MENDHAM TOWNSHIP ELEMENTARY SCHOOL
18 West Main ST.
BROOKSIDE, NJ 07926
973-543-7107/FAX: 973-543-2872
www.mendhamtwp.org

REGISTRATION/TRANSPORTATION FORM K-4/2024-2025

Please include your child's birth certificate for our files

One per student

STUDENT'S NAME____
LAST FIRST MI

GRADE ENTERING__________DATE OF BIRTH_____________________SEX___________

DOMINANT LANGUAGE SPOKEN IN THE HOME______________________________________

FULL NAME OF MOTHER OR GUARDIAN____

FULL NAME OF FATHER OR GUARDIAN ____

STREET ADDRESS____

TOWN_______________________________STATE________________ZIP_______________

MAILING ADDRESS____

TOWN_______________________________STATE________________ZIP_______________

NEAREST INTERSECTION____

HOME PHONE #____

MOTHER'S CELL/WORK #____

FATHER'S CELL/WORK#____

IF PARENT OR GUARDIAN LIVES IN A SEPARATE DWELLING/Request for separate important document copies/and or mailing YES ______ NO _______

NAME____

ADDRESS AND PHONE: ____

____

PREVIOUS SCHOOL____

PREVIOUS SCHOOL ADDRESS____

____

PREVIOUS SCHOOL PHONE NUMBER/FAX NUMBER _______________________________

I AUTHORIZE THE RELEASE OF ALL RECORDS FROM ______________________________
NAME OF SCHOOL

PARENT OR GUARDIAN SIGNATURE: ____

____

OFFICE USE ONLY;

LOCAL ID. #____

NJ SMART ID # _________________________________

Copy/Fax to Transportation: ______________________ Date: _____________

HOMEOWNER/RENTER
CERTIFICATE OF RESIDENCY

<u>PLEASE ANSWER ALL QUESTIONS</u>

I CERTIFY THAT THE INFORMATION PROVIDED BELOW IS CORRECT.

Parent/Guardian Name ____
Last   First

Address ____

Telephone _______________________

Student Name(s) and Grade(s)____

____

1. Do you reside at the above address? __________
2. Do you own or rent a home in Mendham Township? __________
3. Date moved in ____
4. Former Address ____

5. Appropriate Documents – Please submit two (2) of the following:

Mortgage Statement	Tax Bill	Gas/Electric Bill
Certificate of Occupancy	Lease	Telephone Bill
Homeowner's Insurance	Deed	Contract

6. I fully understand that I will be held responsible for the full payment of tuition in the following amounts, if the residency requirements have been found to be falsely reported:

Kindergarten	$21,291.00 ($2,129.10 per month)
Grades 1-4	$22,123.00 ($2,212.30 per month)
Grades 5-8	$23,573.00 ($2,357.30 per month)

Tuition costs are based on 2022-2023 estimated tuition calculation. These rates are subject to adjustment billings and are based on state certified tuition rates which are available 18 months after the end of the school year.

____
Parent/Guardian

Sworn and subscribed before me
This___ day of ___________ 2024/2025

NOTARY PUBLIC OF NEW JERSEY

_______________________________________   _____________________
Signature of staff member reviewing proof of residency   Date

MENDHAM TOWNSHIP ELEMENTARY SCHOOL
OFFICE OF THE PRINCIPAL
Dr. Julianne Kotcho

KINDERGARTEN STUDENTS ONLY 2024-2025 School Year

Registration is underway for the 2024-2025 school year. Prospective Kindergarten students must turn 5 on or before October 1, 2024.

Medical requirements for Kindergarten students:

1) **ES FORM #1/ Physical Exam & Child Health History-within prior year of starting the program** (*for Doctor clearance and any medical considerations/exceptions*)

2) **ES FORM #2/ Immunization Documentation** (Minimum immunizations required by the State prior to starting):

   DTap - any child entering **Pre-K** & ***Kindergarten** needs a minimum of *4 doses:
   *Kindergarten - one of the doses needs to be done on or after the 4th birthday and by the 5th birthday.
   Polio – minimum 3 doses
   Measles/Mumps/Rubella – any child > 15 mo. entering Pre-K or Kindergarten needs 2 doses live vaccine
   Varicella – 1 dose or parent verification of having Varicella disease acceptable
   Haemophilus Influenzae B (HIB) -3 doses
   Pneumococcal – 3 doses
   Influenza – 1 dose annually (between September 1 and December 31) for students<5 yrs.
   Hepatitis B - 3 doses

3) **ES FORM #3/Asthma Treatment Plan Student**

4) **ES FORM #4/Food Allergy & Anaphylaxis Emergency Care Plan**

5) **ES FORM #5/Seizure Action Plan (SAP)**

6) **Emergency Card completed with physician/medical group name**
   (Sign consent and check off if your student may or may not have Tylenol or Advil.)

7) **Physician orders for any medications to be taken in school**
   The School Nurse may not give any prescription medication without a doctor's order.

8) **Epi Pen and Inhalers** must be in the original container, labeled with the student's name and the expiration date current

If you have any questions or to deliver and discuss any of these points, please contact me. I look forward to getting to know you and your child in the year to come.

QUESTIONNAIRE FOR KINDERGARTEN PARENTS ONLY

Dear Parents,
Please take a few minutes to answer the questions below. This will help us to get to know your child better. Please refrain from any teacher requests.

Child' Name________________________________ Child's Birthday____________________________
Month Day Year

What do you want your child's materials to be labeled in school?______________________________

1. **Please list the names and ages of your child's brothers/sisters.**

   ________________________________ ___________________________

   ________________________________ ____________ _____________

2. **Has your child had preschool or play-group experience? (Please give name of school and number of years attended.)**

   ________________________________(school) __________________________(years)

3. **Does your child have any difficulties with speech?________________________________**
4. **Does your child have any health problems?______________________________________**
5. **Does your child have any food allergies?____**
6. **What time does your child go to bed?____**
7. **Can your child tie their own shoes?_____ _button clothes?_______dress self?_________**

   Recognize letters?_________know numbers to ten?__________
8. **How does your child feel about entering kindergarten?____________________________**

   ____
9. **Would you be interested in helping in the classroom?______________________________**
10. **Please list the names of a few friends attending our kindergarten program____________**

    ____
11. **If your child is a twin, triplet, etc., would you like them to be in the same class or in separate classes?**

    ____
12. **Is there any other information you feel is important?**

    ____

This will be an exciting year! We look forward to getting to know you and your child.

Thank you!
The Kindergarten Teachers

FORM M 3 (2 PAGES)

MENDHAM TOWNSHIP SCHOOLS

PHYSICAL EXAMINATION/IMMUNIZATION RECORD

Child's name (last)_________________(first)___________________B.D.__________Sex_____

Height________Weight________Date Of Examination______________________

CHECK IF THERE IS A PROBLEM/ABNORMALITY

Nose________________ Spine____________Lungs Vision Glasses
Throat___________ Chest___________ Gums/teeth_______ near______ yes______
Abdomen________ Genitals________ Glands__________ far_______ no______ Feet_________ Skin
Nutrition_______ Hearing
Blood pressure________Heart________ ___________ right______
Healthy child? Yes_______ No ______ left _______
Allergies ____
Required Daily Medications______________________________________
Special Problems/Physical Restrictions______________________________
Student may participate fully in all school programs including Physical Ed.______

IMMUNIZATIONS	DATES	IMMUNIZATIONS	DATES
*DPT 1	_______	POLIO—(OPV) OR(IPV)	
*DPT 2	_______		
*DPT 3	_______	*1__________	_______
*DPT/DTaP 4	_______	*2__________	_______
*DTP/DTaP 5	______	*3__________	_______
(on or after 4th birthday)		*4__________	_______
		(On or after 4th birthday)	
Tdap (On or after 11th birthday)	______ _		
MMR# 1 *(on or after first birthday)	______	* HIB ________	2________3_________
MMR# 2 *(on or after fourth birthday)	______		4________5________
		*Varicella	#1_________#2_________
Tuberculin Test: (Type) Mantoux____Tine____ ______ (result) __________________		* HBV #1_______#2_______ #3________	
Meningococcal ____ ____ ____ ____ (Entering Grade 6)		Pneumococcal _____ _____ ______	

____ ____ ____ ____ _____ _____ ______
Hepatitis A _____ _____
*

____
Physicians signature
See school nurse for medical or religious exemptions

FORM M 3

NAME:___________________________ (To be filled out by parent)

CHILD'S HEALTH HISTORY

PRENATAL AND BIRTH HISTORY

Problems during pregnancy____________________________Full term?____________
Length of labor________Type of delivery: normal, forceps, caesarean
Condition at birth: normal_____jaundiced _________, cyanotic_________
Birth weight_____________

***DEVELOPMENTAL HISTORY:** Please record any developmental problems (i.e. delayed speech, poorcoordination)*

___

___

***MEDICAL HISTORY:** Please check and include dates if possible.*

Communicable diseases: Chicken pox__________ Scarlet fever____________________
Measles__________________ Mumps_____________
Other Illnesses: Strep infections________, Tonsillitis________, Lyme Disease _______
Frequent colds__________, ear infections____________, other_____________________
Surgical procedures:____
____
Injuries: (i.e. fractures concussions)_______________________________________
Physical limitations: ____
Allergies: ____
Deficiencies: Vision______, Hearing________, Speech__________________________
Eyes examined by an eye specialist? __________ If so, when______________________
Wearing glasses?______________________
Date of most recent dental check-up ______________Dentist Name_________________

HEALTH HABITS: Please check any that cause parental concern:
Elimination______, Bedwetting______Diet_______________Appetite______________
Fears__________Peer relations____
Sibling rivalry___________________Temper tantrums__________________________
Sleep______________________Other____
Indicate # of hours sleep averaged per night____________________

MEDICATIONS: Does your child take daily medications?________
If so, please list: ____
I give the school nurse permission to share pertinent health information with other essential staff members when *it is necessary to assist in meeting the health and educational needs of my child.*

Signature of Parent or Guardian:____

MENDHAM TOWNSHIP ELEMENTARY SCHOOL
18 West Main Street, Brookside, N.J. 07926
Phone #: (973) 543-7107/FAX #: (973) 543-4631

CHILD'S NAME: ________________________ ________________________
Last Name *First Name*

Grade: ______ **D.O. Birth:** ________________________ **SEX:** _________

Please complete the following immunization sections. If you have any questions, please contact our school nurse, Ms. Kerri McCloskey at kmccloskey@mendhamtwp.org (A record of the immunization record can also be attached).

Dtap/DTP

AGE 1-6: (4) doses, with (1) dose given on or after 4th birthday, OR any (5) doses/AGE 7-9: Minimum (3) doses

DOSE #		DATE:
#1		
#2		
#3		
#4		
#5		

POLIO

AGE 1-6: (3) doses, with (1) dose given on or after 4th birthday, OR any (4) doses/AGE 7 or older Any (3) doses

DOSE #		DATE:
#1		
#2		
#3		
#4		

MMR (Measles/Mumps/Rubella)

Pre-School: A minimum of (1) dose of MMR vaccine by 15 months of age
Kindergarten thru 12th grades: (2) doses

DOSE #		DATE:
#1		
#2		

HAEMOPHILUS INFLUENZAE B (HIB)

AGE 2 thru 11 months: (2) doses/AGE 2 thru 59: (1) dose
Kindergarten thru Twelfth grade: Not Required

DOSE #		DATE:
#1		
#2		
#3		
#4		
#5		

HEPATITIS B (HBV)

Pre-School: Not Required/Kindergarten thru twelfth Grade (3) doses

DOSE #		DATE:
#1		
#2		
#3		

VARICELLA (Chicken Pox)

(1) dose on or after 1st birthday

DOSE #		DATE:
#1		
#2		

PNEUMOCOCCAL

AGE 2 thru 11 months: (2) doses/AGE 2 thru 59: (1) dose
Kindergarten thru Twelfth grade: Not Required

DOSE #		DATE:
#1		
#2		
#3		
#4		
#5		
#6		

INFLUENZA

(1) dose Pre-K Only ~ between 9/1-12/31

DOSE #		DATE:
#1		

* ____

Physician's Signature

***REQUIRED BY NJ STATE LAW TO ENTER KINDERGARTEN**

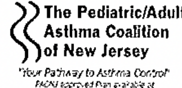
*See *school nurse for medical or religious exemptions*
kmccloskey@mendhamtwp.org

2/2/23 kr

ES FORM #3

ASTHMA TREATMENT PLAN/STUDENT

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

HEALTHY (Green Zone)

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

Continue daily control medicine(s) and ADD quick-relief medicine(s).

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to_____

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:______________

And/or Peak flow below ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ☐ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ☐ Foods:
  - ○ __________
  - ○ __________
  - ○ __________
- ☐ Other:
  - ○ __________
  - ○ __________
  - ○ __________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Disclaimers: [illegible]

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE______________________ DATE________

Physician's Orders

PARENT/GUARDIAN SIGNATURE______________________

PHYSICIAN STAMP

REVISED AUGUST 2014

Permission to reproduce blank form • www.pacnj.org

Make a copy for parent and for physician file, send original to school nurse or child care provider.

ASTHMA TREATMENT PLAN/STUDENT

Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number
2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check **"OTHER" and:**
     - ❖ **Write in asthma medications not listed on the form**
     - ❖ **Write in additional medications that will control your asthma**
     - ❖ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

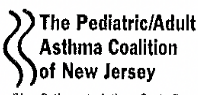
______________________	______________	__________
Parent/Guardian Signature	Phone	Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication ______________________ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ **I DO NOT** request that my child self-administer his/her asthma medication.

______________________	______________	__________
Parent/Guardian Signature	Phone	Date



The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Disclaimers: The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Sponsored by

AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

ES FORM #4

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________________ D.O.B.: ____________

Allergy to: ______________________________

Weight: __________ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

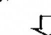
MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ____________________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____________________

Antihistamine Dose: ____________________

Other (e.g., inhaler-bronchodilator if wheezing): ____________________

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

ES FORM #5

SEIZURE ACTION PLAN (SAP)

Name: ______________________ Birth Date: __________

Address: ______________________ Phone: __________

Emergency Contact/Relationship ______________________ Phone: __________

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at __________
- ☐ Call 911 for transport to __________
- ☐ Other __________

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens __________
- ☐ Other __________

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) __________

Name of Med/Rx __________ How much to give (dose) __________

How to give __________

If seizure (cluster, # or length) __________

Name of Med/Rx __________ How much to give (dose) __________

How to give __________

If seizure (cluster, # or length) __________

Name of Med/Rx __________ How much to give (dose) __________

How to give __________

Care after seizure

What type of help is needed? (describe) ____________________

When is person able to resume usual activity? ____________________

Special instructions

First Responders: ____________________

____

Emergency Department: ____________________

____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: ____________________

Important Medical History ____________________

Allergies ____________________

Epilepsy Surgery (type, date, side effects) ____________________

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted ____________________

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) ____________________

Special Instructions: ____________________

____

Health care contacts

Epilepsy Provider: ____________________ Phone: ____________________

Primary Care: ____________________ Phone: ____________________

Preferred Hospital: ____________________ Phone: ____________________

Pharmacy: ____________________ Phone: ____________________

My signature ____________________ Date ____________________

Provider signature ____________________ Date ____________________

Epilepsy.com

©2020 Epilepsy Foundation of America, Inc.
Revised 01/2020 130SRP/PAB1216

MENDHAM TOWNSHIP SCHOOL DISTRICT EMERGENCY CARD
SCHOOL YEAR: 2024-2025

Student's Name________________ ______________________ **Grade** _______ **Homeroom**_____________

Home/Mailing Address____________________________________ **Home Phone** _____________________

With whom does the student reside? ____
Duplicate Document Copies Requested if a Parent/Guardian lives in separate dwelling YES _____ NO _____
Address: ____________ ____

Mother's Name		Father's Name	
Cell #		Cell #	
Work #		Work#	
***Email address**		***Email address**	

E-MAIL ADDRESS FOR MTES E-BLAST COMMUNICATIONS & FRIDAY FOLDER: ______________________________

May we share the above information with the H.S.A. for publication in their directory? ☐ **Yes** ☐ **No**
Would you like to receive news from the Mendham Township Education Foundation? ☐ **Yes** ☐ **No**
Please list your three primary emergency contacts in the order you wish them to be called:

NAME	RELATION TO STUDENT	PHONE

HEALTH INFORMATION
List any health concerns or allergies your child has:
____
As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (ie; conditions, allergies, and treatment regimes) to be exchanged among appropriate professional staff involved in the care of my child. This consent is intended to allow the staff to better serve my child.
Parent/Guardian Signature_____________________________________Date______________________________
If unwilling to document, but have concerns to share with the school nurse, please call.

1. **Is your child covered by Health Insurance?** ☐ **Yes,** name of insurance company______________________________
☐ **No** ____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Signature:______________________________ _**Printed Name:**_________________________**Date:**_______________
………..
PERMISSION TO ADMINISTER MEDICATION (including Tylenol/Advil)
List **all medications** that your child is currently taking:
____
____

If your child needs **Tylenol**_____ **Advil**_____ do we have your permission to administer? ☐___ Yes ___ No

Physician____Telephone______________________
Dentist____Telephone_____________________

In case of emergency, I authorize officials of Mendham Township School District to contact directly the persons named on this form and I authorize the named physicians to render such treatment as deemed necessary. In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I understand that the school officials will first attempt to notify me at the above numbers.

PARENT/GUARDIAN SIGNATURE_____________________________________**DATE**_________________________

NJ SMART DATA

STUDENT NAME: ________________________________DATE _____________

All information should correspond to child's birth certificate or other legal documentation

DATA ELEMENT	EXPLANATION
Last Name	
First Name	
Middle Name	
Generation Suffix – if any	
Gender	
Date of Birth	
City of Birth	
State of Birth	
Country of Birth	
City of Residence	
Ethnicity * Please circle either Yes or No "Yes" = Hispanic or Latino "No" = Not Hispanic or Latino	"Yes" "No"
Race * Please circle either Yes or No Note: More than one race category may be reported	
American Indian or Alaskan Native	"Yes" "No"
Asian	"Yes" "No"
Black	"Yes" "No"
Pacific	"Yes" "No"
White	"Yes" "No"
Health Insurance	"Yes" "No"
Health Insurance Provider – name	
Date of last medical exam	
Date of last lead test	
Lead level (Range of values: 2 – 100.00)	
Date of first polio immunization	

* The categories reflect the revised Standards for the Classification of Federal Data on Race and Ethnicity by the US Office of Management and Budget – Statistical Policy Directive No. 15 (1997)

CONSENT FOR PUBLICITY FORM
SCHOOL YEAR: 2024-2025

Dear Parent/Guardian:

Each school year, with the permission of parents and guardians, the school district celebrates the accomplishments of students and staff by publishing the names, photographs, videos and schoolwork of students. This is done using the district and individual school websites and by permitting students to be interviewed and photographed (by both still and video photographers) by representatives of various media, including newspapers, magazines and other written publications, websites, blogs, local and national TV stations, and motion picture productions.

Concerning website postings, the State of New Jersey requires us to provide you with the following information:

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child. Pursuant to law, the district will not release any personally identifiable information without prior written consent from you as parent or guardian.

The purpose of this form is for you to grant or deny the district permission to use your child's name, image (whether in a photograph or video) or school work for the above purposes. If a child is on a team or in a club, it is very likely that his/her photo or name will be in the media since school events are often covered by the press. ***Please fill out the form below and return it to your child's homeroom teacher.***

☐ **I WILL PERMIT** my child to be interviewed, to have his/her name, photo and/or school work, in print, on video, on TV, in motion pictures, or on district and/or school websites for publicity purposes.

☐ **I WILL NOT PERMIT** my child to be interviewed, to have his/her name, photo and/or school work, in print, on video, on TV, in motion pictures, or on district and/or school websites for publicity purposes.

Student Name: ____

Parent/Guardian: ____

Signature of Parent/Guardian:____________________________ Date: __________________

Relationship to Student: ____

School: ___________________________ Grade:__________

Homeroom: ______________________ Homeroom Teacher: ________________

Mendham Township Elementary School
Acceptable Use Policy- 2024-2025 School Year

Mendham Township Elementary School would like to utilize our computer lab, our networked environment and Internet capabilities as effective learning tools in order to achieve our academic goals in a safe and controlled environment. This policy has been reviewed in your child's computer class. We are asking all parents to discuss the following rules with their children. Please return this signed agreement to your child's classroom teacher.

I will get permission from an adult…
- before I start to use any computer equipment
- before I print anything
- before I view or conduct any google or other internet search

I will tell an adult immediately if…
- I see someone using a computer incorrectly
- I have a problem with a computer
- I see something on the computer that I think is wrong or makes me feel uncomfortable.

I will only use the computer to print or copy something if I have permission from the person who wrote it. I will never give out my last name, address or phone number to anyone on the Internet. I promise to follow these computer rules. I understand that if I break the computer rules, I will lose computer privileges for a period of time. I have discussed these rules with my parents.

Family name (please print clearly) ___________________________

Teacher: ___________________________________

Student's Name _______________________________________

Parent's Signature____

Date:_______________________ **School Year AND grade level**_________________

CHROMEBOOK ACCEPTABLE USE POLICY

MENDHAM TOWNSHIP ELEMENTARY SCHOOL

All students Grades 2-4 of Mendham Township Elementary School will be issued Google Chromebooks for use in school. This document provides students and their parents/guardians with information about taking care of the equipment, using it to complete assignments, and being a good digital citizen.

Students and their parents/guardians are reminded that use of technology is a privilege and not a right and that everything done on any device, network, or electronic communications device may be monitored by the school authorities. Inappropriate use of the technology can result in limited or banned computer use, disciplinary consequences, removal from school, receiving a failing grade, and/or legal action.

Students and their parents/guardians are responsible for reviewing/signing the Chromebook Acceptable Use Policy and returning it to their classroom teacher prior to use.

OWNERSHIP of the CHROMEBOOK:

Mendham Township Elementary School retains sole right of possession of the Chromebook. MTES administration and faculty retain the right to collect and/or inspect Chromebooks at any time.

TRAINING:

Students will be trained on how to use the Chromebook by their technology teacher and classroom teacher.

RESPONSIBILITY for the CHROMEBOOK:

1. Students are solely responsible for the Chromebooks issued to them.
2. Must comply with the Chromebook Acceptable Use Policy and all policies of the school when using their Chromebook.
3. Must treat their device with care and never leave it unattended.
4. Must promptly report any problems with their Chromebook to the teacher leading the lesson.
5. May not remove or interfere with the serial number or other identification.
6. May not attempt to remove or change the physical structure of the Chromebook, including the keys, screen cover or casing.
7. May not attempt to install or run any operating system on the Chromebook other than the ChromeOS operating system supported by the school.
8. Must keep their device clean and must not touch the screen with anything (e.g., your finger, pen, pencil, etc.) other than approved computer screen cleaners.
9. No food or drink is allowed next to your Chromebook while the screen is open.
10. Chromebooks should be shut down when not in use to conserve battery life.
11. Chromebooks should never be shoved into a locker or wedged into a book bag or desk as this may break the screen. 12. Do not expose your Chromebook to extreme temperatures or direct sunlight for extended periods of time.

Student's Initials______ **Parent/Guardian Initials _____**

RESPONSIBILITY for ELECTRONIC DATA:
Users of school technology have no rights, ownership, or expectations of privacy to any data this is, or was, stored on the Chromebook, school network, or any school-issued applications and are given no guarantees that data will be retained or destroyed.

COPYRIGHT and FILE SHARING:
Students are required to follow all copyright laws around all media including text, images, programs, music, and video. Downloading, sharing, and posting online illegally obtained media is against the Acceptable Use Policy.

MANAGING YOUR FILES and SAVING YOUR WORK:
Students may save documents to their Google Drive which will make the files accessible from any computer with Internet access. Students using Google Drive to work on their documents will not need to save their work, as Drive will save each keystroke as the work is being completed. Students will be trained on proper file management procedures.

SPARE EQUIPMENT and LENDING:
If a student's Chromebook is inoperable, the school has a limited number of spare devices for use while the student's Chromebook is repaired or replaced. This agreement remains in effect for loaner Chromebooks. Loss of privileges and/or disciplinary action may result for failure to turn in the Chromebook.

ORIGINALLY INSTALLED SOFTWARE:
Chromebook software is delivered via the Chrome Web Store. These are web-based applications that do not require installation space on a hard drive. Some applications, such as Google Drive, are available for offline use. The software originally installed on the Chromebook must remain on the Chromebook in usable condition and easily accessible at all times. From time to time, the school may add software applications for use in a particular area of study. This process will be automatic with virtually no impact on students. Applications that are no longer needed will automatically be removed by the school. Students are not permitted to add apps or extensions to their Chromebooks and are blocked from this type of function. A list of applications currently being used on the chrome books are available on the 4th Grade Teachers' Home Webpage.

INSPECTION:
Students may be selected at random to provide their Chromebook for inspection. The purpose for inspection will be to check for proper care, maintenance and inappropriate use.

DIGITAL CITIZENSHIP:
Students must follow the six conditions of begin a good digital citizen:

1. **RESPECT YOURSELF** I will show respect for myself through my actions. I will select online names that are appropriate. I will consider the personal information and images that I post online. I will NOT be inappropriate. I will not visit sites that are inappropriate.
2. **PROTECT YOURSELF** I will ensure that the information, images, and materials I post online will not put me at risk. I will not publish my personal details, contact details, or schedule of my activities. I will report any inappropriate behavior directed at me. I will protect passwords, accounts, and resources.
3. **RESPECT OTHERS** I will show respect to others. I will not use electronic mediums to antagonize, bully, harass, or bother other people. I will show respect for other people in my choice of websites.

4. **PROTECT OTHERS** I will protect others by reporting abuse, not forwarding inappropriate materials or communications; I will moderate unacceptable materials and conversations.
5. **RESPECT INTELLECTUAL PROPERTY** I will request permission to use resources. I will cite any and all use of websites, books, media, etc. I will acknowledge all primary sources. I will validate information.
6. **PROTECT INTELLECTUAL PROPERTY** I will request to use the software and media others produce. I will use free and open source alternatives rather than pirating software. I will act with integrity.

CONSEQUENCES FOR VIOLATIONS OF THE STUDENT CHROMEBOOK ACCEPTABLE USE POLICY

1. Violations of these policies may result in one of the following but not limited to these disciplinary actions:
   - Restitution (money paid in compensation for theft, loss, or damage
   - Student/Parent Conference with school administrator/principal or other school official
   - Removal of unauthorized files and folders
   - Restriction of Internet and Chromebook privileges*
   - Detention, suspension, alternative school placement or expulsion
   - Police referral

2. If a violation of the Student Chromebook Acceptable Use Policy violates other rules of the MTES Student Code of Conduct, consequences appropriate for violation of those rules may also be imposed.

*If a student's Internet privileges are restricted, this means that for the period of the restriction, the student may only access the Google Drive offline and will not be permitted to access the Internet without strict teacher supervision.

Student's Initials: _______ **Parent/Guardian Initials: ______**

CHROMEBOOK ACCEPTABLE USE POLICY SIGNATURE FORM

By signing below, the student and their parent/guardian understand, accept, and agree to follow:

1. Chromebook Acceptable Use Policy
2. Website and Social Media Guidelines (Below)
3. The Chromebook and software is owned by Mendham Township Elementary School

WEBSITE and SOCIAL MEDIA GUIDELINES:

THINK before you act because your virtual actions are real and **permanent**!

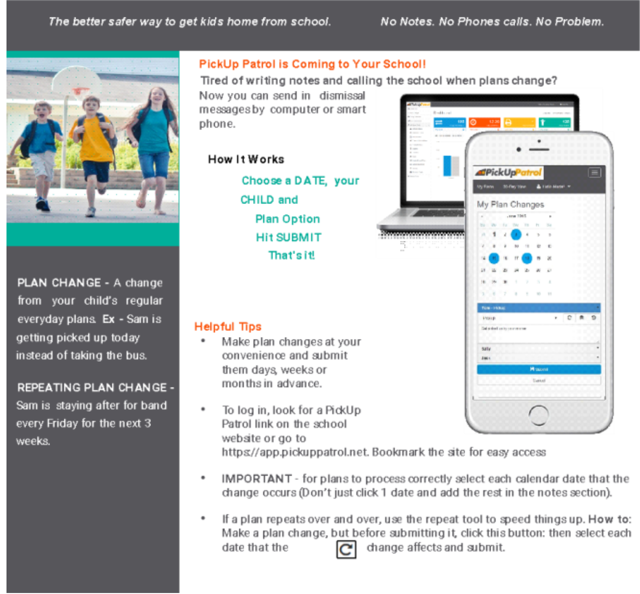
GUIDELINES	**Student Initials**	**Parent Initials**
Be aware of what you post online. Website and social media venues are very public. What you contribute leaves a digital footprint for all to see. Do not post anything you wouldn't want friends, parents, teachers, future colleges, or employers to see.		
Follow the school's code of conduct when writing online. It is acceptable to disagree with other's opinions; however, do it in a respectful way. Make sure that criticism is constructive and not hurtful. What is inappropriate in the classroom is inappropriate online.		
Be safe online. Never give out personal information, including, but not limited to, last names, phone numbers, addresses, exact birthdates, and pictures. Do not share your password with anyone besides your teachers and parents.		
Do your own work! Do not use other people's intellectual property without their permission. Be aware that it is a violation of copyright law to copy and paste other's thoughts. It is good practice to hyperlink to your sources.		
Be aware that pictures may also be protected under copyright laws. Verify that you have permission to use the image or that it is under Creative Commons attribution.		
How you represent yourself online is an extension of yourself. Do not misrepresent yourself by using someone else's identify.		
Online work should be well written. Follow writing conventions including proper grammar, capitalization, and punctuation.		
If you run across inappropriate material that makes you feel uncomfortable or is not respectful, tell your teacher right away.		

PRINT STUDENT NAME: ____

SIGNATURE: ____ DATE: ______________________

PRINT PARENT/GUARDIAN NAME: ____

SIGNATURE: ____ DATE: ______________________



We utilize the Pick Up Patrol Program for all student after school pick-ups and after school programs

****PLEASE CHECK OUT THE PICK UP PATROL WEB-SITE FOR FURTHER INFORMATION:**

https://www.pickuppatrol.net/Default

Mendham Township Elementary School

18 West Main Street, Brookside, N.J. 07926

Attendance Procedures & Potentially Missing Children

(5113)

The Mendham Township Elementary School remains committed to ensuring the safety of each and every one of our students. The following outline represents the procedures that parents, students, teachers, and office staff should utilize in order to expediently detect and report "potentially missing children":

1. **Parents**: If for any reason a student is going to be absent from school, it is critical to contact the Elementary School office at any time of day or night before 9:15 AM on the day of the absence.

2. **Office / School Staff:** Flag Salute/daily announcements commence at 9:00 AM.

3. **Teachers:** Prior to daily announcements, homeroom teachers utilize a "structured roll call procedure" to take attendance. Enter an 'X' (absent) next to every absentee student. Once a student's status is officially entered onto the attendance sheet during roll call, it should not be changed – the office staff will rectify discrepancies via the student tardy sign-in sheet.

4. **Teachers:** Tardy students must have a pass signed by the office staff. If the student does not have a pass the office should be contacted to confirm the late arrival.

5. **Teachers / Office Staff:** OnCourse Attendance needs to be taken ASAP but no later than 9:15 AM.

6. **Office Staff:** Account for all absences. If a student is absent and the parent or guardian has not notified the office, all emergency contact numbers must be utilized to locate the student. If the student cannot be located by 9:30 AM, contact the Mendham Township Police Department and request a "locator check" (no later than 10 AM).

7. **Teachers / Office Staff:** Office will provide Daily Attendance Report to all instructional staff no later than 9:45 AM.

8. **Teachers:** Take attendance at beginning of every period – notify office of discrepancies.

9. **Office Staff:** Immediately upon securing update from MTPD, inform Superintendent via email copied to principal. Detail event in Administrators Plus and include "welfare check report" in Superintendent's monthly report.

MENDHAM TOWNSHIP ELEMENTARY SCHOOL

OFFICE OF THE PRINCIPAL

PICK UP/DROP OFF PROCEDURE

Dear Parents,

As we begin a new school year, I would like to notify those of you who are new to the district and remind our 'veteran' parents of the arriving and departing procedure in order to ensure the safety of our children. To make this process safe, orderly and efficient, I respectfully request that you carefully follow the established procedure detailed below. It is imperative that the traffic flow in each instance of morning arrival and afternoon departure is precisely adhered to.

All morning arrivals and afternoon departures by car will take place at the rear of the building. You should be aware ***that supervision is unavailable prior to 8:45 a.m.*** Therefore, it is essential that you drop off your child at or after this time. Once on the property, please proceed along the drive and bear to the right, both as you approach the circle and upon reaching the side parking lot. The line will proceed around the perimeter of the side lot, along the soccer field, and approach the entrance to the new gym.

In order to ensure that the car line moves along smoothly we kindly request, upon arriving and departing, that you remain in your vehicle throughout the process. The staff member on duty will assist your child with entering your vehicle. To support us with expediting this procedure we would greatly appreciate you placing a placard clearly identifying your last name on the passenger side window when picking up so that your child (ren) can be called quickly from the gymnasium.

With your assistance, I'm sure we will make this procedure as safe and efficient as possible. I thank you in advance for your anticipated cooperation and look forward to working with you as the year progresses.

18 WEST MAIN ST. – BROOKSIDE, N.J. 07926
PHONE: 973-543-7107/ FAX: 973-543-2872