# Wyckoff School District

WYCKOFF, NEW JERSEY

## DEVELOPMENTAL HISTORY

Date _____

The purpose of this form is to help us learn more about your child. Please feel free to provide us with as much information as you wish.

Name of Child _____ Birth Date _____

Other schools attended:

| School | Address | Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Other Children in Home:

| Name | Birth Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Others in home besides parents and children: _____

_____

By what name is your child called at home: _____

Has your child attended nursery school? _____ If so, how long? _____

How often? _____

Has your child had experience in any other kind of structured group? _____

If so, explain. _____

_____

Has your child taken private or group lessons? _____

If so, explain. _____

_____

Does your child have the opportunity to play with other children regularly?

_____

_____

How much experience has your child had in going on trips or outings?

_____

_____

_____

What is the primary language spoken in your home? _____

Is your child fluent in any language other than English? _____

If parents are divorced, who has custody? _____

Please note any outstanding experiences which have influenced or affected your child:

Is there any other important information about your child which you feel the school personnel should know?

Please use the space below for additional information or comments.

_____

Parent's Signature

**Wyckoff School District**
Wyckoff, New Jersey

# HEALTH HISTORY

Name of Child _____ Birthdate _____

My child ☐ **does** ☐ **does not** have health insurance.

Health Insurance Provider: _____
(Optional)

_____ Date of last lead test

_____ Lead level test result

_____ Date of first polio immunization

Please *check box* if your child has a history of any of the following. Please explain in the space provided any item you have circled.

**Explanation**

**Accidents/Injuries**
Surgeries/Hospitalizations

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**Allergies**
- ☐ Foods
- ☐ Drugs
- ☐ Animals
- ☐ Environment
- ☐ Required use of EpiPen or any other medication

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**Respiratory**
- ☐ Asthma/Reactive Airway Disease
- ☐ Hayfever
- ☐ Croup
- ☐ Bronchitis/Pneumonia
- ☐ Required use of oral medicine/inhalers/nebulizer

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**Bones/Joint Diseases**
- ☐ Fractures/Dislocations
- ☐ Arthritis
- ☐ Lyme Disease
- ☐ Stitches
- ☐ Scoliosis

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**Cardiac**
- ☐ Rheumatic Fever
- ☐ Murmurs
- ☐ Surgery
- ☐ High Cholesterol/High Blood Pressure

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**Chicken-pox Disease or Immunization**
- ☐ If yes, specify which and give date.

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**Dental Appliances**
- ☐ Braces
- ☐ Palate Expanders
- ☐ Caps

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**Dermatology**
- ☐ Birthmarks/ scars
- ☐ Eczema/Psoriasis

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**Diabetes**
- ☐ Insulin
- ☐ Diet

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**Explanation**

**Ear/Nose/Throat**

- ☐ Ear Infections/ Tubes
- ☐ Hearing Loss/Hearing Aids
- ☐ Frequent Strep Throat
- ☐ Tonsillitis
- ☐ Sinusitis

**Gastrointestinal Conditions**

- ☐ Frequent Vomiting
- ☐ Diarrhea/Constipation
- ☐ Eating Problems

**Kidney or Liver Disease**

- ☐ Urinary Tract Infections
- ☐ Hepatitis Vaccine

**Neurological**

- ☐ Concussions
- ☐ Headaches/Migraines
- ☐ Seizures

**Speech**

- ☐ Delayed Speech
- ☐ Stuttering or Difficulty With Certain Sounds

**Vision**

- ☐ Crossing or Wandering of Eyes
- ☐ Color Blindness
- ☐ Glasses/Contacts

**Birth History**

- ☐ Premature
- ☐ Difficulties at birth

**Behaviors Medically Diagnosed**

- ☐ Impulsiveness
- ☐ Inattention
- ☐ Hyperactivity

Does your child take any daily medication including vitamins or herbs?

Does your child have any other physical conditions not covered above?

Is there any other medical information which you feel will help the school nurse and your child's teacher understand your child?

**MEDICAL/PHYSICAL INFORMATION**

Doctor's Name _____ Telephone # _____

In a medical emergency we hereby authorize the school district to seek emergency medical assistance for our child when we cannot be reached.

| Parent/Guardian Name **(Please Print)** | Signature | Date |
|---|---|---|
| Parent/Guardian Name **(Please Print)** | Signature | Date |

**Wyckoff School District**

Wyckoff, New Jersey

# HOME LANGUAGE SURVEY

Dear Parents or Guardians:

In order to comply with New Jersey State Law, we are required to survey new students as to language use background, so that student help in this regard can be provided if necessary. We would appreciate you completing the form below and returning it to your child's school office.
Thank you.

Student's Name _____

School _____

Grade _____ Teacher _____

What language or languages are spoken in your home?

_____

2. What was your child's first spoken language?

_____

3. If English was not your child's first spoken language, at what age was your child first exposed to English?

_____

4. What language does your child use most often:

a. When speaking to you?_____

b. When speaking to brothers, sisters and friends? _____

c. When speaking to other adults in the home (grandparents, aunts, uncles)?

_____

_____ _____

Signature of Parent or Guardian Date Completed

**Wyckoff School District**
Wyckoff, New Jersey

IV

# VISION FORM

Dear Parents/ Guardians:

Good vision is essential to success in school. Therefore, the Board of Education requests that all preschool children have an eye examination before entering school in the fall.

Upon completion of the eye examination by your primary care provider or eye specialist, please have the examiner indicate his/her findings and recommendations on the form below. Please return the form to the school nurse at your earliest convenience.

Richard Kuder
Superintendent

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I have given _____ _____
(First Name) (Last Name)

a complete eye examination with the following diagnosis and recommendations:

| | Distance | Near | Distance | Near |
|---|---|---|---|---|
| Vision Without Correction | 0.D. _____ | _____ | 0.S. _____ | _____ |
| Vision With Correction | 0.D. _____ | _____ | 0.S. _____ | _____ |

Muscle Balance Color Test _____

Fusion-Depth Dominant Eye _____

Eye Disease or Defects _____

Recommendations _____

_____

Signature _____ Date: _____

# Wyckoff School District

Wyckoff, New Jersey

# SCHOOL AND ATHLETIC EXAMINATION FORM

_____ _____ _____ _____/_____/_____

Last Name First Name Address Date of Birth

_____ _____

Parent's Name Phone

DATE OF PHYSICAL EXAM _____/_____/_____

FINDINGS:

Ht _____ Wt _____ BP _____

Eyes _____ R20/ _____ L20/ _____; Ears _____ Hearing R _____ L _____

Respiratory _____

Cardiovascular _____

Abdomen _____ Genitalia _____

Musculoskeletal _____ Scoliosis Exam _____ Skin _____

Neurological _____

LABORATORY: Urinalysis _____ HGB/HT _____ Other/Lead Level _____

## RECOMMENDATIONS

| | YES | NO |
|---|---|---|
| 1. Any defect of vision, hearing or speech that the school could compensate for by property seating, etc? ..... | | |
| 2. Any conditions limiting * Classroom activity? * Physical education?..... | ☐ | ☐ |
| 3. Any significant allergies?..... | | |
| 4. Any condition which may result in a classroom emergency? | ☐ | ☐ |
| 5. Any emotional, mental or physical condition requiring periodic medical observation?..... | ☐ | ☐ |
| | ☐ | ☐ |

## COMMENTS:

## IMMUNIZATIONS

(Insert dates)

| | | |
|---|---|---|
| _____ DPT | _____ DPT | _____ DPT |
| _____ DPT | _____ DPT | _____ DPT |
| _____ TET | _____ TET | |
| _____ OPV | _____ OPV | _____ OPV |

MMR (1) ____/____/____ (2) ____/____/____

MEASLES (LIVE) (1) ____/____/____ (2) ____/____/____

RUBELLA ____/____/____

MUMPS ____/____/____

| | | |
|---|---|---|
| _____ Hep B | _____ Help B | _____ Hep B |

VARNAX ____/____/____ (2) ____/____/____

_____ _____

MANTOUX/DATE RESULTS

Phone _____

Physician Signature & Stamp (Required) _____ Date _____/_____/_____

**Wyckoff School District**

Wyckoff, New Jersey

**RECEIPT OF POLICY**

I,_____

(Parent Name)

certify that I have received a copy of the Wyckoff Board of Education policy as it relates to residency in the district. I understand that this policy comes directly from the statutes that govern the State of New Jersey.

_____ _____

Parent Signature Date