

# Fort Lee Public Schools

## Central Administration Offices

2175 Lemoine Avenue, 6<sup>th</sup> Floor ✧ Fort Lee, New Jersey 07024

Phone: 201.585.4612 Ext. 7506 ✧ Fax: 201.585.7997

www.FLBOE.com

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**In order to register for Fort Lee Public Schools, each student must be accompanied by a parent or guardian and submit or provide the following:**

1. Proof of age:
  - \*A. Birth certificate – if child was born in United States
  - \*B. Passport/visa, alien card or family register
  - C. Divorce/custody papers, if applicable
  
2. Proof of residence:

Lease, deed, mortgage or stock certificate
  
3. Three (3) proofs of residency are needed. Examples are:
  - A. Home or cell phone bill **with number and address of service** (Page ONE of bill)
  - B. Current bills (PSE&G, water, or cable)
  - C. Official correspondence
  - D. Current major credit card bill
  - E. Post office change of address
  - F. Work orders or invoices
  
4. Transfer card and report card from previous school.
  
5. A completed physical examination form for registration. This must be signed, and dated by the Doctor within twelve (12) months prior to entering.
  
6. If child is entering from a country outside of the United States, documentation must be provided of the mantoux tuberculin skin test given no more than six (6) months, and given in the United States, prior to entering. If the mantoux tuberculin skin test is positive, you must submit a separate report from the radiologist of the x-ray results.

**\*Please note that photo identification is not required for enrollment.** In compliance with N.J.A.C. 6A:22-3 et seq the Fort Lee School District is restricted to requesting only information on child's age and residence. Please refer to district policy and regulation 5111 available on the Fort Lee School District website.



**Fort Lee Board of Education  
2175 Lemoine Ave. 6<sup>th</sup> floor  
Fort Lee, N.J. 07024**

**Central Registration  
Phone #: (201) 585-4612 X-7506  
Fax: (201) 585-7997**

**IF STUDENT IS GOING TO BE ABSENT OR LATE TO SCHOOL,  
PLEASE CALL THE SCHOOL BY 8:30 A.M. DAILY.**

SCHOOL #1	-----	585-4620
SCHOOL #2	----	585-4630
SCHOOL #3	----	585-4640
SCHOOL#4	----	585-4650
MIDDLE SCHOOL	---	585-4660
HIGH SCHOOL	----	585-4675

## **MEDICAL FORM REQUIREMENTS**

DOCTOR'S CERTIFICATE MUST SHOW A MINIMUM OF:

- ❖ DATES (MONTH, DAY AND YEAR) OF **3 DPT IMMUNIZATIONS AND A BOOSTER DOSE**. THE BOOSTER MUST BE GIVEN ON OR AFTER THE 4<sup>TH</sup> BIRTHDAY.
- ❖ DATES (MONTH, DAY AND YEAR) OF **2 POLIO IMMUNIZATIONS AND A BOOSTER DOSE**. THE BOOSTER MUST BE GIVEN ON OR AFTER THE 4<sup>TH</sup> BIRTHDAY.
- ❖ DATE (MONTH, DAY AND YEAR) OF **MEASLES IMMUNIZATION** GIVEN ON OR AFTER THE 1<sup>ST</sup> BIRTHDAY, AND A SECOND DOSE GIVEN AFTER AT LEAST ONE MONTH.
- ❖ DATE (MONTH, DAY AND YEAR) OF **RUBELLA (GERMAN MEASLES) IMMUNIZATION** GIVEN ON OR AFTER THE 1<sup>ST</sup> BIRTHDAY.
- ❖ DATE (MONTH, DAY AND YEAR) OF **MUMPS IMMUNIZATION** GIVEN ON OR AFTER THE 1<sup>ST</sup> BIRTHDAY.
- ❖ DATE (MONTH, DAY AND YEAR) OF **VARICELLA (CHICKEN POX) IMMUNIZATION** GIVEN ON OR AFTER THE 1ST BIRTHDAY.  
THIS IS REQUIRED FOR ALL CHILDREN BORN ON OR AFTER JANUARY 1, 1998.
- ❖ DATES (MONTH, DAY AND YEAR) OF **3 HEPATITIS B IMMUNIZATIONS.**
- ❖ **ADDITIONALLY FOR STUDENTS ENTERING GRADES 6 – 12:**
  - DATE (MONTH, DAY AND YEAR) OF **Tdap IMMUNIZATION** GIVEN AFTER THE 10<sup>TH</sup> BIRTHDAY.
  - DATE (MONTH, DAY AND YEAR) OF **MENINGOCOCCAL IMMUNIZATION** GIVEN AFTER THE 10<sup>TH</sup> BIRTHDAY.
  -
- ❖ **ADDITIONALLY FOR STUDENTS ENTERING PRE-SCHOOL:**
  - DATES (MONTH, DAY AND YEAR) OF **HAEMOPHILUS B (HIB) VACCINES** WITH ONE DOSE GIVEN AFTER THE 1ST BIRTHDAY.
  - DATES (MONTH, DAY AND YEAR) OF **PNEUMOCOCCAL (PCV-13) VACCINES** WITH ONE DOSE GIVEN AFTER THE 1ST BIRTHDAY.
  - DATE (MONTH, DAY AND YEAR) OF **ANNUAL INFLUENZA VACCINE.**
- ❖ **FOR STUDENTS ENTERING FROM OUTSIDE THE UNITED STATES:**
  - DATE (MONTH, DAY AND YEAR) AND RESULT OF **MANTOUX TUBERCULIN SKIN TEST** DONE WITHIN 6 MONTHS PRIOR TO ENTERING SCHOOL.
  - A SEPARATE REPORT OF **X-RAY RESULTS** SUBMITTED BY THE RADIOLOGIST **IF THE MANTOUX TUBERCULIN TEST IS POSITIVE.**
- ❖ **ALL REGISTRANTS MUST HAVE A PHYSICAL EXAMINATION BY THEIR FAMILY PHYSICIAN WITHIN 365 DAYS PRIOR TO ENTERING SCHOOL.**

**THE COMPLETED PHYSICAL EXAMINATION FORM MUST BE RETURNED WITH THE REGISTRATION PACKET.**



# Fort Lee School District

## STUDENT'S VERIFICATION OF RIGHT OF ATTENDANCE

STUDENT'S NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
LAST FIRST

HOUSE: ONE FAMILY \_\_\_\_\_ TWO FAMILY \_\_\_\_\_  
APARTMENT: IN HOUSE \_\_\_ IN HIGH RISE \_\_\_ COMPLEX'S NAME \_\_\_\_\_

APPLIED FOR ADMISSION TO: SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

### STATEMENTS OF EVIDENCE OF PROOF OF RESIDENCY:

LEASE OR DEED UTILITY PHONE BILL OTHER MEDICAL

CERTIFICATION OF BIRTH: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### AFFIDAVIT (IF APPLICABLE)

GUARDIAN'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SCHOOL LAST ATTENDED: \_\_\_\_\_  
NAME ADDRESS

I HAVE BEEN FULLY INFORMED AND UNDERSTAND THE MEANING OF AND THE CONSEQUENCES OF GIVING FALSE INFORMATION WITH REGARD TO MY RESIDENCE (ADDRESS) AS STATED IN CHAPTER 6 NJS 18A: 38 - 1.

DATE: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_

**NOTE: IF PUPIL'S ADDRESS IS NOT THE SAME AS PARENT'S, IS THE PUPIL AN AFFIDAVIT STUDENT? YES \_\_\_\_\_ NO \_\_\_\_\_**

I HAVE CHECKED THE ABOVE FACTS AND FIND THEM TO BE CORRECT.

DATE: \_\_\_\_\_ VERIFICATION OFFICER: \_\_\_\_\_

## Fort Lee Board of Education NJSMART DATA SHEET

(Please Print)

Today's date:			RESIDENT SCHOOL:			
STUDENT INFORMATION						
Students Last name:		First:	Middle:	Suffix(Sr., Jr., III)	Parent/Guardian Marital status (circle one) Single / Mar / Div / Sep / Wid	
Birth date: / /	City of birth:	State/Country of birth:		Social Security # (optional):	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	
Street address:			Home Phone #: ( )	Parent/Guardian Cell Phone #: ( )		
City:			State:	Zip		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			Parent/Guardian Email Address: ____@____ ____@____	
Please <input checked="" type="checkbox"/> the appropriate box. You may <input checked="" type="checkbox"/> more than one.						
Previous school attended before entering the Fort Lee School District:				City:	State:	

HEALTH INFORMATION	
Does the student have Health Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the name of the students Health Insurance Carrier?	
Date of last medical examination:	
Date of last lead test:	Lead Level:
Date of polio immunization:	
Parent/Guardian signature:	Date:

\*\*\*\*\*OFFICIAL USE\*\*\*\*\*

ID ASSIGNED: \_\_\_\_\_ NJSMART ID #: \_\_\_\_\_

County Code Resident: 03 District Code Resident: 1550 School Code Resident: \_\_\_\_\_

District Entry Date: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

County Code Attending: \_\_\_\_\_ District Code Attending: \_\_\_\_\_ School Code Attending: \_\_\_\_\_

School Entry Date: \_\_\_\_\_ School Exit Date: \_\_\_\_\_ School Exit Withdrawal Code: \_\_\_\_\_

If student has exited, List the name and city and state of the new school:  
\_\_\_\_\_  
\_\_\_\_\_



Central Registration  
2175 Lemoine Ave.  
(201) 585-4612 ext. 7506  
Fax (201) 585-7997

**I UNDERSTAND THE FORT LEE SCHOOL DISTRICT  
POLICY STATES THAT A CHILD MUST BE  
FIVE YEARS OF AGE  
ON OR BEFORE OCTOBER 1<sup>ST</sup>  
FOR KINDERGARTEN REGISTRATION.**

**CHILD'S NAME:** \_\_\_\_\_

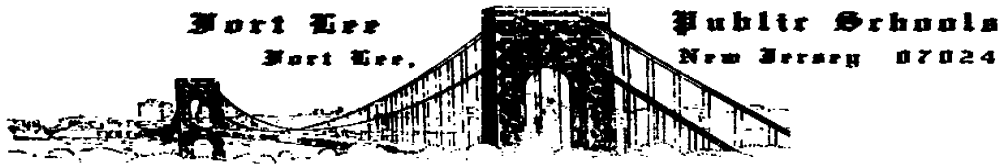
**DATE OF BIRTH:** \_\_\_\_\_

**DID YOUR CHILD ATTEND PRE-K? \_\_\_\_\_ WHERE? \_\_\_\_\_**

**PARENT'S NAME:** \_\_\_\_\_

**PARENT'S SIGNATURE:** \_\_\_\_\_

**DATE SIGNED:** \_\_\_\_\_



Central Registration  
2175 Lemoine Ave.  
(201) 585-4612 ext. 7506  
Fax (201) 585-7997

**I UNDERSTAND THAT THE FORT LEE SCHOOL DISTRICT  
POLICY STATES THAT A CHILD MUST BE  
SIX YEARS OF AGE  
ON OR BEFORE October 1<sup>ST</sup>  
FOR FIRST GRADE REGISTRATION.**

**CHILD' NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**DID YOUR CHILD ATTEND PRE-K? \_\_\_\_\_ WHERE? \_\_\_\_\_**

**DID YOUR CHILD ATTEND KINDERGARTEN? \_\_\_\_\_ WHERE? \_\_\_\_\_**

**PARENT'S NAME:** \_\_\_\_\_

**PARENT'S SIGNATURE:** \_\_\_\_\_

**DATE SIGNED:** \_\_\_\_\_



**FORT LEE SCHOOL DISTRICT  
FORT LEE, NEW JERSEY**

The Fort Lee Board of Education requests you provide the following information:

\_\_\_\_\_

FULL Name of Student

\_\_\_\_\_

Grade

\_\_\_\_\_

Address

List ALL brothers and sisters residing with the above named child. Include those who do not attend school as well.

PRINT FULL NAME(S)	CIRCLE SEX	D. O. B.	GRADE	SCHOOL
1. _____	M F	_____	_____	_____
2. _____	M F	_____	_____	_____
3. _____	M F	_____	_____	_____
4. _____	M F	_____	_____	_____
5. _____	M F	_____	_____	_____
6. _____	M F	_____	_____	_____
7. _____	M F	_____	_____	_____

List ALL Other Children Residing with you. Include Relationship to you.

PRINT FULL NAME(S)	CIRCLE SEX	D.O.B.	GRADE	SCHOOL	RELATION
1. _____	M F	_____	_____	_____	_____
2. _____	M F	_____	_____	_____	_____
3. _____	M F	_____	_____	_____	_____

\_\_\_\_\_

SIGNATURE

\_\_\_\_\_

DATE

\_\_\_\_\_

NAME (PRINT)

**FORT LEE BOARD OF EDUCATION**

**2175 Lemoine Ave.  
FORT LEE, NJ 07024**

**PROOF OF RESIDENCE**

DATE \_\_\_\_\_

Print \_\_\_\_\_  
Name of Parent or Legal Guardian

Print \_\_\_\_\_  
Name of Student

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

\_\_\_\_\_  
Previous Address

\_\_\_\_\_  
Previous Telephone #

I hereby certify that my son/daughter \_\_\_\_\_, resides with me at the above address in Fort Lee, New Jersey, and that this is our primary permanent residence.

I hereby authorize my Landlord/Management Company to release information regarding my residence to the Board of Education.

I further certify that I am the parent or legal guardian of the above student and that he/she is entitled, according to the State of New Jersey Education Laws, to attend the public schools of the Borough of Fort Lee.

Signed \_\_\_\_\_

**PLEASE READ CAREFULLY BEFORE SIGNING**

**The Fort Lee Board of Education will pursue, with legal action, any attempt to defraud the Board by sending to any of its schools, a student who legally is not a bona-fide permanent resident of the Borough or is not legally eligible for a free public education in Fort Lee.**

**The Fort Lee Board of Education will seek full tuition payment on a pro-rata basis for any child attending the Public Schools of Fort Lee, New Jersey, who by law is not entitled to a free public education in the District. As per N.J.S.A. 18A:38-1(b) (2) – “Tuition shall be computed on the basis of 1/180 of the total annual per pupil cost to the local district multiplied by the number of days of ineligible attendance.”**

Signed \_\_\_\_\_

Date \_\_\_\_\_

**PLEASE CHECK ONE:**

Parent \_\_\_\_\_

Guardian \_\_\_\_\_

FORT LEE BOARD OF EDUCATION

2108-2019

STUDENT LANGUAGE INFORMATION SHEET AND NEW JERSEY HOME-  
LANGUAGE SURVEY (HLS)

<b>Background Information</b>	
Student Name:	
Address:	
Telephone #:	Date of Birth:
City of Birth:	Country of Birth:
<b>Languages Spoken at Home</b>	
By Parents:	By Student:
Primary Language of Student:	Dialect Spoken:
<b>Education Information</b>	
Date of First Entry into a US School:	Date of Entry into a NJ School: Grade?:
How many years has the student been in the US?	How many years has the students been in the public school system in the US?
What grade was the student in as of Sept. 30th?	
<b>Ethnicity of Student</b>	
Please circle one: White, Black/African-American, Asian, Hispanic/Latino, American Indian/Alaskan Native, Hawaiian Native/Other Pacific Islander, Other	

STUDENT LANGUAGE INFORMATION SHEET AND NEW JERSEY HOME-LANGUAGE SURVEY (HLS)

**New Jersey Home Language Survey**

**Purpose:** This survey is the first of three steps to identify whether or not a student may be eligible for English language learner services.

**Directions:** Start with question 1 and continue until the HLS is complete. Circle the answer for each question and follow the directions. If you arrive at a “decision”, the HLS is complete.

- 1) What was the first language used by the student?  
 a) English (continue) to question 2B)  
 b) Language other than English (continue to question 2A)

- 2A) At home, does this student hear or use a language other than English more than half of the time?  
 a) Yes (List home language(s) spoken, proceed to Step 2 HLS is complete)  
 b) No (continue to question 4)

List home language(s) spoken:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- 2B) At home does this students hear or use a language other than English more than half the time?  
 a) Yes (continue to question 4)  
 b) No (continue to question 3)

- 3) Does this student understand a language other than English?  
 a) Yes (continue to question 4)  
 b) No (HLS is complete. Student is not an ELL)

- 4) When interacting with caregivers other than their parents or guardians, does this student use a language other than English more than half of the time?  
 a) Yes (List home language(s) spoken. Proceed to Step 2. HLS is complete)  
 b) No (continue to question 5)

List home language(s) spoken:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- 5) Has this student recently moved from another school district where he/she were identified as an English language learner?  
 a) Yes (List home language(s) spoken and proceed to Step 2. HLS is complete.)  
 b) No (HLS is complete. Student is not an ELL.)

List home language(s) spoken:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FORT LEE SCHOOL DISTRICT**

**2175 Lemoine Ave.  
Fort Lee, N.J. 07024**

**TRANSCRIPT REQUEST FORM**

Dear Principal:

\_\_\_\_\_, a former student in your school is now enrolled in the Fort Lee Public School System.

Please furnish us with a complete transcript, grade level, and any other available information including Child Study Team records and health records. If student is in High School credits earned must be stated.

Sincerely yours,

\_\_\_\_\_  
Principal

\_\_\_\_\_  
Parent Consent

School No. 1 - 250 Hoym St. ( )  
PH: (201) 585-4620/ FAX: (201) 585-8082

\_\_\_\_\_  
Previous School

School No. 2 - 2047 Jones Rd. ( )  
PH: (201) 585-4630/FAX: (201) 585-8972

\_\_\_\_\_  
Street

School No.3 - 2405 Second St. ( )  
PH: (201) 585-4640/FAX: (201) 585-1488

\_\_\_\_\_  
City

School No. 4 - 1193 Anderson Ave. ( )  
PH: (201) 585-4650/ FAX: (201) 585-1546

\_\_\_\_\_  
State Zip Code

Lewis F. Cole Middle School ( )  
467 Stillwell Avenue: Attn: Secretary  
PH: (201) 585-4660/ FAX: (201) 585-1688

\_\_\_\_\_  
Phone Number

Fort Lee High School ( )  
3000 Lemoine Avenue; Attn: Guidance  
PH: (201) 585-5686/ FAX: (201) 585-2296

\_\_\_\_\_  
FAX Number

FORT LEE SCHOOL DISTRICT  
FORT LEE , NEW JERSEY

**PHYSICAL EXAMINATION FOR REGISTRATION**

Student's Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ School: \_\_\_\_\_ Grade / Teacher: \_\_\_\_\_

Parent / Guardian's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**EXAMINATION**

EYES _____	HEART _____	ALLERGIES _____	HEIGHT _____
EARS _____	LUNGS _____	NUTRITION _____	WEIGHT _____
NOSE _____	ABDOMEN _____	NERV.SYS _____	
THROAT _____	GENITALIA _____	COORDINATION _____	B.P. _____
TEETH _____	HERNIA _____	SCOLIOSIS _____	VISION _____
SKIN _____	LYMPH NODES _____	FEET _____	HEARING _____

**IMMUNIZATIONS - VACCINES**

VACCINE TYPE	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diphtheria, Tetanus & Pertussis ( DTaP/ DT/ Td)						
Tdap--booster (after age 10)			Meningococcal (after age 10)			
Polio ( IPV / OPV ) - indicate						
MMR (combination )*				*if immune, attach serology titers report		
If single doses enter here:	Measles*		Rubella*		Mumps*	
<b>Haemophilus B (HIB)**</b>						
Hepatitis B - 3 doses						
Varicella (after 1st birthday)			Varicella Disease:			
<b>Pneumococcal conjugate**</b>						
<b>Influenza vaccine**</b>						
Hepatitis A - 2 doses***			**required for pre-school		***not required	
Other (type/date)						

Mantoux Tuberculin Test: Date done: \_\_\_\_\_ Date read: \_\_\_\_\_ Result: \_\_\_\_\_ mm

Chest X-Ray: Date: \_\_\_\_\_ Results: \_\_\_\_\_ INH: Date begun: \_\_\_\_\_ Dosage: \_\_\_\_\_

**HEALTH HISTORY (DATES) : PLEASE ATTACH COMPLETE HISTORY AND RECOMMENDATIONS**

Allergies _____	Asthma _____	Mononucleosis _____	Congenital Defects (type ) _____
Drug Sensitivity _____	Seizure Disorder _____	Immunodeficiency _____	
Otitis Media _____	Diabetes _____	Other: _____	Operations / Injuries (dates) _____
Strep Infections _____	Heart Disease _____		
Hepatitis _____	Neuromusc. Dis. _____		

1. General Health: \_\_\_\_\_
2. May \_\_\_\_\_ May not \_\_\_\_\_ participate in all physical activities. (specify limitations )
3. Is \_\_\_\_\_ Is not \_\_\_\_\_ taking medication.
4. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_
5. **Lead testing** Date: \_\_\_\_\_ Level: \_\_\_\_\_
6. Other Tests done: \_\_\_\_\_

**ALL NEW REGISTRANTS TO FORT LEE PUBLIC SCHOOLS MUST HAVE A PHYSICAL EXAMINATION WITHIN 365 DAYS PRIOR TO ENTERING SCHOOL**

PHYSICIAN'S NAME/ADDRESS ( STAMP )

PHYSICIAN'S SIGNATURE

DATE of EXAM

**\*IMPORTANT MEDICAL INFORMATION REQUIRED\***

FORT LEE SCHOOL DISTRICT  
FORT LEE NEW JERSEY

Dear Parents/Guardians:

The Fort Lee School District **requires a written annual update** of the condition of students who have any one of the following:

1. **ALLERGIES: FOOD PRODUCTS, INSECTS, LATEX, MEDICATIONS, ETC.**
2. **ASTHMA AND OTHER LUNG DISORDERS**
3. **BLOOD DISORDERS**
4. **CARDIAC DISORDERS**
5. **DIABETES**
6. **ORTHOPEDIC DISORDERS**
7. **SEIZURE DISORDER**
8. **OTHER CONDITIONS REQUIRING REGULAR MEDICAL ATTENTION INCLUDING PSYCHIATRIC/EMOTIONAL DISORDERS**
9. **DAILY PRESCRIBED MEDICATION: HOME OR SCHOOL**
10. **RECENT HOSPITALIZATIONS OR SURGICAL PROCEDURES**

Updated documentation regarding your child’s condition is required each year. Acceptable documentation is a **full physical examination report or a written statement from your attending physician** detailing current level of health and special needs or considerations. The physician must **SIGN, STAMP, and DATE the form**. Submitted information may be shared with school physicians and/or nurses.

Either document must be submitted to the school nurse-teacher in your child’s school as soon as possible at the beginning of the school year.

Your compliance in this process will greatly assist the school district in providing the safest environment for your child. We appreciate your cooperation.

Sincerely yours,

Maryann J. Colenda, M.D.  
Jen F. Lee, M.D.

**Check appropriate response below and return to student’s teacher on the first day of school.**

My child, \_\_\_\_\_, **does** have a medical condition as noted above.  
I will submit a physician’s report promptly.

My child, \_\_\_\_\_, **does not** have any known medical conditions.

**FORT LEE SCHOOL DISTRICT  
FORT LEE, NEW JERSEY**

**STUDENT MEDICAL HISTORY**

**MUST BE COMPLETED BY PARENT OR GUARDIAN.**

Student' s Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Parent / Guardian \_\_\_\_\_  
Grade / Teacher \_\_\_\_\_ School \_\_\_\_\_

**PLEASE CIRCLE ANSWERS TO THE FOLLOWING:**  
( EXPLAIN YES ANSWERS BELOW and on reverse if necessary)

The student named above:

- |                                                                               |       |     |    |
|-------------------------------------------------------------------------------|-------|-----|----|
| 1. has had injuries requiring medical attention:<br>type(s) & date(s) _____   | ..... | YES | NO |
| 2. has had special health problems or difficulty :<br>type(s) & date(s) _____ | ..... | YES | NO |
| 3. is under a physician's care for a medical condition :<br>type & date _____ | ..... | YES | NO |
| 4. takes medication :<br>type / dose _____<br>reason _____                    | ..... | YES | NO |
| 5. wears corrective lenses :<br>(circle) glasses contact lenses since _____   | ..... | YES | NO |
| 6. has a hearing problem :<br>explain: _____                                  | ..... | YES | NO |
| 7. has had surgical operations:<br>type(s) & date(s) _____                    | ..... | YES | NO |
| 8. has been hospitalized :<br>when & why _____                                | ..... | YES | NO |

\* Do you know of any reason why this individual should NOT participate in all physical education activities ? ..... YES NO

\* Is this student subject to any condition which may create a classroom emergency, such as seizure disorder, fainting spells, diabetes, allergies, asthma, etc? ..... YES NO

**EXPLAIN** \_\_\_\_\_

If this student has had any of the following illnesses, please indicate the year(s) below.

	YEAR		YEAR
Chicken Pox	_____	Strep Throat	_____
Whooping Cough	_____	Scarlet Fever	_____
Measles	_____	Rheumatic Fever	_____
Mumps	_____	Lyme Disease	_____
Rubella	_____	Pneumonia	_____
Hepatitis (type ____ )	_____	Other _____	_____
Immunodeficiency (HIV)	_____		

\_\_\_\_\_  
Signature of Parent / Guardian                      Date