O MY LORD! ADVANCE ME IN KNOWLEDGE (SURAH TA-HA 20:114)

Sadiq School Registration Packet

Address: 49 Cedar Grove Lane Somerset, NJ 08873

Website: www.sadiqschool.org Email: info@sadiqschool.org Phone: 732-532-2030

Registration Requirements

We welcome your child(ren) to Sadiq School. Please complete this document and return to us as soon as possible.

We will need the following to complete the registration of your child:

- Copy of Child's Birth Certificate *
- Copy of updated immunization record *
- Physical/health history form- must be signed and stamped by your child's physician and dated within 1 year *
- Permission to administer medication *
- Emergency Contact Form *
- Photo/Video release *
- (B6T) Nonpublic School Transportation Application (N.J.A.C 6A:27-2.5)

We have created a handbook for parents which has very important information about School policies and requirements. Please visit https://www.sadiqschool.org/ and under School to see the parent handbook, calendar and registration packet. .

***THESE REQUIREMENTS CAN NOT BE WAIVED EXCEPT WITH THE EXPRESSED PERMISSION OF THE CHIEF SCHOOL ADMINISTRATOR OR HIS DESIGNEE AFTER CONSULTATION WITH THE BOARD ATTORNEY.**

Registration Application Form

STUDENT'S NAME:

(Last) _____ (MI)_____ (First)_____

Date of Birth (M/D/Y)_____Place of Birth: _____

Parent (Guardian) Name: _____

Address: _____

Telephone Number: Home _____Work_____Mobile:_____

Email: _____

Health History

Disease History	If yes, please note the type and year, If no, please note "None"	Disease History	If yes, please note the type and year, If no, please note "None"
Allergies		Convulsive d\Disorder	
Drug sensitivities		ADHD	
Lyme Disease		Diabetes	
Hepatitis		Heart Disease	
Neuromuscular Disease		Hearing Disorder	
Asthma		Vision Disorder	
Chicken Pox		Congenital Disease	

Operations/Injuries (please specify). If none please note "none"

1:_____2:_____3:_____

For Office Use:

Date Application Received: _____

Deposit Received: _____

Registrar Signature: _____

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 the child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date	This form may be released to WIC. ☐Yes ☐No		

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No		
Abnormalities Noted:		Weight *(must be taken within 30 days for WIC)*	
		Height *(must be taken within 30 days for WIC)*	
		Head Circumference *(if <2 Years)*	
		Blood Pressure *(if ≥3 Years)*	
IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:		

MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries ● List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments ● List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity ● List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs ● List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities ● List allergies:	☐ None ☐ Special Care Plan Attached	Comments

Special Diet/Vitamin & Mineral Supplements ● List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis ● List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans ● List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

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

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

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

CH-14 OCT 17 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provide

EMERGENCY CONTACT FORM

STUDENT'S NAME: _____
(Last) (MI) (First)

Student date of birth:_____ Gender: M___ F___

Mailing Address:_____

Name of Mother/Step-Mother/Guardian (circle one) _____

Home Phone #_____Cell Phone #_____Work Number_____

Occupation_____

Name of father/Step-father/Guardian (circle one) _____

Home Phone #_____Cell Phone #_____Work Number_____

Occupation_____

Student primarily lives with: ____Both Parents ____Mother ____Father ____Parent/Step-Parent ____Guardian(s)

If the student's biological parents reside together, they are: _Married ____Single/Living Together

If the student's biological parents do not reside together, they are: _Separated ____Divorced _Single ____Widowed

If you are this student's guardian, indicate your relationship to student_____

Are there custody or guardianship documents for this student? ____Yes ____No

Please Note: If there are court documents regarding parental custody or guardianship, a copy must be on file with Sadiq School. Please call 732-532-2030 for more information

EMERGENCY CONTACTS: PLEASE LIST PERSONS OTHER THAN YOURSELF WHO YOU AUTHORIZE TO RECEIVE PHONE CALLS OR PICK UP THIS STUDENT IN THE EVENT THAT YOU CANNOT BE REACHED. WE **WILL NOT** ALLOW PERSONS OTHER THAN THOSE ON THIS LIST FOR PICK UP FROM SADIQ SCHOOL. PLEASE MAKE SURE TO CALL THE SADIQ SCHOOL AHEAD OF TIME IF THERE ARE ANY CHANGES TO THE REGULAR SCHEDULED PICKUP PERSONS. ALL NAMES AND IDS MUST MATCH.

Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student

Parent/Guardian Email Address_____

Family Physician_____

Phone #_____

In case of emergency, I hereby give permission for this student to be taken to the hospital for treatment, if necessary. Please provide a preferred hospital name and address, if desired.

_____

Signature of Parent/Guardian Date

Is this student covered by health insurance: Yes___ No____

Name of the insurance company: _____

NJ Family care provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online. I hereby give you permission to release my name and address to NJ Family Care

ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF MEDICAL EQUIPMENT IN SADIQ SCHOOL

If your child requires medication at Sadiq School, please request for administration of medication, treatments or use of equipment in Sadiq School. Please remember Sadiq School personnel will not administer any medication without a signed document by the child's Physician **AND** parent/guardian's written approval. All medication administered at Sadiq School must be kept in the original container. Medications will be administered by Sadiq School supervisor, or designee. Non- prescription medicine will not be administered.

For Physician

The below named student must take prescribed medication during Sadiq School hours as it is required to be administered more than three times a day and cannot be given at home only.

Name of Student:
(LAST) (FIRST) (MI)

Diagnosis: _____

Medication prescribed: _____

Dosage required: _____

Time during Sadiq School day to be given: _____

Duration of medication: _____

Possible side effects/adverse reaction: _____

Physician's Name and Signature _____

Date: _____ Contact number: _____

Parent (guardian) name and signature:_____

PHOTOGRAPH/VIDEOTAPE RELEASE Form

Sadiq school may occasionally take pictures and videos of children enrolled. Such material may appear in the Sadiq School media pages and brochures for marketing purposes.

Please check one of the following:

- ○ I authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Sadiq school.

- ○ I do not authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Sadiq School.

Parent/Guardian Signature: Date:

_____

Please add any other comments you may have that Sadiq School admin should know about your child.

Please click on the following link for the (B6T) Nonpublic School Transportation Application:

https://drive.google.com/file/d/1r3jn-c0GsiUSXgMa3IyYOyRdYQ89fRo-/view?usp=sharing