THE OLC SCHOOL AND LITTLE HARBOR ACADEMY APPLICATION

248 MARIN BLVD. - JERSEY CITY, NJ 07302 - 201.434.2405 - OLCSCHOOL.ORG

Child's Name _____ ❑ Boy ❑ Girl Preferred Name _____

Date of Birth _____ Place of Birth _____ U.S. Citizen ❑ Yes ❑ No

If no, please provide Visa and proper documentation.

Student's Ethnicity:

❑ African American ❑ Caucasian ❑ Native American
❑ Asian American ❑ Hispanic ❑ Other, please specify: _____

Is a language other than English spoken in the home? (If yes, please specify) _____

Mother's Name _____	Father's Name _____
Home Address _____	Home Address _____
City, State, Zip _____	City, State, Zip _____
Home Phone _____	Home Phone _____
Occupation _____	Occupation _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____
Cell _____	Cell _____
Email _____	Email _____
Is email a good way to contact you? ❑ Yes ❑ No	Is email a good way to contact you? ❑ Yes ❑ No

With whom does the child live? If different from above, please provide name, relationship, address and phone number for the child's guardian _____

Check all that apply:

❑ Parents are married ❑ Parents are separated ❑ Parents are divorced ❑ Parents were never married
❑ Father remarried ❑ Mother remarried ❑ Stepmother's name _____
❑ Father deceased ❑ Mother deceased ❑ Stepfather's name _____

Name of Present School _____

Address of School _____

How did you hear about us? _____

Do you know any families currently enrolled in LHA or OLC School? ❑ Yes ❑ No
If yes, which families?

— over —

Religion Affiliation _____ Place of Worship _____

Names, ages and present schools of applicant's siblings _____

_____

_____

What are some of your child's favorite activities or interests? _____

_____

_____

Has your child had or been recommended to have any testing, therapy or early childhood intervention services? ❑ Yes ❑ No If yes, please explain: _____

_____

_____

Please share with us any special circumstances of which we should be aware (i.e. medical, familial, etc.)

_____

_____

_____

For K-8th Graders: Will you be applying for a scholarship? ❑ Yes ❑ No

For Toddler 2 Session Options: Morning Session: 8:30 -11:30am Full Day Session: 8:30 - 2:30pm
Rank in order of preference (1 being your first choice and 6 being your sixth choice) the programs you are applying for:

___ 2 mornings per week (T,Th) ___ 3 mornings per week (M,W,F) ___ 5 mornings per week

___ 2 full days per week (T,Th) ___ 3 full days per week (M,W,F) ___ 5 full days per week

_____

Signature(s) of parent(s) or guardian(s) _____

_____

_____

_____

Please return this form to the OLC School office along with a non-refundable registration fee and 2 months tuition for Toddlers-8, payable in cash, check or money order:

Registration fee: $500

National Blue Ribbon School

THE OLC SCHOOL
248 MARIN BLVD.
JERSEY CITY, NJ 07302
201.434.2405
registration@olcschool.org
olcschool.org

Middle States School Accredited

The OLC School does not discriminate on the basis of race, color, national origin, or sex in admissions & educational policies, scholarship programs, or other school administered activities.

THE OLC SCHOOL AND LITTLE HARBOR ACADEMY MEDICAL HISTORY

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Student's Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

PLEASE EXPLAIN YES ANSWERS BELOW:

1. Has your child had injuries requiring medical attention? ❑ Yes ❑ No _____

2. Has your child had special health problems or difficulty? ❑ Yes ❑ No _____

3. Is your child under a physician's care? ❑ Yes ❑ No _____

4. Takes medication? ❑ Yes ❑ No _____

Type: _____ Dose: _____ Reason: _____

5. Wears corrective lenses: ❑ Yes ❑ No ❑ Glasses ❑ Contact Lenses _____

6. Has a hearing problem: ❑ Yes ❑ No _____

7. Has had surgical operation(s): ❑ Yes ❑ No _____

8. Has been hospitalized: ❑ Yes ❑ No _____

9. Do you know of any reason why your child should not participate in all physical education activities? ❑ Yes ❑ No _____

10. Is your child subject to any condition which may create classroom emergency, such as seizure disorder, fainting spells, diabetes, allergies, asthma, etc? ❑ Yes ❑ No _____

11. Has your child ever had:

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

BEFORE WE CAN FORMALLY ACCEPT YOUR APPLICATION, DUE TO NEW JERSEY STATE REGULATIONS, YOU ARE REQUIRED TO TAKE THE APPROPRIATE VACCINATIONS FOR YOUR CHILD'S AGE.

_____

Parent/Guardian Signature DATE

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

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

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

PREVENTIVE HEALTH SCREENINGS

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

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

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

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

Section 1 - Parent

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

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

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

      Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.