Madrasatu Ahlis Sunnah

2026 – 2027

Enrollment/ Registration Portfolio

215 No. Oraton Parkway
East Orange, NJ 07017
Phone #: 973-672-4124

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

PLEASE RETURN APPLICATION WITH ALL OF THE FOLLOWING DOCUMENTS

Student's Name: _____ D.O.B. ___/____/_____ Age _____

Enrollment Date: ___/____/_____ Grade _____

Previously Enrolled at Madrasatu Ahlis Sunnah? ☐ Yes (if yes, which year) ☐ No

Has your child traveled in the last month? ☐ Yes ☐ No

Has anyone in the household traveled in the last month? ☐ Yes ☐ No

Does your child receive any of these Educational Services? ☐ Title I ☐ Comp Ed. ☐Speech

Does your child have an IEP? ☐ Yes ☐ No

Does your child have any behavior issues? ☐ Yes ☐ No

If yes, please explain: _____

PLEASE RETURN APPLICATION WITH ALL OF THE FOLLOWING DOCUMENTS

_____ One (1) Completed application for each child

_____ Transfer Records from previous school (if applicable)

_____ IEP (if applicable)

_____ Birth Certificate

_____ Annual Physical examination (for each child)

_____ Current Immunization Records or Letter of Religious Exemption

_____ Proof of Hepatitis B vaccine (Grades 6th – 12th)

_____ Mandatory Mantoux test results for all incoming students

The following forms are found in this Application Packet, and all must be COMPLETED AND SIGNED

_____ Tuition Payment Worksheet (please calculate fees before submitting)

_____ Authorization to Pick Up Form

_____ Transfer Request Form

_____ Allergy Alert Form (if applicable)

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Dear Parents and Incoming Students,

As this is the beginning of a new school year, we are all excited about having an opportunity to strive together toward our goals. First and foremost, we are striving to please our Lord, the Exalted, and secondly, we want to continue striving toward scholastic excellence.

A former valedictorian, Abraham Evans-EL, who was awarded a full scholarship to MIT for his academic excellence, serves to remind us how we have to "stay focused". He cautioned us that most of the students at the prestigious MIT "wake up" in September; they get excited about learning, are very studious and hardworking, and they only begin to relax in June.

If we want to benefit from this reminder, we will realize that being focused and alert are essential components of the learning process. Our beloved Prophet Muhammad, ṣallā llāhu ʿalayhi wa-sallam, was given the command, "*Iqra*". And to achieve great things in life, we have to read! We have to ask questions! We must study! We have to "wake up" and work hard all year long.

With this in mind, we pray parents and students get excited about education this school year. We encourage parents to sit with their children when they do their homework. Let them know that you are as excited about the learning process as they are. Ask them questions about their homework so that they can build greater confidence when answering questions in the classroom. Encourage them to think "outside of the box", by practicing critical thinking techniques with them. Contribute to their educational process by being actively involved at school, communicating with their teachers on a regular. The parts of our institution are only as good as the whole. It really takes a village.

Let us establish a partnership that will bring about success for our children. Administratively, we intend to handle those things that help to bring about a better institution (i.e. qualified teachers, administrators, trained staff, and an enriched curriculum). If you do your part and send us a student who is focused, cooperative, prepared, and eager to learn, we will have a formula for success.

Come on and let's get excited about the new school year. Let's get excited about growing the next generation of leaders into young men and women who will rule the world. Let's get excited about nurturing scholars and professors and doctors and scientists. Let's get excited about building a model of excellence as an Islamic institution that is recognized across the country. Get "on board – wake up" and help make this vision a reality, in shaa Allah.

Jzaakumu Allaahu Khairun

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Admissions 2026-2027

Non-Discrimination Policy

Madrasatu Ahlis Sunnah admits students of any race, color, national and ethnic origin to all rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate based on race, color, national and ethnic origin in the administration of its educational policies, admissions policies, scholarship programs, athletics, and other school-administered programs.

Age Requirements for Pre-School, Pre-K, KG

- For admission to Pre-School, your child must be 2 ½ years old by October 1st, 2026 and "potty-trained". (Note: student must reach 4 years of age following Pre-School to be eligible for Pre-Kindergarten).
- For admission to Pre-Kindergarten, your child must be 4 years old by October 1st, 2026.
- For admission to KG, your child must be 5 years old by October 1st, 2026.

Admission Process

- Visit our website: **thesunnah.org/school**.
- Apply and submit the application online.

Then come into the Main Office to pick up your Welcome Packet.

If your child is accepted and seats are available, you will be notified and required to submit the following within two weeks of notification.

1. Copy of Birth Certificate
2. Complete Immunization Record
3. Release of Records Form (for Grades 1st to 12th only)
4. Annual Physical Report (Please use the Universal Child Health Record Form provided in this packet)

Note:

1. Madrasatu Ahlis Sunnah uses email as the official means of communication to parents/guardians.

2. Any policy that the school adopts, anytime thereafter, will be considered as accepted after ten business days or providing amendments to parents/guardian. Any objections are to be posed before the end of the ten days. Should parents/guardians choose not to accept the policy or object to the amendments for any reason, Madrasatu Ahlis Sunnah reserves the right to prohibit the student from attending the school until the parent/guardian withdraws the student or accepts the school policy in writing.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Hours of School Day 2026-2027

07:00 – 08:00 a.m.....Before Care

08:15 a.m. .....1st Period Starts

03:15 p.m. .....School Dismissal

03:30 p.m. – 5:30 p.m. .....Aftercare

Late Policy

Madrasatu Ahlis Sunnah's Policy requires attendance at school for all days and hours that school is in session. Students who are not in their homeroom by 8:15 am or who arrive after that time are late for school and MUST be marked late by the homeroom teacher in Gradelink.

Any student who arrives after 8:15 a.m. will be marked late for class by their teacher.

- Arrangements must be made 24 hours in advance through the Main Office for appointments such as medical, dental, or court appearances.
- Three (3) incidents of unexcused late arrival are considered one (1) unexcused absence.

Absence Policy

Excessive absences are the total absences for any reason from school, eighteen (18) days in a full-year course or nine (9) days in a half-year course.

Those students who are excessively absent will receive no credit for the course in which they are absent.

Afterschool Detention Policy

Grades 7th – 12th students will serve detention after school hours.

Please consult the Parent/Student Manual for more information.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

School Dress Code 2026-2027

THE DRESS CODE WILL BE STRICTLY ENFORCED. IF STUDENTS DON'T COMPLY, THEY WILL NOT BE PERMITTED TO ATTEND SCHOOL.

Kindergarten & 1st through 12th Grade

Brothers

- White, or black thoub (*clean and ironed*)
- Black or white pants hemmed above the ankle (No Jeans or sweatpants).

Sisters

- Black closed front over-garment
- White or Black khimar (**If an under-scarf is worn, it must be black or white**)

Footwear: Students are required to wear black shoes.

Gym Uniform (To be worn only during Gym Days)

- Black sweatpants above the ankle, with clean and laced sneakers
- White T-shirt
- A white, or black thoub must be worn over the gym uniform on gym days!

Gym Uniform (Only to be worn during gym days)

- Black sweatpants with clean and laced sneakers
- White T-shirt.
- **All sisters must wear overgarment on gym days!**

Sneakers are NOT to be worn to or in school. Students are to bring sneakers ONLY ON GYM DAYS

General Uniform Restrictions

Brothers

- You must wear a clean and ironed thoub.
- All pants must be **hemmed above the ankles. No cuffed or rolled-up pants permitted. If a student comes to school with cuffed or rolled-up pants, the parents will either have to bring the approved uniform pants, or the child will be sent home.**
- All footwears must be laced and tied completely
- No Qaza' haircuts (Qaza' is to have some hair shaved and some not, e.g., a tight fade)
- **No braids, twists, dreadlocks or knotty hairstyles**
- No jewelry, except one ring, can be worn
- During cold weather months, brothers will only be permitted to wear a black sweater over their thoub.

Sisters

- **Sisters are to wear completely closed over-garment at all times**
- No shoes are to be worn that make noise when a sister walks in them (e.g., high heels or clogs). Shoes are to be black and completely tied and laced
- Any sister who wears a niqab to school must wear it all day. Sisters are not allowed to remove their Niqab when walking in the halls
- Open display of jewelry will not be permitted
- During the cold weather months, sisters will only be permitted to wear loose-fitting, black over their over-garments.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Tuition Policy 2026-2027

We intend to make sure that Madrasatu Ahlis Sunnah is fiscally sound and can continue to serve our community and offer the best academic and Islamic education to our children. We appreciate your cooperation and continuous support of the school.

Tuition must be paid by the third of each month. Students' records will not be released until all financial obligations have been met. To preserve the best interests of our students and Madrasatu Ahlis Sunnah as an institution, student registration for the 2025-2026 school year should be considered a commitment to pay for the entire year.

FINANCIAL AID: Parents requesting financial assistance must contact the county office for NJ Cares for Kids (NJCK). NJCK provides subsidized childcare vouchers for working families who meet the guidelines mandated by the state of New Jersey. If you qualify then this childcare subsidy through the NJCK Program will assist you to pay for childcare for toddlers, preschool-aged children and school-age children up to age thirteen (13). Please contact the agency within your specific county for more information (see last page for list of county agencies).

TUITION PAYMENT POLICY

THIS POLICY APPLIES TO ALL PARENTS, **INCLUDING** PROGRAMS FOR PARENTS FAMILIES WHO HAVE CO-PAYMENTS

- All tuition/co-payments are due by the 3rd of each month.
- On the 5th a phone call will be made as a reminder.
- By the 8th of each month, a letter will be sent to accounts who have not paid.
- If a child withdraws and the account is not current, no school records, report cards, and/or transcripts will be issued until the account is made current.

I have read the Madrasatu Ahlis Sunnah Tuition Policy above and understand and agree to it in its entirety

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Tuition and Other Fees: 2026-2027

Tuition is annual per school year and can be paid in full at any time.

Tuition Rates/ Applicable Fees

- **Registration Fee:** $30
- **Books Fee:** $100
- **MAP Growth:** $50 (Grades 1st–11th only)
- **Trips Fee:** $100
- **Extended/Aftercare:** $100 per month/per child (K–6th only) – Due on the first business day of every month.

Monthly Tuition Schedule (1st–12th Grade)

Student Count	Sept – June (MonthPortfolioPortfolioly)	Total Annual
One Child	$600.00	$6,000.00
Two Children	$1,200.00	$12,000.00
Three Children	$1,800.00	$18,000.00
Four Children	FREE	FREE

Monthly Tuition Schedule (Early Childhood: PS, Pre-K, K)

Student Count	Sept – June (Monthly)	Total Annual
One Child	$800.00	$8,000.00
Two Children	$1,600.00	$16,000.00
Three Children	$2,400.00	$24,000.00
Four Children	FREE	FREE

Terms and Conditions

All tuition payments are due on the 1st of every month. A thirty (30) day notice is required for all student withdrawals. Transfers, school records, etc. will not be provided to parents who have tuition in arrears. NO EXCEPTIONS. Students of parents whose accounts are found delinquent are subject to dismissal from Madrasatu Ahlis Sunnah until such accounts are made current.

I have read the terms & conditions above and understand and agree to it in entirety.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Tuition Payment 2026-2027

Parent's / Guardian's Name_____ Phone# _____

Programs for Parents? ☐ Yes ☐ No

Pre-School / Pre-Kindergarten / Kindergarten = **$800/mo.**
First Grade Through twelfth grade = **$600/month.**

	Child (ren)'s Name(s)	Grade	Age	Monthly Tuition
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Total Registration Cost $ _____ Paid _____

Total Monthly Tuition Cost $ _____ Paid _____

Before & Aftercare **($100)** per Child $ _____ Paid _____
Before care (7:00 a.m. – 8:00 a.m.)
After care (3:30 p.m. – 5:30 p.m.)

VERY IMPORTANT

☐ I will not require aftercare services, and I am aware that my child is to be picked up immediately after dismissal. Non-compliance (15 minutes after dismissal) will result in a $5.00/child daily aftercare fee, payable when picking the child(ren) up.

Initial Payment Due **$** _____
(Due to Registration)

Monthly Payment **$** _____

I agree with the above terms of this payment arrangement.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Records Request 2026-2027

To the Parent or Guardian:

To assist in the prompt and efficient transfer of your child's school records, if you haven't already provided the records, please complete the form below, sign where indicated, and return this form along with your completed application.

First Middle Last

Student's Full Name: _____ Grade: ___

Name of Previous School: _____

Address of Previous School: _____

Previous School Phone: _____

Parent Authorization & Signature

I give my permission for the transfer of my child's school records to Madrasatu Ahlis Sunnah.

The records should include copies of the following:

_____ IEP

_____ Current transcript / permanent school records

_____ Transcript of grades or evaluations for previous years

_____ Results / scores of all standardized tests

_____ Health records including current immunization records

_____ Behavior / discipline records

_____ Other information maintained in the student's permanent record.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Authorization to Pick Up 2026-2027

Student's Name: _____

Age: _____ Grade: _____ Date of Birth: _____/_____/_____

PARENT INFO

Home Phone #: _____

Father's Cellphone #: _____ Work Phone #: _____

Mother's Cellphone #: _____ Work Phone #: _____

AUTHORIZATION TO PICK UP CONTACT INFO:

Please list three (3) Individuals who you authorize to pick up your child(ren).

1. Name: _____ Phone #: _____
   Relationship to Child: _____
2. Name: _____ Phone #: _____
   Relationship to Child: _____
3. Name: _____ Phone #: _____
   Relationship to Child: _____

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Allergy Alert Form 2026-2027

Student's Name: _____ Grade: _____ Age: _____

☐ My child has no allergies

☐ My child has allergies

Allergic to:

_____

_____

_____

Allergic Reaction that occurs when the student is exposed to an allergen:

_____

_____

_____

Medication ordered if student has allergic reaction: No: _____ Yes: _____

If yes, Medication: (as ordered by MD)

_____

_____

Notify school nurse immediately for evaluation. Main office to contact immediately
Parent / guardian at: ( ) _____
Contact MD at: ( ) _____

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Allergy Action Plan 2026-2027

Very Important to Complete if Your Child Suffers from Allergies

PLACE CHILD'S PICTURE HERE

Student's Name: _____ Age _____ D.O. B __/____/____

ALLERGIC TO: _____ Teacher: _____

Asthmatic ☐ Yes* ☐ No *Higher risk of severe reaction

STEP 1: TREATMENT

Symptoms: Give Checked Medication**:

If a food allergen has been ingested, but no symptoms:		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other	_____		

If reaction is progressing (several of the above areas affected), give:

The severity of symptoms can quickly change. Potentially life-threatening

DOSAGE: (see reverse side for instructions)

Epinephrine: Inject intramuscularly (Circle One) EpiPen®®® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: Give _____
Medication/dose/route

Other: Give _____
Medication/dose/route

STEP 2: EMERGENCY CALLS

I. Call 911 (or Rescue Squad): _____. State that an allergic reaction has been treated, and additional epinephrine may be needed.

II. Dr. _____ at: _____

III. Emergency contact: Name / Relationship Phone Numbers

1. _____ _____
2. _____ _____
3. _____ _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE TO TAKE CHILD TO MEDICAL FACILITY!

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Asthma Plan 2026-2027

Very Important to Complete if Your Child Suffers from Asthma

(Required)

☐ No, my child does not have asthma.

_____, has been identified by his/her personal physician as being at risk for an asthma attack at school. We (school nurse, principal, and your child's teacher) have formulated the following plan.

- If the child appears to be in slight respiratory distress, he/she will come to the office.
- They will be allowed to use their inhaler as prescribed.
- If, within 5-10 minutes, the child does not feel relief from his/her symptoms, we will call the parents for further instruction.
- In the event no responsible adult can be notified, we will attempt to notify the family physician for his instruction.
- If the child appears to be in acute distress, the parents will be notified, the inhaler will be administered, and if the results are not relief of respiratory distress, we will notify the ambulance and transport to the nearest hospital.

Inhaler prescribed: _____ Dose (puffs): _____

☐ I agree with this plan.

Very Important to Complete, if Your Child Suffers from Asthma.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Asthma Treatment Plan – Student

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

The Pediatric/Adult Asthma Coalition of New Jersey — "Your Pathway to Asthma Control" PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. in New Jersey — NJ Health New Jersey Department of Health

(Please Print)

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

HEALTHY (Green Zone)

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 _____

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

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)

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_____

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

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)

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 _____

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

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.

REVISED AUGUST 2014

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

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

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

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

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		

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Child Care Subsidy 2026-2027

CHILD CARE ASSISTANCE SERVICES (Listed by County)

The following is a listing of agencies that provide childcare assistance towards your tuition cost, for children 2 ½ to 13 years old.
To determine if you qualify for assistance, contact the agency in your country of residence.

COUNTY	NAME OF AGENCY	ADDRESS OF AGENCY	PHONE/ FAX NUMBERS
Bergen	Bergen County Office for Children	One Bergen County Plaza 2nd Fl. Hackensack, NJ 07601-707	Phone: (201) 336-7150 Fax: (201) 336-7155
Essex	Programs for Parents Inc.	570 Broad Street 8th Floor Newark NJ 07102	Phone: (973) 297-1114 Fax: (973) 297-1263
Hudson	Urban League of Hudson County	253 MLK Drive 3rd Floor Jersey City, NJ 07305	Phone: (201) 451-8888 Fax:
Middlesex	Community Child Care Solutions	103 Center Street Perth Amboy, NJ 08861	Phone: (732) 324-4357 Fax: (732) 376-0271
Morris	Child and Family Resources	111 Howard Blvd Ste. 104 Mt. Arlington, NJ 07856	Phone: (973) 398-1730 Fax: (973) 398-0319
Passaic	4Cs of Passaic County Inc.	2 Market Street Suite 300 Paterson NJ 07501	Phone: (973) 684-1904 Fax: (973) 684-0468
Somerset	Community Child Care Solutions	86 East Main Street Somerville NJ 08876	Phone: (908) 927-0869 Fax: (908) 927-9653
Union	Community Coordinated Child Care	2 City Hall Plaza 3rd Floor Rahway NJ 07065	Phone: (973) 923-1433 Fax: (973) 923-1311
Warren	NORWESCAP	350 Marshall Street Phillipsburg NJ 08865	Phone: (908) 454-1078 Fax: (908 454-3117

Parent's/ Guardian's Name: _____

Parent's/ Guardian's 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, Vaccine Preventable Diseases Program at 609-826-4860.
   - 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.nj.gov/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.

CH-14 *(Instructions)*
JUL 12

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

Nonpublic School Transportation Application Form

School Year: Resident District Board of Education:

Student Name:
Last First Middle

Date of Birth (mm/dd/yy): Parent/Guardian Name:

Daytime Phone: Email Address:
Area code + number

Home Address: City: Zip:

Mailing Address: City: Zip:

Full name of school to be attended:

Phone: Address of School:
Area code + number

Student's grade for the coming year: 2026 2027

Shortest one-way mileage between home and school:
(shortest route along public roadways or walkways to the nearest tenth of a mile)

Date school opens (mm/dd/yy): Date school closes (mm/dd/yy):

School hours: AM to PM

Name of school of attendance in prior year:

Address:

Signature: Date (mm/dd/yy):

Public School Use Only (Do not write below this line)

Your application has been reviewed by the resident district board of education. The following determination has been made:

☐ Transportation will be provided ☐ You are eligible for payment in lieu of transportation ☐ Ineligible

Reason:

Title:

Signature: Date (mm/dd/yy):

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____

New Jersey Department of Education
Office of School Finance

(B6T) Nonpublic School Transportation Application (N.J.A.C 6A:27-2.5)

Instructions

It is the obligation of the parent or guardian of nonpublic school students to annually obtain the Nonpublic School Transportation Application from the administrative office of the nonpublic school for each student for which transportation services are being requested. Submit a separate application for each student.

Note:

- If there is a change of home address, a new application shall be submitted to the public school district of residence.
- If there is a change in the nonpublic school of attendance, a new application shall be submitted to the public school district of residence.
- Complete this application and return it to the nonpublic school on or before March 10th preceding the school year in which transportation is being requested.
- Late applications — Any application received after March 10th will be a late application and must be accompanied by a statement of the reason for lateness. Eligible students will receive transportation or aid in lieu of transportation based on the date the application is received by the public school.
- It is the obligation of the nonpublic school administrator to annually collect the application and submit it to the public school district from which transportation is being requested prior to March 15th.
- It is the obligation of the public school administrator to notify the parent or guardian as the determination of each application by August 1st.
- A district board of education shall pay aid in lieu of transportation to the parent or guardian of an eligible student only after receiving a signed "Nonpublic School Transportation Payment" voucher (B7T) as prescribed by the Commissioner of Education.

Parent's/ Guardian's Name: _____

Parent's/ Guardian's Signature: _____ Date: _____