# Demarest Public Schools Emergency Information Card

**Please Print All Information**

Grade_____

Student's Name_____ Birth Date _____
Last First Month/Day/Year

Address_____ Home Phone # _____

**Parent/Guardian: To serve your child in case of accident/ sudden illness, it is necessary that you give the following information for emergency calls:**

Parent 1 Contact Name_____ Relationship to Student_____

Work # _____ Cell # _____ Email Address_____

Parent 2 Contact Name_____ Relationship to Student_____

Work # _____ Cell # _____ Email Address_____

Address of Non-custodial Parent if pertinent. Address_____

**List 2 neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.**

Name_____ Relationship_____

Home # _____ Work #_____ Cell #_____

Name_____ Relationship _____

Home #_____ Work #_____ Cell # _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physicians named below and follow their instructions. In the event that it is impossible to contact the physician, school officials are hereby authorized to take whatever action is deemed necessary for the health of the aforesaid child. I will not hold the school district responsible for the emergency care and/or transportation for said child.

Local Physician's Name_____ Office #_____

Local Dentist's Name _____ Office #_____

(2020)

# DEMAREST PUBLIC SCHOOL DISTRICT

| ☐ County Road School | ☐ Luther Lee Emerson School | ☐ Demarest Middle School |
|---|---|---|
| 1 30 County Road | 15 Columbus Road | 568 Piermont Road |
| Demarest, NJ 07627 | Demarest, NJ 07627 | Demarest, NJ 07627 |
| (201)768-6060 x51600 | (201)768-6060x52600 | (201)768-6060x53600 |

## RECORDS REQUEST FORM

To: _____
**(School Name)**

_____

_____

Re: _____
**Student's Name**

Grade: _____

The above named student has enrolled in the Demarest Public School District as of _____. Please forward the student's entire school record at your earliest convenience. Thank you.

- State identification number
- State test scores
- Results of Dyslexia Screening
- Health record
- ESL record
- Attendance record
- Psychological reports including any IEP or 504 Plan
- Report cards (including interpretation of your grading system)
- Discipline record(s)
- Any other pertinent information that would help us appropriately place this student

**Parent's Authorization to Send Records**

I hereby authorize you to send all school records for my child named above to the Demarest Public School District.

_____ _____
**Signature of Parent or Guardian** **Date**

_____
**Relationship**

**DEMAREST PUBLIC SCHOOL DISTRICT**

| County Road School | Luther Lee Emerson School | Demarest Middle School |
|---|---|---|
| 130 County Road | 15 Columbus Road | 568 Piermont Road |
| Demarest, NJ 07627 | Demarest, NJ 0762 | Demarest, NJ 07627 |
| (201)768-6060 x51600 | (201)768-6060x52600 | (201)768-6060x53600 |


# Home Language Survey Form

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

**Student Information**

Student name:_____ Student birth date:

Street Address:_____

City:_____ State:_____ Zip Code:

Phone number:

**Survey Questions**

**Question 1**

What was the first language used by the student?

A language other than English – Proceed to question **2a.**

English – Proceed to question **2b**

**Question 2a**

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to 7.

No. Proceed to question 4.

**Question 2b**

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question 4.

No. Proceed to question 3.

**Question 3**

Does the student understand a language other than English?

Yes. Proceed to question 4.

No.

**Question 4**

When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

Yes. Proceed to 7.

No. Proceed to question 5.

**Question 5**

When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

Yes

No

**Question 6**

Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?

Yes

No

**7. List home languages spoken:**_____

_____

# DEMAREST PUBLIC SCHOOL DISTRICT


County Road School
130 County Road
Demarest, NJ 07627
(201)768-6060 x51600

Luther Lee Emerson School
15 Columbus Road
Demarest, NJ 07627
(201)768-6060x52600

Demarest Middle School
568 Piermont Road
Demarest, NJ 07627
(201)768-6060x53600


## INFORMATION FORM FOR NEW STUDENTS

The following information is provided to assist teachers in integrating the student into our school as quickly as possible.

NAME _____
First Middle Last

DATE OF BIRTH _____

LANGUAGE SPOKEN AT HOME _____

ENROLLING IN GRADE _____

LAST SCHOOL ATTENDED_____
(Including Pre-School if applicable)

ADDRESS OF
SCHOOL_____

---

WEARS GLASSES: YES _____ NO _____

USES HEARING AID: YES _____ NO _____

ALLERGIES: YES _____ NO _____

IF YES, DESCRIPTION:

_____

_____

## Demarest Public School District
## Demarest, New Jersey 07627

Dear Parent/Guardian,

Welcome to the Demarest Public School system. Registering your son/daughter for **Kindergarten -8th Grade** requires that the following information be included and submitted to the Health Services Department.

1. Record of **physical examination within one year** of entry date to school. (NOTE: Please use the **appropriate form—Kindergarten-Grade 4** physical or **Grade 5-8** physical.
2. **Immunization record** consisting of **primary** series and **booster** doses as listed below. **(N.J.S.S.C.** Chapter 14 requires immunizations must be complete and up-to-date or student may be excluded from school.)
    - **DTP – must have minimum of 4 doses – one dose must be on or after the 4th birthday.** A child who has received a total of **5 doses** will be in compliance with this regulation. (NOTE: If a child is **age 7-9**, 3 doses of Td or combination of DTP, DTaP or DT **totaling 3 doses** is acceptable.)
    - **Tdap – this is for pupils entering grade 6 and born on or after 1/1/1997.** Not required if DTP or Td within five years of entering grade 6.
    - **Polio – must have minimum of 3 doses – one dose must be on or after the 4th birthday.** A child with **4 doses** of polio vaccine will meet this requirement. (NOTE: For children age **7 or older, any 3 doses** of OPV or IPV will be in compliance with this regulation.)
    - **Measles-Mumps-Rubella—must have 2 doses of measles vaccine and 1 dose of mumps and rubella vaccine given on or after the first birthday.** (NOTE: Documented laboratory evidence of measles, mumps and/or rubella immunity will be in compliance with this regulation.)
    - **Hepatitis B Vaccine—must have completed a 2-dose hepatitis B regimen or a 3- dose hepatitis B regimen.** All children entering Kindergarten thru eighth grade must have 3 doses. If a child is over age 11 and has not received any doses, he/she may receive the 2 dose formula.
    - **Varicella Vaccine—must have one dose for all children born after January 1, 1998, given on or after first birthday.** (NOTE: Laboratory evidence of immunity, physician or parental statement of previous varicella disease is acceptable.)
    - **Meningitis Vaccine—must have one dose on entering grade 6 for all children born on or after January 1, 1997.** Applies to children turning 11 and in 6th grade.
3. **Mantoux Tuberculin Test**—Required on students entering the school system from **out of country as directed by New Jersey Department of Health annually.** Valid only if administered **within the previous six months.**

Students transferring within the state must bring their records with them to enter. Students entering from out of state or from another country have a 30-day period in which to obtain records. If records are not received within the stated time, the student will be excluded from school.

YOUR COOPERATION IS ESSENTIAL!

Very truly yours,
Health Services

---

Cut and return

I have read and understand the rules of registration concerning immunization requirements.

Student's Name _____ Grade _____

Parent/Guardian
Signature _____ Date_____

1/17

**ATTENTION PARENT/GUARDIAN:** The preparticiaption 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**

_____

_____

_____

_____

_____

_____

_____

_____

_____

**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 _____



HE0503

9-2681/0410

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

## PREPARTICIPATION PHYSICAL EVALUATION

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

| |
|---|
| 1. Type of disability |
| 2. Date of disability |
| 3. Classification (if available) |
| 4. Cause of disability (birth, disease, accident/trauma, other) |
| 5. List the sports you are interested in playing |

| | Yes | No |
|---|---|---|
| 6. Do you regularly use a brace, assistive device, or prosthetic? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | | |
| 9. Do you have a hearing loss? Do you use a hearing aid? | | |
| 10. Do you have a visual impairment? | | |
| 11. Do you use any special devices for bowel or bladder function? | | |
| 12. Do you have burning or discomfort when urinating? | | |
| 13. Have you had autonomic dysreflexia? | | |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | | |
| 15. Do you have muscle spasticity? | | |
| 16. Do you have frequent seizures that cannot be controlled by medication? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

**Please indicate if you have ever had any of the following.**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

**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 _____



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

**NOTE:** The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

# PREPARTICIPATION PHYSICAL EVALUATION
# PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

## PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

| **EXAMINATION** | | |
|---|---|---|
| Height Weight ☐ Male ☐ Female | | |
| BP / ( / ) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____



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9-2681/0410

# PREPARTICIPATION PHYSICAL EVALUATION
# CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

_____

_____

_____

_____

_____

**EMERGENCY INFORMATION**

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

**HCP OFFICE STAMP**

**SCHOOL PHYSICIAN:**

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

**Completed Cardiac Assessment Professional Development Module**

Date _____ Signature _____



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

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3. Click **Update Membership** in the *My Memberships* box
4. Choose a Membership Plan
5. Enter your Checking Account information & start saving!