LONG HILL TOWNSHIP SCHOOL DISTRICT
OFFICE OF THE SUPERINTENDENT
759 Valley Road
Gillette, N.J. 07933

Dr. Edwin Acevedo
Superintendent of Schools

Phone: (908)647-1200 ext. 1031
Fax: (908) 647-7818

January 23, 2017

Dear Parents and Guardians,

Welcome to the Long Hill Township School District! We are pleased that you have chosen our school community. In order to register your child, you will need to complete and bring the following five documents which are attached:

1. New Student Registration Application
2. Affidavit of Residency (Notary may be available in each school)
3. Home Language Survey
4. Health History Form/Emergency Medical Information
5. Universal Child Physical Exam Form (may be brought prior to child beginning school)

Additionally, please bring the following documents when registering your child:

1. Child's original Birth Certificate (The school will make a copy of the original birth certificate) and,
2. Proof of **Homeownership/Renter status** (<u>one</u> of the following documents): voter registration card, tax bill, deed to home, mortgage statement, or dated and signed rental lease by both parties, and,
3. Proof of **Residency** (<u>two</u> of the following documents) utility bills, cell phone bill, bank statement, credit card bill, vehicle insurance card with current address, and or a valid driver's license with current address.

Children entering our district will require a recent physical examination within the past 365 days and official documentation from either a physician or public health department documenting immunization dates before beginning school. Attached you will find some general information as to the medical requirements. In the event you need more information, please contact your respective schools listed below.

Gillette School
Grades P-1
Dr. Jones, Principal
Mrs. Andreski, Nurse
759 Valley Rd
Gillette, NJ 07933
P: 908-648-2313
F: 908-647-4969

Millington School
Grades 2–5
Mrs. Dawson, Principal
Mrs. Freeman, Nurse
91 Northfield Rd
Millington, NJ 07946
P: 908-647-2312
F: 908-647-4917

Central Middle School
Grades 6 - 8
Mr. Villar, Principal
Ms. Lozowski, Nurse
90 Central Ave
Stirling, NJ 07980
P: 908-647-2311
F: 908-647-0610

I wish you and your child much success in our school district. Once again, welcome to our schools.

Sincerely,

Dr. Edwin Acevedo
Superintendent of Schools

Long Hill Township School District

NEW STUDENT REGISTRATION APPLICATION

759 Valley Road
Phone: 908-647-1200 FAX: 908-647-7818 www.longhill.org

V1.17 - To Be Filled in by Office:
Date of Entrance: _____ Home Base Teacher/ Room No.: _____ SID# _____ Bus No.: CSV _____ GM____ Bus Stop: _____ W___ R___

Student's Name: _____ Grade: _____ Date of Birth: _____ _____ _____

City/State of Birth: _____ Country _____ If born outside the U.S., entry date _____

Address: _____ Town: _____ Home Ph. #: _____

Previous School Attended:

Name: _____ Phone Number: _____

Address: _____

Siblings (include ages): _____

Family Status: (Married, Div., etc.): _____ Native Language/Dialect Most Spoken in the Home: _____ Language Most Spoken By Pupil: _____

Tendency toward **right** or **left** handedness (circle one)

For 7th and 8th Grade students only-please indicate Foreign Language Selection _____ French _____Spanish

Parent/Guardian Information: Please circle relationship: *Parent Step-parent *Guardian / Mr.__ Ms. __ Mrs. __ Dr. __*

Last Name: _____ First Name: _____

Address: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Employer's Name and Address: _____

_____ Email : _____

Parent/Guardian Information: Please circle relationship: *Parent Step-parent *Guardian / Mr.__ Ms. __ Mrs. __ Dr. __*

Last Name: _____ First Name: _____

Address: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Employer's Name and Address: _____

_____ Email : _____

List any custody issues or special legal arrangements and attach documents: _____

_____

(CONTINUED ON REVERSE SIDE)

Family doctor/pediatrician: _____

Address: _____

List any physical, emotional, social, concerns/recommendations: _____

_____

Is your child on any medication that must be taken on a regular basis? Yes___ No ___ During school hours? _____
If "Yes," please explain: _____

_____

Sometime during the school year, does your child take medication for:
Asthma: _____ If "yes," please explain: _____
Allergies: ____ If "yes," please explain: _____

List Below:
Childhood illnesses (including dates): _____

_____

Accidents, unusual experiences, etc.:

_____

Emergency Contact that you will allow your child to be released to, due to illness or emergency if you can not be reached.

#1 Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

#2 Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

The following information <u>is required</u>, and mandated by the State of New Jersey, under NJSMART (which is part of *the Federal No Child Left Behind Act*). It is a means of tracking student performance as children progress through the school system.

Date your child entered the Long Hill Township School System: _____ Month _____ Day _____ Year

ETHNIC CODE:

African-American	☐	Hispanic	☐
American Indian/Alaskan Native	☐	Native Hawaiian./Other Pac. Islander	☐
Asian	☐	White	☐

Is the student classified as having an educational disability? Yes ☐ No ☐
Is there a medical or physical disability of which we should be aware? Yes ☐ No ☐
If "*yes*", please specify: _____

PARENT/GUARDIAN MILITARY STATUS:
Active Duty ☐ National Guard/Reserve ☐ Non Military ☐

***Legal Guardians must complete an annual "Sworn Residency Affidavit"**

PLEASE PROVIDE ***ORIGINAL*** BIRTH CERTIFICATE & 1 DOCUMENT VERIFYING HOME/RENTAL & 2 DOCUMENTS FOR RESIDENCY.
School will make copies for our records.

IMMUNIZATION RECORDS
PARENTS MUST PRESENT OFFICIAL DOCUMENTATION FROM EITHER A PHYSICIAN OR PUBLIC HEALTH DEPARTMENT TO PROVIDE PROOF OF PUPIL IMMUNIZATION DATES

LONG HILL TOWNSHIP SCHOOL DISTRICT
759 Valley Road
Gillette, NJ 07933
908-647-1200

AFFIDAVIT OF RESIDENCY

Date:_____

THIS IS TO CERTIFY THAT:

1. I am a bona fide resident of Long Hill Township and have provided one evidence of homeownership/rental (i.e., voter registration card, tax bill, deed to home, mortgage statement, a dated and signed rental lease by both parties **and** two forms of proof of residency (i.e., utility bills, cell phone bill, bank statement, credit card bill, vehicle insurance card with current address, and or a valid driver's license with current address.)

2. I vote in District #_____.

3. _____lives full time with me in Long Hill Township.
   Name(s) of Child(ren)

4. I am supporting the child(ren) gratis.

5. I will assume all personal obligations for the child relative to school requirements.

6. I intend to keep and support the child gratuitously for a longer time than merely through the school term.

7. _____(child/ren's name) will attend the Long Hill Township Schools only during the period of time that my home is his/her legal residence.

I, _____ (Parent or Guardian) being of legal age, certify to the Long Hill Township Board of Education that I am the parent, stepparent, or legally appointed guardian, parent surrogate or foster parent of the above named child. I am seeking to enroll this child in the Long Hill Township Board of Education. This child resides at the address listed below with myself or with another person who is the child's parent, stepparent or legally appointed guardian, parent surrogate or foster parent. I recognize that the Long Hill Township Board of Education is relying on the truth of the statements made herein. I realize that if any of these statements are false, the Long Hill Township Board of Education may seek tuition from me.

Signature of Parent or Guardian:_____

Address of Parent of Guardian:_____

SWORN AND SUBSCRIBED TO BEFORE A NOTARY PUBLIC OF THE STATE OF NEW JERSEY ON_____DAY OF_____.

_____
Signature of Notary Public of New Jersey

LONG HILL TOWNSHIP SCHOOL DISTRICT

HOME LANGUAGE SURVEY

Dear Parent/Guardian:

In order to improve our planning for your child's educational needs, we ask that you answer the questions listed below regarding your child's native language.

Please answer all questions and sign the form.

If you have any problems or need help with answering the questions, please see the principal or the ESL teacher at the school your child attends.

Thank you for your cooperation.

_____

Student's Name _____

School _____ **Grade** _____ **Date** _____

1. **What language do you most often use when speaking to your child?**
   _____
2. **What language did your child first use for communication?** _____
3. **What language does your child most often use when speaking to brothers, sisters, and other children at home?** _____
4. **What language does your child often use when speaking with you or other adults in the home (grandparents, aunts, uncles)?**
   _____
5. **What language does your child most often use when speaking with friends or neighbors?** _____
6. **In which language do you wish to receive communication?** _____

Dialect _____ **Country** _____

_____ _____

Parent/Guardian Signature **Date**

**Definition of native language from the New Jersey Department of Education:
The language first used by the student, or the language most often spoken at home regardless of the language spoken by the student.

Distribution: Student File (original)
School ESL Teacher (copy)
ESL Coordinator (copy)

1.17

Long Hill Township School District
Student Health Entrance Requirements

Kindergarten – Grade 8

I. A **Physical Examination** is required and must be completed between September 1 of the year your child is entering school and September 1 of the previous year.

II. **Immunizations** – the following immunizations are required prior to beginning school. Please ensure you have provided official documentation from either a physician or public health department documenting your child's immunization dates.

☐ **DTP (Diptheria, Tetanus Toxoid and Pertussis)**
Age 1 – 6 years old – 4 doses, with one dose given on or after the fourth birthday, or any 5 doses.
Age 7 or older – 3 doses of Td or a combination of DTP, DtaP, and Td.

☐ **Tdap Booster**
Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher

☐ **Poliovirus Vaccine**
Age 1 – 6 years old – 3 doses, with one dose given on or after the 4th birthday, or any 4 doses
Age 7 or older – 3 doses, either OPV or IPV separately or in combination

☐ **Measles**
2 doses of a measles containing vaccine. First dose give on or after the first birthday (if before first birthday, re-immunization is required). Intervals between first and second measles/MMR cannot be less than one month. Laboratory evidence of immunity is also acceptable.

☐ **Rubella**
1 dose or laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).

☐ **Mumps**
1 dose or laboratory evidence of immunity. First dose given on or after the first birthday. (If before first birthday, re-immunization is required).

☐ **Hepatitis B Virus Vaccine**
3 doses (age 1-15) or 2 doses Adult Formulation (age 11-15) or laboratory evidence of immunity

☐ **Varicella (Chicken Pox) Vaccine**
1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity

☐ **Meningococcal Vaccine 6th – 8th grades**
Students born on or after 1/1/97 attending or transferring into NJ School at grade six or higher

☐ **Mantoux Test (PPD)**
Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test

Antigua and Barbuda	Cyprus	Ireland	Montserrat	Switzerland
Australia	Czech Republic	Israel	Netherlands	Trinidad and Tobago
Austria	Denmark	Italy	Netherlands Antilles	United Kingdom
Barbados	Finland	Jamaica	New Zealand	U.S.A.
Belgium	France	Jordan	Norway	U.S. Virgin Islands
Bermuda	Germany	Lebanon	Puerto Rico	
Canada	Greenland	Luxembourg	Saint Kitts & Nevis	
Cayman Islands	Grenada	Malta	San Marino	
Cuba	Iceland	Monaco	Sweden	

Long Hill Township School District
Student Health Entrance Requirements

Pre-Kindergarten

I. A **Physical Examination** is required and must be completed between September 1 of the year your child is entering school and September 1 of the previous year.

II. **Immunizations** – the following immunizations are required prior to beginning school. Please ensure you have provided official documentation from either a physician or public health department documenting your child's immunization dates.

☐ **DTP (Diptheria, Tetanus Toxoid and Pertussis)**
Age 1 – 5 years old – 4 doses

☐ **Poliovirus Vaccine**
Age 1 – 5 years old – 3 doses

☐ **Measles**
1 dose of a measles containing vaccine given on or after the first birthday.

☐ **Rubella**
1 dose given on or after the first birthday.

☐ **Mumps**
1 dose given on or after the first birthday.

☐ **Varicella (Chicken Pox) Vaccine**
1 dose given on or after their first birthday, or documented proof of disease by a parent or physician statement or laboratory evidence of immunity

☐ **Hemophilus influenza type b (Hib) conjugate Vaccine**
At least one dose of a separate or a combination Hib conjugate vaccine, on or after the first birthday.

☐ **Pnuemococcal Conjugate Vaccine**
At least 1 dose, on or after the first birthday

☐ **Influenza Vaccine**
Shall receive one does of influenza vaccine between September 1 and December 31 of each year

☐ **Mantoux Test (PPD)**
Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed below must receive an IGRA or Mantoux tuberculin skin test

Antigua and Barbuda	Cyprus	Ireland	Montserrat	Switzerland
Australia	Czech Republic	Israel	Netherlands	Trinidad and Tobago
Austria	Denmark	Italy	Netherlands Antilles	United Kingdom
Barbados	Finland	Jamaica	New Zealand	U.S.A.
Belgium	France	Jordan	Norway	U.S. Virgin Islands
Bermuda	Germany	Lebanon	Puerto Rico	
Canada	Greenland	Luxembourg	Saint Kitts & Nevis	
Cayman Islands	Grenada	Malta	San Marino	
Cuba	Iceland	Monaco	Sweden	

Long Hill Township School District
Student Health Entrance Requirements

STUDENT HEALTH HISTORY

(To be completed by Parent(s)/Guardian)

Student Name: _____ Date of Birth: ____/____/____ Sex: _____
Last First

Parent's Name: _____ Parent's Name: _____

Address: _____ Phone Number: _____

Email Address: _____ (Please Print Clearly)

Student Place of Birth: _____ Entering School From: _____
City / State / Country

Siblings: Name _____ Age: _____ | Name _____ Age: _____
Name _____ Age: _____ | Name _____ Age: _____

Please review the conditions listed below and indicate any that apply with a check (✓) Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items.

✓	CONDITION	COMMENTS
	ADD/ADHD	
	Allergies	
	Food	
	Medication	
	Bee Sting	
	Environmental	
	Anaphylactic Reaction (give date)	
	Anemia	
	Asthma / Bronchitis	
	Bowel Problem	
	Cancer	
	Chicken Pox	
	Chronic / Recurrent Illness	
	Convulsions/Seizures	
	Concussion/Head Injury (give date)	
	Diabetes	
	Ear Infections	
	Eating Disorders	
	Emotional / Psychiatric Problems	
	Fainting	
	Fracture / Dislocation / Sprain	
	Frequent Colds / Sore throat	
	Frequent Headaches	
	Frequent Stomach Aches	

✓	CONDITION	COMMENTS
	Hearing Problem	
	Heart Problem	
	Hepatitis	
	Hypertension	
	Kidney/Urinary Problem	
	Leukemia	
	Lyme Disease	
	Mononucleosis	
	Neuromuscular Disease	
	Orthopedic Problem	
	Operations/Conditions Requiring Hospitalization	
	PDD / Autism	
	Rheumatic Fever	
	Scoliosis	
	Sickle Cell Anemia	
	Skin Condition	
	Speech Communication Problem	
	Strep Infections	
	Sustained illness past 3 months	
	Substance Abuse (alcohol, drugs)	
	Toothache, Dental problem	
	Tumor	
	Vision Problem	
	None of the above	

List any other concerns you may have about your child's health, development, learning, behavior or home situation, which might affect his/her performance: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Long Hill Township School District
Nursing Department

Student ID: _____

EMERGENCY MEDICAL INFORMATION

Student Name_____ School_____

Reliable information is necessary should a sudden accident or illness occur while your student is at school.

We will attempt to contact you if any type of medical attention is needed. However, in the event that treatment is necessary and we are unable to contact you, your signature below will authorize the school authorities, doctor, or hospital to use their best judgment in the interest of your child's health.

Emergency Treatment Permission

Authorization is given to perform necessary emergency treatment of my child whose medical history is listed on the bottom of this form.

_____ _____ _____ _____

(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

Tylenol Authorization

I hereby authorize the nurse with the school physician's order to administer Tylenol (acetaminophen), (age and weight appropriate).

_____ _____ _____ _____

(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

Release of Medical Information

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that the medical information may be shared, when necessary, with appropriate professional staff involved in the care of my child.

_____ _____ _____ _____

(Signature of legal guardian) (Date) (Signature of student if 18 or older) (Date)

Emergency Health Information

List any illnesses; injuries or surgeries that have taken place in the last year: _____

_____

List allergies to food, medications, insect bites or stings (list and be specific): _____

_____

List any physical disorders, conditions or limitations: _____

_____

List ANY medications that are currently being taken: _____

_____

Epi-Pen: Yes No Inhaler for:_____ Yes No Type_____

Is this student covered by health insurance? _____
If yes, please provide Insurance Company name: _____
If no, you may release my name and address to NJ Family Care** to contact me about health insurance.

_____ _____ _____
Signature Printed Name Date

** NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For information, call (800) 701-0710 or visit www.njfamilycare.org to apply online.

UNIVERSAL CHILD HEALTH RECORD

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

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, Vaccine Preventable Diseases Program at 609-826-4860.
   - 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.nj.gov/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.