RIDGEWOOD
PUBLIC SCHOOLS

EDUCATION CENTER
49 COTTAGE PLACE
RIDGEWOOD NJ 07451

# SCHOOL REGISTRATION PACKET

Mid-Year Entrance

1. School Registration Form – Student / Family / Emergency Information
2. Physical Examination & Immunization Requirements
3. NJ DOE Annual Athletic Pre-Participation Physical
4. Immunization Record
5. Vision Exam Form
6. Official Records Request Form – Transfer Card

RIDGEWOOD PUBLIC SCHOOLS

EDUCATION CENTER
49 COTTAGE PLACE
RIDGEWOOD NJ 07451

# SCHOOL REGISTRATION

School _____ Grade _____ Entry Date _____ Student ID # _____

## STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Nickname: _____ Student Email (Grades 6-12): _____ Gender: M ☐ F ☐

Home Address [Street] _____

If Renting, Date Lease Expires: _____ Home Telephone: (_____)_____

Ethnicity (***must check one***): Hispanic ☐ Non-Hispanic ☐

Race (***must check at least one, or all that apply***):

White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐

Date of Birth: _____ City, State, Country of Birth: _____

***If student was born outside of the US, please provide the following information:***

US School Entry Date:_____

1st Language Spoken: _____ Primary Language Spoken at Home: _____

Proficient in English: Yes ☐ No ☐ All Languages Spoken: _____

| Names, Dates and Grades of Previous Schools of Attendance (including Pre-K): | | | | |
|---|---|---|---|---|
| School and Address | Grades Attended | First Date of Enrollment | Last Date of Enrollment | Public or Private |
| | | | | |
| | | | | |
| | | | | |

***NJ State ID # (if transferring from another NJ Public School):***_____

## FAMILY INFORMATION

### # 1 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other ☐_____

Last Name: _____ First Name: _____Middle Name:_____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: (____)_____ Business Phone: (____)_____ Occupation: _____

Employer Name/Address:_____

### # 2 - Home Where the Child Lives

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other ☐_____

Last Name: _____ First Name: _____Middle Name:_____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Cell Phone: (____)_____ Business Phone: (____)_____ Occupation: _____

Employer Name/Address: _____

* If checked, guardianship papers must be produced for examination

Continued on back…

## FAMILY INFORMATION (CONTINUED) FOR:

**# 3 – Non-Custodial Parent** **No Contact Allowed:** ☐ **Receives Extra Mailing:** ☐

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other ☐_____

Last Name: _____ First Name: _____Middle Name:_____

Home Address [Street]: _____ [City, State, Zip] _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Business Phone:(____)_____

Employer/Address: _____ Occupation: _____

**# 4 – Student Resides at More than One Address:** ☐ **Receives Extra Mailing:** ☐

Relationship to Student: Mother ☐ Father ☐ Parent ☐ Guardian * ☐ Affidavit ☐ Other ☐_____

Last Name: _____ First Name: _____Middle Name: _____

Home Address [Street]: _____ [City, State, Zip] _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Business Phone:(____)_____

Employer/Address: _____ Occupation: _____

## SIBLING INFORMATION

| Name | Birthdate | Grade | Gender | Relationship | School | Resides w/Student |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## EMERGENCY INFORMATION

In the case of an emergency or early dismissal the parent/guardians will be contacted, Please list the individuals to whom the school may entrust your child if parent/guardians are unreachable. **DO NOT** list a parent or guardian as Emergency Contact. No student shall be released from school unless accompanied by an adult designated by the parent.

***Please check if your child may ONLY be released to parent:*** ☐

| Contact Name ***(Not parent/guardian)*** | Relationship | Address | Home Phone | Work Phone | Cell Phone |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

## PHYSICIAN/INSURANCE INFORMATION

My child's medical care is provided by: _____ _____
(name of Doctor, Clinic, or HMO) (Telephone)

My child has Health Insurance: Yes ☐ No ☐

*If **Yes**, please provide name of Insurance Company:* _____

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

Parent/Guardian Signature: _____ Date: _____

School Official Signature: _____ Date: _____

* If checked, guardianship papers must be produced for examination

# RIDGEWOOD PUBLIC SCHOOLS

**Ridgewood, New Jersey**

## PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

### Kindergarten – Grades 12

**All of the required information must be submitted prior to the first day of school (or starting date). A student can be refused entry until all requirements are met. If registering in the spring for the next school year, the forms are due June 15. If registering during the summer for September entrance, the forms are due prior to September 1. If registering for the current school year, the immunization record and health history are due before entrance.** The physical exam form is due within 30 days of entrance. Exceptions may be granted only for religious beliefs or medical recommendations.

**All students entering Kindergarten in the State of New Jersey must have documentation of a completed physical examination by their personal physician before entering the school district.** We have provided you with the form. This exam must have been performed within 365 days prior to the first day of school (or starting date) and must state what, if any, modifications are required for full participation in the school program. Dental, hearing and eye examinations are also recommended, but not mandatory. A record of the student's medical history, physical and emotional make-up may be very helpful in handling and teaching the student should problems subsequently develop. Families who do not have a personal physician or access to medical care should discuss this with the school nurse.

In addition to the requirements noted above, TB (Mantoux Testing) may be required for a select group of foreign born students and/or students transferring from a high TB incidence country into the Ridgewood Public Schools. Please consult your school nurse for details.

### Immunization Requirements for Children Entering Kindergarten & Higher Grades:

**DTaP (Diphtheria and Tetanus Toxoids and Pertussis Vaccine)**

Age 5-6 years: A minimum of four (4) doses of DTaP are required. One dose must have been administered on or after the fourth birthday or any five (5) doses.
Age 7-9 years: A minimum of three (3) doses of Td or any previously administered combination of DTP, DTaP and DT to equal three (3) doses.

**Tdap (Tetanus and Diphtheria Toxoids and Acellular Pertussis Vaccine)**

One (1) dose for students entering Grade 6, or comparable age level for special education programs.

**OPV (Oral Poliovirus Vaccine) or IPV (Inactivated Polio Vaccine)**

Age 5-6 years: A minimum of three (3) doses of poliovirus vaccine is required, providing one dose is given on or after the fourth birthday, or any four (4) doses.
Age 7 and older: Any three (3) doses

**MMR (Measles, Mumps, Rubella)**

Administered after the first birthday:
Two (2) doses of a live Measles-containing vaccine
One (1) dose of live Mumps-containing vaccine
One (1) dose of live Rubella-containing vaccine

**Hepatitis B Vaccine**

Three (3) doses are required.

**Varicella Vaccine**

One (1) dose administered on or after the first birthday for children born after 1/1/1998

**PCV (Pneumococcal Conjugate)**

Two (2) doses - Ages 2–11 months
One (1) dose - Ages 12-59 months

**Meningococcal**

One (1) dose for students entering Grade 6, or comparable age level for special education programs

**HPV (Human Papillomavirus Vaccine) - Optional**

Administer to females, minimum age 9 years, and ages 13 to 18 if not previously vaccinated
1st dose – Age 11 or 12 years
2nd dose - 2 months after first dose
3rd dose - 6 months after first dose (at least 24 weeks after 1st dose)

**HIB (Haemophilus Influenza Type B)**

One (1) dose annually - Ages 12 months to 59 Months

# 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*

# 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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# 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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**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*

# RIDGEWOOD PUBLIC SCHOOLS
**Ridgewood, New Jersey**

State of New Jersey

## IMMUNIZATION RECORD

**Kindergarten – Grades 12**

| | | | |
|---|---|---|---|
| | | **Immunization Registry Number** | |
| **Name of Child (Last, First, M.I.)** | | **Date of Birth (Mo/Day/Yr)** | **Sex** ☐ Male ☐ Female |
| **Parent/Guardian** | **Name** | | |
| | **Address** | **Telephone No.** | |

## TO BE COMPLETED BY HEALTH CARE PROVIDER

| **DISEASE** | **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** | | | |
|---|---|---|---|---|---|---|---|---|
| **DTaP (DIPHTHERIA, TETANUS, PERTUSSIS)** or any combination **If Td or DT, indicate in box* | /_____/ | /_____/ | /_____/ | /_____/ | /_____/ | | | |
| **Tdap (TETANUS, DIPHTHERIA TOXOIDS, ACELLULAR PERTUSSIS)** | | | | | | | | |
| **IPV (INACTIVATED POLIOVIRUS) OR OPV (ORAL POLIOVIRUS)** *If IPV or OPV, indicate in box* | /_____/ | /_____/ | /_____/ | /_____/ | /_____/ | | | |
| **MMR (MEASLES, MUMPS, RUBELLA)** | | | | | | | | |
| **HEPATITIS B** | | | | | | | | |
| **VARICELLA** | | | | | | | | |
| **PCV (PNEUMOCOCCAL CONJUGATE)** | | | | | | | | |
| **MENINGOCOCCAL** | | | | | | | | |
| **HPV (HUMAN PAPILLOMAVIRUS)** | | | | | | | | |
| **HIB (HAEMOPHILUS INFLUENZA TYPE B)** | | | | | | | | |

| **Lead Screening** | |
|---|---|
| **Test Date** | **Result** |
| | |
| | |
| | |
| | |

| **Document below single antigen vaccine receipt, serology titers, or varicella disease history** | | |
|---|---|---|
| **Hepatitis B** | **Date:** | **Titer:** |
| **Varicella** | **Date:** | **Titer:** |
| **Measles** | **Date:** | **Titer:** |
| **Mumps** | **Date:** | **Titer:** |
| **Rubella** | **Date:** | **Titer** |

☐ **Provisional Admission Attached-Date Granted:** _____

☐ **Medical Exemption Attached**

☐ **Religious Exemption Attached**

**RIDGEWOOD PUBLIC SCHOOLS**
**Ridgewood, New Jersey**

## VISION EXAMINATION FORM

The Board of Education recommends that all pre-school children have a complete eye examination before entering school in the fall. Good vision is essential to success in school. It is our hope that pre-school eye examinations will help many children to receive the proper vision correction through early detection and/or treatment.

Vision Screening is required for athletic participation at the middle and high schools.

Upon completion of the eye examination, have the examiner indicate his/her findings and recommendations on the form below. This form should be returned to the school nurse.

**Student's Name**_____ **Date**_____

I have given a complete eye exam with the following diagnosis and recommendations:

| | | Distance | Near | | Distance | Near |
|---|---|---|---|---|---|---|
| Vision Without Correction | O.D. | | | O.S. | | |
| | | | | | | |
| Vision With Correction | | | | | | |

Muscle Balance _____ Color Test _____

Stereopsis Eye _____

Eye Defects _____

Recommendations/Conclusions

1. Normal Eye Examination Yes ☐ No ☐
2. Corrective lens prescribed Yes ☐ No ☐
3. Re-examine on _____ (Date of Return Visit)
4. Other (Preferential seating, low vision, aides, etc.) _____

_____ _____
Physician's Signature Date

Please Print:
Name of Physician _____

Address _____

Phone Number _____

# RIDGEWOOD PUBLIC SCHOOLS
## Ridgewood, New Jersey

### OFFICIAL RECORDS REQUEST FORM
### TRANSFER CARD

Please Print

## Student Information

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

| Street | City | State | Zip | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Place of Birth [City, State, Country] | Languages Spoken at Home |
|---|---|
| | |

## Previous School

Name of School — Public ☐ Private ☐

Address [Street, City, State, Zip]

Telephone — Fax

Last Date of Attendance — Last Grade Attended

NJ State ID# (if transferring from a Public School in NJ)

## Entering School – Send Info to:

- Hawes ES, 531 Stevens Ave, Ridgewood, NJ 07450
- Orchard ES, 230 Demarest St, Ridgewood, NJ 07450
- Ridge ES, 325 W. Ridgewood Ave, Ridgewood, NJ 07450
- Somerville ES, 45 S. Pleasant Ave, Ridgewood, NJ 07450
- Travell ES, 340 Bogert Ave, Ridgewood, NJ 07450
- Willard ES, 601 Morningside Ave, Ridgewood, NJ 07450
- Benjamin Franklin MS, 335 N. Van Dien Ave, Ridgewood, NJ 07450
- George Washington MS, 155 Washington Place, Ridgewood, NJ 07450
- Ridgewood HS, 627 E. Ridgewood Ave, Ridgewood, NJ 07450

## Records to Be Released

| | |
|---|---|
| District Assessments | Is student in an ESL or Bilingual Program? ☐ Yes ☐ No |
| State Assessments | Has student ever been referred for Special Education? ☐ Yes ☐ No |
| Special Education Records | Has student ever been referred for Special Education? ☐ Yes ☐ No<br>If yes, please indicate the specific classification, if any: |

## Comments

## Office Use Only

| Requested By | Requested Date | Received By | Received Date |
|---|---|---|---|
| | | | |

I hereby give my permission for release of the above records and for the school district to contact my child's former district for further information.*

| Signature of Parent/Legal Guardian (circle one) | Signature of Student (18 or above) | Date |
|---|---|---|

* Parental permission is no longer required when records are requested by authorized school personnel. (Family Education Rights and Privacy Act, Final Rule on Educational Records. Federal Register, June 17, 1976, Vol.41, No. 118, page 24673). The prior District may also release the following mandated records: transcript of grades, health records, attendance records, child study team records and disciplinary records pursuant to N.J.A.C. 6:3-6.5