John Bricker, NRCS State Conservationist in Virginia that the proposed works of improvement for the Lick Creek Watershed project will not be installed. The sponsoring local organizations have concurred in this determination and agree that Federal funding should be deauthorized for the project. Information regarding this determination may be obtained from John Bricker, NRCS State Conservationist in Virginia at the above address and telephone number.

No administrative action on implementation of the proposed deauthorization will be taken until 60 days after the date of this publication in the **Federal Register.**

[Catalog of Federal Domestic Assistance Program No. 10.904, Watershed Protection and Flood Prevention. Executive Order 12372 regarding State and local clearinghouse review of Federal and federally assisted programs and project is applicable]

POPE JOHN PAUL II REGIONAL SCHOOL

11 SOUTH SUNSET ROAD • WILLINGBORO • NEW JERSEY 08046
609-877-2144

Dear Parents,

In order that Pope John Paul II Regional School receives the needed allocation from the State of New Jersey for textbooks, **it is necessary for you to fill out and sign a request form for <u>each</u> of your children attending Pope John Paul II Regional School.** Please complete the form below and return it with the other registration materials.

INDIVIDUAL PUPIL REQUEST FOR LOAN OF TEXTBOOKS

School Year 2019-2020

Board of Education
Willingboro Township
44 Beverly Rancocas Road
Willingboro, NJ 08046-3529

To Whom It May Concern:

Under the provisions of Chapter 79, Laws of 1974, I request that my local Board of Education loan the necessary textbooks for the use of my child who attends Pope John Paul II Regional School located in Willingboro, NJ.

Child's Name: _____

Child's Address: _____

_____

Child's Grade in September 2019: _____

Signature of
Parent/Guardian: _____

NEW JERSEY STATE DEPARTMENT OF EDUCATION
OFFICE OF STUDENT TRANSPORTATION

(B6T) APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION

Please submit a separate application for each child to the private school

SCHOOL YEAR _____ RESIDENT DISTRICT BOARD OF EDUCATION _____

STUDENT's NAME _____ (LAST / FIRST / MIDDLE) DATE OF BIRTH _____ (MONTH / DAY / YEAR)

PARENT OR GUARDIAN _____ DAYTIME PHONE _____ (AREA CODE + NUMBER)

HOME ADDRESS _____ CITY or TWP _____ ZIP _____

NEAREST INTERSECTION TO STUDENT'S RESIDENCE _____

MAILING ADDRESS _____ ZIP _____

FULL NAME OF SCHOOL TO BE ATTENDED **Pope John Paul II Regional School** PHONE **609-877-2144**

ADDRESS OF SCHOOL **11 South Sunset Road Willingboro, NJ 08046**

STUDENT'S GRADE FOR THE COMING YEAR _____ SHORTEST ONE-WAY MILEAGE BETWEEN HOME AND SCHOOL _____ (MILES TENTHS) (MEASURED VIA THE SHORTEST ROUTE ALONG PUBLIC ROADWAYS OR WALKWAYS IN MILES AND TENTHS)

DATE SCHOOL OPENS _____ CLOSES _____ SCHOOL HOURS FROM _____ AM TO _____ PM

NAME AND ADDRESS OF LAST SCHOOL OF ATTENDANCE _____

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE * FOR PUBLIC SCHOOL USE ONLY

YOUR APPLICATION HAS BEEN REVIEWED BY THE RESIDENT DISTRICT BOARD OF EDUCATION. THE FOLLOWING DETERMINATION HAS BEEN MADE:

_____ TRANSPORTATION WILL BE PROVIDED _____ YOU ARE ELIGIBLE FOR PAYMENT IN LIEU OF TRANSPORTATION

_____ INELIGIBLE _____ (REASON)

DATE _____ SIGNATURE _____ TITLE _____

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION (B6T) N.J.A.C. 6A:27-2.5

1. IT IS THE OBLIGATION OF THE PARENT OR GUARDIAN OF PRIVATE SCHOOL STUDENTS TO:

- ANNUALLY OBTAIN THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION FROM THE ADMINISTRATIVE OFFICE OF THE PRIVATE SCHOOL FOR EACH STUDENT FOR WHICH TRANSPORTATION SERVICES ARE BEING REQUESTED. SUBMIT A SEPARATE APPLICATION FOR EACH STUDENT.

NOTE:

- IF THERE IS A CHANGE OF HOME ADDRESS, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.
- IF THERE IS A CHANGE IN THE NONPUBLIC SCHOOL OF ATTENDANCE, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.

- COMPLETE THIS APPLICATION AND RETURN IT TO THE PRIVATE SCHOOL ON OR BEFORE MARCH 10TH PRECEDING THE SCHOOL YEAR IN WHICH TRANSPORTATION IS BEING REQUESTED.

LATE APPLICATIONS – ANY APPLICATION RECEIVED AFTER MARCH 10TH WILL BE A LATE APPLICATION AND MUST BE ACCOMPANIED BY A STATEMENT OF THE REASON FOR LATENESS. ELIGIBLE STUDENTS WILL RECEIVE TRANSPORTATION OR AID IN LIEU OF TRANSPORTATION BASED ON THE DATE THE APPLICATION IS RECEIVED BY THE PUBLIC SCHOOL.

2. IT IS THE OBLIGATION OF THE NONPUBLIC SCHOOL ADMINISTRATOR TO ANNUALLY COLLECT THE APPLICATION AND SUBMIT IT TO THE PUBLIC SCHOOL FROM WHICH TRANSPORTATION IS BEING REQUESTED PRIOR TO MARCH 15TH.

3. IT IS THE OBLIGATION OF THE PUBLIC SCHOOL ADMINISTRATOR TO NOTIFY THE PARENT OR GUARDIAN AS TO THE DETERMINATION OF EACH APPLICATION BY AUGUST 1ST.

TUITION PAYMENT PREFERENCE FORM

School Name:_____

Responsible Party:_____

Address:_____ City:_____ State:_____

Student(s) Name: _____ Year of Graduation: _____

_____ _____

For the 19/20 school year, I will pay my student's tuition by the payment option checked below. If not previously enrolled with FACTS, please visit https://online.factsmgt.com/signin/3FLTV to complete the enrollment process prior to registration.

- ☐ **OPTION 1** **Full Tuition Payment** due 8/29/19. This option entitles the responsible party to a 2% discount. This payment must be paid directly to the school by the due date.
- ☐ **OPTION 2** **10 Monthly Payments through FACTS.** This option entitles the responsible party to budget payments over 10 months through FACTS Management Company beginning July. Payments can be made on either the 5th or 20th.
- ☐ **OPTION 3** **5 Bi-Monthly Payments through FACTS beginning in August**

☐ **Please add Registration Fee to FACTS Account**

COMPLETE ONLY IF RE-ENROLLING IN FACTS

Peace of Mind Tuition Protection Plan
FACTS offers an optional Peace of Mind Tuition Protection Plan. For a nonrefundable annual fee of $20 per FACTS Agreement, FACTS will pay the remaining unpaid balance on your FACTS Agreement (except payments in arrears) to your school in the event of the death of the responsible party or his/her legal spouse. Coverage begins when the fee for Peace of Mind has been paid to FACTS.

Please indicate below whether or not you wish to enroll in the Peace of Mind Plan. Your Peace of Mind election for the previous school year will remain the same for the current school year, unless you check a box below.

☐ Yes, please enroll me in the POM plan. I agree to pay a nonrefundable annual fee of $20 per FACTS Agreement.

If you are enrolling in POM, you must complete the following information as it applies to the person responsible for payment.
Marital Status: ☐ Married ☐ Single Date of Birth: _____

☐ No, please do not enroll me in POM.

If you are re-enrolling in FACTS, you do not have to complete a new FACTS Agreement. The missed payment fee charged by FACTS will be $30.00. If your bank information has changed from last year's FACTS Agreement: 1) for a checking account attach a voided check (no deposit slips) or 2) for a savings account provide the bank name _____, routing number_____, and savings account number _____. Any other changes must be given to the school as soon as possible. Adjustments due to financial assistance, scholarships, or other awards will be made directly by the school. You will be notified of these changes.

I agree to make tuition payments for the 2019-2020 school year according to one of the options above. I have read the school policy regarding tuition and agree to abide by this policy.

_____ _____
Responsible Party's Signature Date

This form must be returned to school with the registration paperwork.

This form is for use in collecting information to complete agreements/re-enrollments.
DO NOT ATTACH THIS SHEET TO AGREEMENTS/RE-ENROLLMENTS.

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Dear Pope John Paul II Regional School Families,

It is registration time again and the time to start thinking about the 2019-2020 academic school year. The PTA would like to say "Welcome" to all the new and returning families. We are looking forward to another great year here at Pope John Paul II Regional School.

The PTA works closely with the pastor, principal, teachers, and parents to help provide the best regional school for our students. The PTA is responsible for planning the student events, activities, assemblies, and fundraisers. These plans are only successful with the participation from all the parents and staff of our school.

Our school requires the PTA to meet a budget assessment of $90,000.00 to our school. This is not a negotiable assessment as this money is used toward the operating expenses of our school. To ensure we meet our monetary obligation to our school each family is required to pay a $50.00 PTA dues that can be paid at the time of registration or the dues can be paid by October 1, 2019. Also, in addition to the PTA Dues each family is required to pay the $350.00 PTA Fundraising Dues, this too can be paid at the time of registration or the fundraising dues can be raised by participating in the many fundraising events set up throughout the year by the PTA. If you are unsure of how your family can raise the fundraising dues through our fundraisers please contact the school and a PTA representative will contact you as soon as possible. The $350.00 fundraising dues are due by April 1, 2020.

For those families that are new to our school and to refresh the memories of our returning families, an event calendar for the 2019-2020 school year will be established over the 2019 summer by the PTA Executive Board and a PTA packet will be given to each family at "Back to School Night" in September 2019. This packet will contain the event calendar and an explanation of each event. Please use this calendar to help schedule your family's participation in the school's events. A volunteer form for parents to volunteer and help with the school's events will also be in the packet. Remember the success of our school depends on the full participation of our families.

The PTA is looking forward to the opportunity to work with the many great PJPII Families. Thank you.

Sincerely,

Your PTA Executive Board

PTA Agreement Form

	Tuition Prices	PTA Dues	PTA Fundraising Dues	Total
PreK (5 Full Days)	$5,485.00	$50.00	$350.00	$5,885.00
Catholic (K-8):				
1 Child	$4,210.00	$50.00	$350.00	$4,610.00
2 Children	$7,150.00	$50.00	$350.00	$7,550.00
3 Children	$9,675.00	$50.00	$350.00	$10,075.00
4 or More	$10,050.00	$50.00	$350.00	$10,450.00
Non-Catholic (K-8):				
1 Child	$5,565.00	$50.00	$350.00	$5,965.00
2 Children	$9,150.00	$50.00	$350.00	$9,550.00
3 Children	$12,425.00	$50.00	$350.00	$12,825.00
4 or More	$12,900.00	$50.00	$350.00	$13,300.00

Please check one:

_____ I will pay the $50.00 PTA dues at the time of registration.

_____ I will pay the $50.00 PTA dues by October 1, 2019.

_____Please add the $50.00 PTA dues to my 2019-2020 FACTS Tuition Payment. I understand my monthy payments will increase to include the $50.00 PTA dues.

Please check one:

_____ I will pay the $350.00 PTA fundraising dues at the time of registration.

_____ I will fundraise the $350.00 PTA fundraising dues during the 2019-2020 school year. If I do not meet this obligation through fundraising, I will pay the balance required by April 1, 2020.

_____Please add the $350.00 PTA fundraising dues to my 2019-2020 FACTS Tuition Payment. I understand my monthly payments will increase to include the $350.00 PTA fundraising dues.

Signature_____

Print Name_____

Child/ren Name_____ Grade(s)_____

Phone Number_____

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Emergency and Release Authorization Form

The information set forth on this form **must be completed** for two purposes: (1) To insure that your child will receive emergency medical care in the event that you are unavailable; and (2) To identify the persons to whom your child may be released in both emergency and non-emergency situations. Please print neatly and provide all the information requested.

Name of Student: _____
Last First Middle

Address: _____
Street Address City/Town Zip Code

Date of Birth: _____ Place of Birth: _____ Gender: □ Male □ Female

Parent/Legal Guardian Name: _____

Address: _____
Street Address City/Town Zip Code

Relationship to Student: _____ Home Phone Number: _____

Parent Name-Cell Number: _____ Parent Name-Cell Number: _____

Siblings attending Pope John Paul II Regional School:

Name: _____ Grade in 2019: _____

Name: _____ Grade in 2019: _____

List emergency names, in the order to be called, in the event a parent cannot be reached!

Emergency Contact 1 Name: _____

Emergency Contact 1 Address: _____

Relationship to Student: _____ Emergency Contact 1 Home Phone Number: _____

Emergency Contact 1 Cell Phone Number: _____

Emergency Contact 2 Name: _____

Emergency Contact 2 Address: _____

Relationship to Student: _____ Emergency Contact 2 Home Phone Number: _____

Emergency Contact 2 Cell Phone Number: _____

List any medical conditions that should be known to the school: _____

List any allergies the student has and the reaction to that allergen. _____

List any medication and dosage the student is presently taking: _____

Name of Family Physician: _____ Phone Number: _____

Name of Family Dentist: _____ Phone Number: _____

Does your child have health insurance?

□ Yes If Yes, name of insurance company _____ Policy Number: _____

□ No NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

According to the State of New Jersey (N.J.A.C.6A:16-2.2), a physical examination is required for all students upon enrollment in school. Pupils transferring into any school in the State of New Jersey from a school outside the State of New Jersey are also required by law to have a physical examination. This physical examination must include documentation of immunizations received as required by the state. Failure to comply with these requirements will result in the student's exclusion from school until the required entry physical examination has been completed and turned into the school nurse. Physical examination forms may be obtained from the nurse's office.

Medical and Personal Information Release

"I understand that relevant information regarding my child's health, medications, or special needs may be shared with appropriate school personnel and other healthcare providers as necessary." In the event of serious illness or injury, the school will make every effort to contact the parent or other individual listed on this form. Should these persons be unavailable; the school principal is authorized to have my child transported to a medical facility for treatment.

Signature of Parent/Guardian: _____ Date: _____

Permission for Health Screenings

Please check one - YES to indicates you give permission for health screening s to be done by the school nurse or NO indicates that you will have your child screened at your primary doctor.

□ **Yes,** I give permission for my son/daughter to participate in all of the following health screenings, as required by New Jersey law.
Vision Screening (for Kindergarten and Grades 2,4,6,8)
Hearing Screening (for Kindergarten and Grades 1,2,3, and 7)
Height and Weight Screening (for Kindergarten and Grades 1,2,3,4,5,6,7,8)
Blood Pressure Screening (for Kindergarten and Grades 1,2,3,4,5,6,7,8)
Scoliosis Screening (for students age 10 and older every other year)

□ **No,** I do not want my child to participate in the screening. **Instead, I will have my child's physician provide the results of these screenings.** I understand that these will be added to my child's school health record.

Signature of Parent/Guardian: _____ Date: _____

Medication Policy

There are times when students must take medication during school hours. These medications are of two varieties: prescription and over-the-counter (non-prescription).

The rules listed below are proposed in order to:
1. Protect the physical welfare of students on medication; i.e. knowing what medication a child is taking could facilitate the course of action a nurse would follow when side effects become apparent.
2. Protect students from unwittingly consuming medication prescribed for another.
3. Ensure that the school has fulfilled its obligation to students on medication.
4. Prevent the unauthorized use of prescription medication during school hours on school property.
5. Inform the school of any child suffering from an illness which requires medication and which may influence both his/her academic performance and behavior in school.

Rules For Medication Taken During School Hours

1. All prescription medication to be taken by students during school hours shall be;
   A. Kept in the nurse's office.
   B. Supplied by the student's parents/guardian along with a physician's written authorization that the medication is to be given during school hours.
   C. Clearly labeled with the child's name, name of the medication, drug store where purchased, name of prescribing Physician, and the time and amount of medication to be given.
2. Parents are urged, when possible, to have their child take any necessary medication before and after school hours.
3. Parents are requested to keep children at home during acute stages of illness, especially when medication is necessary at frequent intervals.
4. Tylenol, aspirin, cough drops, and other non-prescription remedies can only be dispensed by the nurse if the medication is sent to school in the original, labeled container accompanied by a properly signed and dated note from the parents. **A written order from your physician is also required. Please note: No medication, prescription or non-prescription, will be dispensed this year without a note from your physician.** If you think your child will need any of the above non-prescription medicines during the year, please send in a note from your doctor as soon as possible along with the medication which will be kept in the nurse's office. (Permission forms to dispense medication may be requested from nurse's office 1-609-877-2144 option #4 to be filled out by your physician.)
5. All requests for children to take medications must be renewed each school year.

NOTE: If you have any question regarding the above procedures, please contact the school nurse at 609-877-2144 option #4.

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

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

PREVENTIVE HEALTH SCREENINGS

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

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

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

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

Section 1 - Parent

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

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

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health 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.

POPE JOHN PAUL II REGIONAL SCHOOL

11 SOUTH SUNSET ROAD • WILLINGBORO • NEW JERSEY 08046

609-877-2144 • www.pjpiirs.com

MEDICATION AUTHORIZATION

Student's Name: _____

Reason for medication: _____

Medication: _____ Dose: _____ Time: _____

Other times of the day this medication is given: _____

Dose: _____

If the morning dose is missed at home, may it be given in school at the parent's request?

□ Yes □ No

Expiration Date: _____ Side Effects: _____

This student is under my medical care, and requires medication during school hours.

_____ _____

Doctor's Signature Date

Office Stamp:

As the parent/legal guardian of the student listed above, I authorize the school to administer this medication during school hours as prescribed. I understand that all medication must be brought to school with the written prescription on the container. Over the counter drugs must be sent in their original container. No medication will be given without the written permission of the physician and the parent or legal guardian. Permission must be renewed each school year.

I acknowledge that the school shall incur no liability as a result of any condition arising from the medication. I shall indemnify and hold harmless the school, its employees or agents against any claims arising from the administration of medication to this student.

_____ _____

Parent/Guardian's Signature Date

INDIVIDUAL MEDICATION RECORD 2019-2020

Name: _____ Allergies: _____

Medication: _____ Dosage: _____

Time of Administration: _____ Daily: _____ PRN: _____

Special Instructions: _____

MEDICATION OMISSIONS: DC = Discontinued
AB = Absent
FT = Field Trip, ½ day
O = Med not available
X = School not in session

INITIALS	NAME

SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
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28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30		30	30	30	30
	31		31	31		31		31	