TRENTON BOARD OF EDUCATION
Office of Early Childhood – Preschool Program
929 Parkside Avenue
Trenton, New Jersey 08618
Phone (609) 656-4900 Ext. 5667 Fax (609) 393-0158

Student ID: _____
PowerSchool Entry: _____
Home School: _____
Home Language: _____

STUDENT REGISTRATION – OPEN ENROLLMENT
CHECKLIST VERIFICATION

Name of Student: _____

Date of Birth: _____ Age by September 30, 2022 _____ 3 years _____ 4 years

School/Provider Name: _____

New Enroll: ☐ Re-Enroll: ☐

- Original Birth Certificate of Student _____ (name of student)
- Custodial Parent/Guardian Documentation (if Applicable)
- Student Immunization Record
- Physical Exams
- Proofs of Address ***Refer to Checklist***
- Home Language Survey is completed and signed by parent/guardian
- Registration Packet is completed and signed by parent/guardian
- Special Services Pupil Placement/Transfer Sheet (IEP – Copy of Cover Page, if applicable)

Residency Documentation: Registration must include the following for each column to be accepted as proof of residency. Provide one piece of evidence from **Column A and column B**. A ***Notarized letter*** will be required along with **two (2) poof of address** in the name of the person who has agreed to provide alternate/temporary living arrangements for families from **Column A** as well as **one (1) proof** in parent/guardian's name from **Column B**. Any document provided must be correctly dated in a manner appropriate for the document (i.e. utility bills no older than thirty (30) days, Lease signed and dated with valid terms).

Column A	Column B
☐ Current Household Utility Bill	☐ Current Household Lease
☐ Original Deed/Contract of Sale	☐ Current Paystub w/ another utility bill
☐ Current Lease Expiration Date: _____	☐ Monthly Benefits Statement
☐ Current Mortgage Statement	☐ Monthly Insurance Documents
☐ Current Property Tax Bill	☐ Document mailed from state or federal agency
☐ Notarized Letter in the name of the person who has agreed to provide alternative/temporary living arrangements	{DO NOT WRITE - - EARLY CHILDHOOD OFFICE USE ONLY}

Checked By: _____ Date: _____

Checked By: _____ Date: _____

EC OFFICE USE ONLY

1st Appointment ☐ Reschedule (Original Date: _____) ☐ Notarized Letter ☐ Flagged ☐ Approved Shelter

TRENTON BOARD OF EDUCATION
OFFICE OF EARLY CHILDHOOD
929 Parkside Avenue
Trenton, NJ 08618
Phone (609) 656-4900 ext. 5667 Fax (609) 393-0809

☐ New Student ☐ Returning Student

STUDENT INFORMATION: Registration Date: _____

Name of Child: _____ Gender: ☐ Male or ☐ Female
(First) (Middle) (Last)

Date of Birth: _____ City of Birth: _____ Age as of September 30th: ☐ 3yrs ☐ 4yrs

Race: ☐ White ☐ Black or African-American ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaska Native ☐ Other: _____

Current Address: _____
(Street/Apt. No) City/Street Zip Code

Home Number: ( ) _____ Cell Number ( ) _____ Work Number ( ) _____

Has your child ever attended a school in Trenton? ☐ Yes ☐ No If Yes, which school? _____

PARNT/LEGAL GUARDIAN INFORMATION:

	Father	Mother	Legal Guardian (if not parent)
Name:			
Address:			
Birth Place:			
Occupation:			
Home #:			
Cell #:			
Email:			

PLEASE LIST EMERGENCY CONTACTS WHO CAN BE REACHED IN CASE WE ARE UNABLE TO REACH YOU AND CAN PICK UP YOUR CHILD. CONTACTS WILL NEED TO PROVIDE IDENTIFICATION.

	Contact #1	Contact #2
Name:		
Phone #:		
Address:		
Relationship to Child:		

PLEASE LIT BROTHERS AND SISTERS FROM OLDEST TO YOUNGEST:

Name:				
School:				
Grade and age				

_____ _____
Parent Signature/Firma Date/Fecha

TRENTON BOARD OF EDUCATION

"Children Come First, Los niños son primero"

Alfonso Q. Llano
Interim Superintendent of Schools

Monica Carmichael
Director
Early Childhood Department
609.656.4960 • 609.393.0289 fax

ELIGIBILITY FOR PRESCHOOL REGISTRATION

Public schools are required to provide a free education to all persons over age 5 and under age 20 who are domiciled in the district. Domiciled means that the student is living with a parent or guardian whose permanent home is located within the boundaries of the district.

- A home is permanent when the person intends to return to it when absent and has no present plan to move from it, even though he/she has existence of homes or residences elsewhere.

- Residency requires bodily presence as an occupant in a given district.

If at any time, you or your child changes domicile or residence, you must report this information immediately to the school building secretary.

IT IS THE POLICY OF THE BOARD THAT SHOULD THE DISTRICT DISCOVER THAT A CHILD IS NOT A LEGAL RESIDENT OF THE DISTRICT AND IS ILLEGALLY ATTENDING TRENTON PUBLIC SCHOOLS, THE DISTRICT WILL ASSESS THE PARENTS THE FULL COSTS OF THE TUITION FOR SUCH ATTENDANCE. ANY ADDITIONAL COSTS FOR SPECIAL EDUCATION SERVICES WILL BE ADDED TO THE REGULAR EDUCATION COSTS.

Parent/Guardian of: _____ School: _____ Grade: _____

By my signature, I am indicating that I have read the information above, understand it, and affirm that my child(ren) and I are legal residents of and are domiciled in the Trenton Public School District.

Signed: _____ Date: _____

PLEASE RETURN THIS FORM TO THE SCHOOL FAMILY WORKER.

THIS COPY IS TO BE MAINTAINED IN THE STUDENT'S CUMULATIVE FOLDER.

Trenton Board of Education

"Children come first, Los Nino's son primero"

Addendum to Registration Packet

Disclaimer: Trenton Public School district is collecting this information in an effort to ensure that all medical and health information is documented in a timely manner for new students entering district schools.

Name of Child (First and Last) _____

1. Did your child recently arrive in the United States? Circle one: Yes No
2. If YES, on what date did your child arrive? Month _____ Day _____ Year _____
3. Have you traveled from Sierra Leone in the last twenty-one (21) days? Circle one: Yes No
4. Have you traveled from Liberia in the last twenty-one (21) days? Circle one: Yes No
5. Have you traveled from Guinea in the last twenty-one (21) days? Circle one: Yes No

If you answered YES to questions three (3), four (4), or five (5), please proceed to question six (6). If you answered NO, proceed to the signature and date section.

6. Are you registering other children in any other school in district? Circle one: Yes No
7. If YES, list the names of each child and school you are registering them at below.

Name of Child (First and Last)	Name of school child will be or is registered at

I hereby authorize the district to release the responses to questions one (1) through five (5) to school-based staff (classroom teachers, paraprofessionals, nurse, and/or principal) who will interact with my child, _____.

_____

Signature of person completing this form Relationship to Child

_____

Name of person completing this form (Please Print) Date

Trenton Public School District Staff ONLY Registrar Initials: _____ Date" _____
Registrar Instructions: Contact nurse when YES is indicated for questions three (3), four (4), or five (5)

- ☐ Copy with registration packet
- ☐ Copy to nurse
- ☐ Copy to principal for affirmative responses ONLY when YES is indicated for questions three (3), four (4), or five (5)

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

HOME LANGUAGE SURVEY

PART A: HOME INSTRUCTION

Student's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Address: _____
(City/State/Zip)

Place of Birth: _____ School: _____

Teacher: _____ Grade: _____

PART B: LANGUAGE INFORMATION

1. What language did your child speak first?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

2. What language do you speak most often to your child at home?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

3. What language does your child most often speak when speaking at you home?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

4. What language does your child use when speaking to: brothers/sisters?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

5. What language does your child speak most often with other family members?
   ☐ English ☐ Spanish ☐ Other _____
   (Language)

PART C: LANGUAGE SELECTION

What language do you prefer the school to send you communications? (Please indicate language below)

_____ _____ _____
Indicate Language Parent/Guardian Signature Date

TRENTON BOARD OF EDUCATION
OFFICE OF EARLY CHILDHOOD
929 Parkside Avenue
Trenton, NJ 08618
Phone (609) 656-4900 ext. 5667 Fax (609) 393-0809

Is the child Spanish, Hispanic or Latino? Mark one or mor group to indicate the child's Spanish/Hispanic/Latino origin.
Es el nino Espanol, Hispano o Latino? Marque uno o mas grupos para indicar el origen Espanol, Hispano o Latino del nino.

	No, not Spanish/Hispanic/Latino	No, No es Espano/Hispano/Latino
	Yes, Mexican, Mexican American, Chicano	Si, Mejicano, Mejicano-Americano, Chicano
	Yes, Puerto Rican	Si, Puerotriqueno
	Yes, Cuban	Si, Cubano
	Yes, other Spanish/Hispanic/Latino (Print group)	Si, Espano/Hispano/Latino de otro grupo (indique en letra de imprenta el grupo)

What language does the child speak most at home? Mark one box.
Que lenguaje habla su hijo a habla en la casa? Marque una respuesta.

	English	Ingles
	Spanish	Espanol
	Arabic	Arabe
	Chinese	Chino
	Creole (Hatian)	Creole (Haitiano)
	Gujarati	Gujarati
	Korean	Coreano
	Polish	Polaco
	Portugese	Portugues
	Russian	Ruso
	Urdu	Urdu
	Some other Language (Print Language)	Otro Lenguaje (Indique el lenguaje)

Does the child have any chronic medical problems, special needs, or handicapping conditions? Mark one box
Padece el nino de algun problema medico cronico, de necesidades especiales o algun tipo de incapacidad. Marque una respuesta

	No	No
	Yes (Pint problem or condition)	Si (Indique en letra de imprenta el problema o condicion.)

Will the child be enrolling for the entire school day?
Su hijo/a sera matriculado para el dia entero escolar?

	Yes, enrolling for the entire school day	Si, sera matriculado el dia entero
	No, enrolling for half day	No, sera matriculado medio dia

What kind of health insurance does the child have?
Que clase de seguro medico tiene el nino?

	Private or employment-based health insurance	Seguro de salud privado o basado en el empleo
	Medicaid	Medicaid
	New Jersey Family Care	New Jersey Family Care
	Some other health insurance	Otro tipo de seguro medico
	Uninsured	No tiene seguro

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

EC-5

DENTAL EXAMINATION/TREATMENT FORM

Section A: **To be completed by parent/guardian**

Pupil's Name: _____ Birthdate: _____

Address: _____

School/Grade: _____

Section B: **To be completed by child's dentist**

REPORT OF EXAMINATION

Please circle tooth (teeth) being treated

Tooth Chart

RIGHT																	LEFT
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UPPER
					A	B	C	D	E	F	G	H	I	J			
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
					T	S	R	Q	P	O	N	M	L	K			

Comments: Please check all that apply

____ fluoride treatment ____ cavities treated

____ sealants ____ further treatment necessary

____ cleaning ____ treatment completed

____ x-rays _____ date of next appointment

_____ _____
Printed Name of Dental/Examiner Signature of Dental/Examiner

_____ _____
Date Phone Number

Please return this form to your child's school once it is completed by the dentist.

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 2

PUPIL HEALTH HISTORY

Pupil's Name: _____ School: _____ Grade: _____
Birthdate: _____ Sex: _____
Address: _____ Telephone: _____
Parent/Guardian's Name: _____ Telephone (Work): _____
Usual Care Provider: (check) Private Physician ____ HMO ____ H.J. Austin Health Center ____ Clinic ____
Doctor's Name: _____ Telephone number: _____

Health History and Development:

1. Length of pregnancy _____ months Delivery (circle one) Normal, Caesarian, Premature
   Birth weight _____lbs _____oz
   Problems at birth or delay sending newborn home. If yes, explain _____
2. Birth sequence of above child 1st ____ 2nd ____ 3rd ____ 4th ____ Other ____
3. What age did your child walk _____ talk _____ toilet-train _____
4. Does your child have any of the following problems?
   Vision _____ Hearing _____ Speech _____
5. Does your child take medications? Yes _____ No _____ If yes, explain _____
   _____
6. Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes _____ No _____
   If yes, explain _____
7. Has your child had a serious injury? Yes _____ Year _____ No _____
   If yes, explain _____
8. Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization?
   Yes _____ Year _____ No _____
   If yes, explain _____
9. Has your child been tested for lead poisoning? Yes _____ No _____ Results _____

Disease History (Age)

Measles _____
Scarlet Fever _____
Pneumonia _____
Convulsions _____
Polio _____
Heart Disease _____
Anemia _____
Frequent headaches ____
Frequent nosebleeds ____

German Measles _____
Whooping Cough _____
Ear Infections _____
Tubes in ears _____
Sickle Cell _____
Fractures _____
Liver Disease _____
Lyme Disease _____

Mumps _____
Asthma _____
Tuberculosis _____
Chicken Pox _____
Epilepsy _____
Frequent Sore throats ___
Diabetes _____
Tonsillitis _____

Any restrictions or limitations to physical activity? _____
Is there anything about your child's health not mentioned above that we should know?
_____

Date _____ Signature of Parent/Guardian _____

CONFIDNETIAL INFORMATION

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 1

HEALTH ENROLLMENT CONSENT/NOTIFICATION FORM

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

SIGNING IS CONSENT FOR MANDATED HEALTH SERVICES:

MEDICAL EXAMINATION

A medical examination is REQUIRED at time of entry to school:

- Students new to this district, and students in pre-school or Kindergarten

State mandate specifies that this medical exam be done by the student's own health care provider, with a full report sent to the school.

Please have your health care provider complete the UNIVERSAL CHILD HEALTH RECORD and return it to the school.

If your child does not have a private physician or health care provider, please understand that he/she will be scheduled for a new entry school medical examination.

THIS ALSO SERVES AS NOTICE OF THE OTHER MANDATED PROGRAMS:

TUBERCULOSIS (MANTOUX) TEST

A skin test for tuberculosis is done on all students entering from another country or an area designated by the NJ Department of Health and Human Services.

SCOLIOSIS SCREENING

A strip to the waist examination is done by the school nurse, and/or the school physician to determine whether your child's spine is developing straight. This screening is done every other year from 10 to 18 years of age.

HEALTH SCREENINGS

Screenings by the school nurse, as required by the State of New Jersey, include: height, weight, dental, vision, hearing, and blood pressure. You will be notified, by a referral form, if your child needs to have an examination by a health professional following these screenings.

_____ _____

Parent/Guardian Signature Date

TRENTON BOARD OF EDUCATION

"Children come first, Los Nino's son primero"

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. **Your child will continue to receive services at no cost to you under this new system**. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

Please fill the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVIES

Child's Name: _____
(First) (MI) (Last)

Child's Date of Birth: _____
(Month) (Day) (Year)

As a parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature: _____ **Date**: _____

Please return this form to:

_____
_____
_____
_____

TRENTON PUBLIC SCHOOL
Trenton, New Jersey
Office of School Health Services

MH-02

MECICAL HOME INFORMATION FORM

Dear Parent/Guardian

In order to determine how many students, have a medical home, it is necessary for you to complete the Medical Home Information Form. Please return the form to the school nurse.

Name of Student: _____ School: _____

Address: _____ Grade: _____
_____
_____

Phone Number: _____

Name of Health Care Provider: _____
(Doctor's Name or Clinic)

Address: _____
_____
_____

Phone Number: _____

Does your child have health insurance? Yes_____ No _____

If yes, name of insurance company: _____

NJ Family Care Provides FREE or low cost health insurance for uninsured children, low income parents. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Print Name: _____

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 sign 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.)
    a. 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.
    b. 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.
    c. Head Circumference – Only enter if the child is less than 2 years
    d. 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.
    a. The Immunization record must be attached for the form to be valid
    b. "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 car plan should be completed and attached for any of the medical issues 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 form 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 an 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. Not, 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 health personnel to track children's health. Please enter the date the test was performed. Not if the test was abnormal or plan n "N" if it was normal.
    a. For lead screening state if the blood sample was capillary or venous and the value of the test performed.
    b. For PPD enter millimeters of induration, and the date listed should be the date read. If the chest x-ray was done, record results.
    c. Scoliosis screening 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)
    a. Print the health care provider's name.
    b. Stamp with health care site's name, address and phone number.

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 dietary specifications:	☐ 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

PREVENTATIVE HEALTH SCREENINGS

Type of Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Led: ☐ 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)
Signature/Date
Health Care Provider Stamp:

Trenton Pubic School District, Office of Early Childhood
Preschool Family Survey

The Office of Early Childhood has developed the following survey in effort to benefit preschool family needs. Input from this survey will help us design parent involvement programs that best fit the needs of our families. The survey information will be kept confidential. We realize your time is very limited and we thank you for completing this survey. Please contact Sheree Dublin, Community & Parent Involvement Specialist at (609) 656-4900 ext. 5669.

Please complete the survey below.

1. What is your relationship to the enrolled preschool student?
   a. ____ Mother ____ Father
   b. ____ Legal Guardian (Individual Raising child)
   Language(s) spoken at home: _____

2. Which of the following topics would you like to learn more about during this school year? (check all that apply)
   ____ Discipline/Behavior
   ____ Nutrition
   ____ Health and Safety
   ____ Bedtime Strategies
   ____ Supporting Math Skills at Home
   ____ Preparing for Kindergarten
   ____ Stages of Child Development
   ____ Preschool Curriculum
   ____ Sibling Rivalry
   ____ Ways to Raise a Reader
   ____ College Saving Plans
   ____ Science can be Fun
   ____ Other: _____

3. What is the best time for you to participate in workshops or activities?
   a. ____ Morning (between 8:30am and 12 noon)
   b. ____ Afternoon (between 12 noon and 4pm)
   c. ____ Evening (between 4pm and 7pm)

4. How did you find out about the Preschool program? (Please check all that apply)
   ____ Flyer sent home
   ____ Childcare
   ____ Newspaper
   ____ Flyer or poster in a business or agency
   ____ Heard it from friend or relative
   ____ District local channel
   ____ Other: _____

5. What is the most effective way to inform you of workshops/activities/meetings?
   ____ Flyer
   ____ Email
   ____ Phone Calls
   ____ Staff
   ____ Other: _____

6. Do you have internet access at home? (Please check all that apply)
   ____ Phone
   ____ Computer at home
   ____ Computer at Work
   ____ Other: _____

7. Would you be interested in obtaining information about any of the following services? If yes, please provide your contact information.
   Name: _____ Child's Name: _____
   Phone number: _____ Center Location: _____
   ____ Parenting Classes
   ____ Social Services
   ____ Legal Services
   ____ Adult Education Classes
   ____ Parent Support Groups
   ____ Job Training Opportunities
   ____ English Language Classes
   ____ Money Management Classes
   ____ Health Insurance/NJ Family Care
   ____ WIC Nutrition Program
   ____ Other: _____

8. Does your family have any special talents that you would be willing to share with our preschool students? (i.e. Musical talents, cooking talents, artistic talents, etc.) If so, please explain and provide contact information.

_____

_____

Name: _____Phone Number: _____

9. What do you think is the best way schools and families can work together to support students?

_____

_____

_____