Please confirm that the STUDENT INFORMATION below is correct, any additional information or corrections that need to be made can be written in.

Student Information

Student's Name: _____ (Last Name) _____ (First Name) _____ (Middle Name)

Birth Date: ___/___/___ Social Security #: _____ ☐Male ☐Female Grade: _____

ADDRESS INFORMATION	PHONE INFORMATION
Street Address Apt. #	HOME PHONE: ( ) -
City State Zip Code	PARENT/GUARDIAN WORK: ( ) -
	PARENT/GUARDIAN MOBILE: ( ) -
	STUDENT MOBILE: ( ) -

Parent/Guardian Information

Parent/Guardian: _____ (Last Name) _____ (First Name) _____ (Relationship To Student)

Address:
☐ Check here if same as above

Street Address Apt. #

City State Zip Code

Best Parent/Guardian Contact Number & Email Address:	
HOME PHONE:	( ) -
PARENT/GUARDIAN WORK:	( ) -
PARENT/GUARDIAN MOBILE:	( ) -
EMAIL ADDRESS:	

Emergency Contact Information

Emergency Contact: _____ (Last Name) _____ (First Name) _____ (Relationship To Student)

Address:

Street Address Apt. #

City State Zip Code

Best Emergency Contact Number:	
Emergency Contact HOME PHONE:	( ) -
Emergency Contact WORK/other:	( ) -
Emergency Contact MOBILE:	( ) -
Please check if you authorize this person to release your child from school.	☐ Yes, I authorize this person to release my child from school.
	☐ No, I DO NOT authorize to release my child from school.

Please sign and date below indicating that the information stated on this form is the most current information for your child. Thank you.

Parent/Guardian Signature: _____ Date: _____

Please confirm that the STUDENT MEDICAL INFORMATION below is correct and provide your signature as authorization of this

information as well as for emergency medical treatment. Any additional information or corrections that need to be made can be written in. Also, please be sure to complete the Important Allergy Information.

STUDENT MEDICAL INFORMATION

Physician's Name or GROUP: _____

Phone Number: ( ) - Address: _____

MEDICAL INFORMATION

List below chronic conditions the student may have (i.e. asthma, diabetes, epilepsy, allergies, etc.):

Please fill out the form below regarding the Administration of both non-prescription and prescription medications. This information is necessary for our files to ensure that we have the most up to date medical information when providing medical treatment to your student. Students will not be provided medication without completion of this form.

Parent Permission for Over-the-Counter Medical Administration

Our School Medical Inspector, Daniel Greenfield, MD has authorized the administration of the following medication by the School Nurse in the School Health Office. However, parental/guardian permission is required before a student can receive any of the listed medication. If you would like your child to be able to receive any of the listed medication in school if needed, please complete the following and return it to the Health Office. **If medication is requested in excess, a recommendation will be sent home to have the student visit their Health Care Provider for evaluation.**

Please check off if your student will be using either of the following products while in school. These products must be supplied by the parent/guardian and will be kept in the Health Office for the assigned student's use only.

_____ contact lens solution _____ sunscreen

The following medications will be supplied by the school district with your authorization:

- Acetaminophen dosed according to weight and product label
- Ibuprofen dosed according to weight and product label
- TUMS® dosed according to product label
- Cough Drops dosed according to product label
- Claritin D® (Loratadine)

Note: if you do NOT wish to have your student receive any one of the above medications, please list it here:

_____

_____ Yes, I authorize the school nurse to administer the above medications to my child as needed.

_____ No, I do not authorize the school nurse to administer the above medications to my child.

Parent/Guardian Signature: _____ Date: _____ Date:

Student's Current Medications

Please list ALL medications that the student is currently prescribed, even if they are not administered in school. If this does not apply to your student, please indicate below by writing n/a:

Medication	Dose	Time

We would appreciate if you could keep us updated during the school your if ANY medications, dosage or frequencies change so that we can be observant for any side effects. Please call the School Nurse, Mrs. Bartiromo, at (732) 469-5892 ext. 30 to report these changes or if you have any questions or concerns. I hereby authorize that the above information I have provided is accurate.

Parent/Guardian Signature: _____ Date: _____

Permission for Emergency Medical Treatment

I hereby authorize the physicians and/or their designated associates or assistants, or their covering physicians, or in the event these persons cannot be contacted, the emergency physician on duty at Somerset Medical Center in Somerville, New Jersey or the nearest emergency facility to provide emergency treatment to my child for the following:

- Any laceration, fracture or other traumatic injury or;
- Any symptom, diseases or injury which in the judgment of the attending physician, if untreated, reasonably may be expected to increase the risk or threaten the health or life of such child, or threaten disfigurement of impairment of his faculties. No major surgery or life threatening procedure may be performed upon my child and no general anesthesia may be administered unless:
  - The Life and Health of my child is in danger; or delaying such treatment to obtain consent would create a threat of serious injury to the health of my child; and
  - The attending physician and one other physician consult and agree that such treatment is necessary for the health of my child.
- I hereby give my consent for admission of my child if in the judgment of the attending physician, it is necessary for any treatment authorized herein.
- This consent is to be effective only after reasonable efforts have been made to contact and obtain specific consent to any emergency treatment.
- This consent is also to be used in conjunction with the hospital's procedure for documented Administrative Authorization.
-

INSURANCE CARD INFORMATION: (PLEASE PROVIDE INFO BELOW OR SUBMIT A COPY OF YOUR CURRENT INSURANCE CARD.

Insurance Carrier: _____ Policy #: _____

Primary Care Provider (PCP) Name: _____ Phone #: _____

I hereby authorize EMERGENCY MEDICAL TREATMENT for my child.

Parent/Guardian Signature: _____ Date: _____

IMPORTANT ALLERGY INFORMATION (If this does not apply to student, please write N/A)

Please list all food allergies: _____

Please list any drug allergies and the reaction: _____

Please list seasonal allergies (i.e. bee stings): _____

Does the student have asthma? _____ YES ____ NO

If yes, please have your physician complete the Prescribed Medication Authorization form attached and send the inhaler to the health office OR have the physician complete the Self-Medication by pupil form. Students may NOT carry an inhaler without a physician order on file.

Does the student have an EpiPen for his/her allergies? _____ YES ____ NO

If yes, please have your physician complete the Prescribed Medication Authorization Form attached and send medication with label to the health office.

Please read the following medical permissions carefully. It is important that we have these permissions on file in the event Brook Academy Staff

believes a student is under the influence of drugs or alcohol.

Substance Abuse Screening Program

Attention: Parents/Guardians

Green Brook Academy has adopted a substance abuse screening program. Random drug/alcohol screenings will not be conducted. Drug/Alcohol screenings will be conducted if Green Brook Academy Staff strongly believe a student is under the influence of an illicit drug/alcohol.

The Substance Abuse Screening Program was established in order to determine if a student needs an evaluation, counseling or treatment due to substance abuse.

Testing your child to determine whether there is drug/alcohol use can only be conducted under the following conditions:

1. The student voluntarily agrees to test.
2. We have your permission to test your child.

Green Brook Academy will use every precaution to protect your child's rights and keep information confidential. The required urine sample will be handled only by designated staff member(s). The identity of your child and the results of the test will be held in strictest confidence.

Test results will be discussed with you. Should the screening reveal that there is drug/alcohol use, you will be informed of the alternatives available to your child for evaluation, counseling and/or treatment. Information concerning the test results will not be released to any unauthorized agency.

If you wish to cooperate with our Substance Abuse Screening Program, please sign the Substance Abuse Screening permission form below and return it. We are earnestly trying to combat the spread of substance abuse. If you do not sign this form, we may not be able to effectively help your child. Your support in this program is truly appreciated.

If you have any questions or concerns regarding our Substance Abuse Screening Program, please contact the school at 732-469-8677.

I hereby give permission to Green Brook Academy to conduct substance abuse screening tests for my child.

I understand that a screening will only be done if there is strong suspicion or evidence of drug/alcohol use. The test results will be used as a therapeutic tool to determine the course of treatment to be followed for my child.

I further understand that every precaution will be taken to protect the rights of my child, and to keep his/her identity and results of this screening confidential.

Student's Name (Please Print):_____

Student Signature:_____**Date:**_____
(required if student is 18 years old or older)

Parent/Guardian Signature:_____**Date:**_____

Witness Signature:_____**Date:**_____

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Please initial in the box next to the selection for the permissions required for each student. Please provide signatures where needed.

Permission for Activities Outside of School	Initial

I give my permission for my child to participate in class trips and other activities that are held away from the Green Brook Academy Campus. _____

I do NOT give permission for my child to participate in any activity that is off the Green Brook Academy Campus. _____

Permission for School Photography/Video/Website	Initial

I give my permission for my child to be interviewed, photographed and/ or videotaped in school related settings for use in school publications (e.g. newspaper, yearbook, website), school productions, or for use by the general news media for print or broadcast purposes. Videotapes will be used to assist in providing the most appropriate educational programming. I understand that an effort will be made to notify me prior to my student being videotaped. _____

I do NOT give permission for my child to be interviewed, photographed and/or videotaped. _____

Green Brook Academy iPad/Chromebook Agreement

Student Agreement for iPad & Chromebook Use

1. I will take good care of my iPad/Chromebook.
2. I will not leave the iPad/Chromebook unattended.
3. I will never loan out my iPad/Chromebook to other individuals.
4. I will know where my iPad/Chromebook is at all times.
5. I will keep food and beverages away from my iPad/Chromebook since they may cause damage to the device.
6. I will not disassemble any part of my iPad/Chromebook or attempt any repairs.
7. I will protect my iPad/Chromebook by keeping it in its protective case.
8. I will use my iPad/Chromebook in ways that are appropriate and are educational in nature.
9. I will not place decorations (such as stickers, markers, etc.) on the iPad/Chromebook. I will not deface the serial number.
10. I understand that my iPad/Chromebook is subject to inspection at any time without notice and remains the property of the Green Brook Academy.
11. I will follow the policies outlined in the Student Handbook.
12. I will be responsible for all damage or loss caused by neglect or abuse.
    a. Note: Any iPad in need of replacement due to negligence or abuse or mistreatment will be billed to the parent/guardian in the amount of $499. Any Chromebook in need of replacement due to negligence or abuse or mistreatment will be bill to the parent/guardian in the amount of $299.
13. I will not utilize photos, video, and/or audio recordings of any myself or any other person in an inappropriate manner.
14. I will not attempt to reset or change any passwords or restrictions placed on the iPad/Chromebook by school staff.
15. I understand that ALL iPads/Chromebooks can be tracked, if they are missing.
16. Individual school iPads/Chromebooks and accessories must be returned to the school at the end of each school day.

I agree to the stipulations set forth in the Student Agreement for iPad/Chromebook use.

Student Name (Please Print):_____Grade:_____

Student Signature:_____Date:_____

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature:_____Date:_____

I have read and completed the above form for the 2019-2020 school year and understand that providing permissions for my student will be for the duration of the current school year. In the event that something changes in regards for the permissions I have provided for my student, I understand that it is my responsibility to contact Green Brook Academy accordingly. In addition, I understand that privileges for my student may be restricted at any time.

_____ _____

Signature of Parent/Guardian Date

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Please complete the following form. This form should be completed with the most current information for your student so that Green Brook Academy may communicate with relevant service providers regarding your student. Please note that this form will remain in

effect for as long as the student is enrolled at Green Brook Academy. Any changes to the Consent of Release form must be provided by written notice to Green Brook Academy Administration.

Consent for Release of Information

Student's Name: _____
Last Name First Name Middle Name

I authorize Green Brook Academy to send and/or receive information regarding my child for the purpose of educational, vocational, mental health, community and/or drug treatment planning.

The following represents a list of professionals presently servicing my child. PLEASE LIST ALL THAT APPLY.

Physician	_____	Phone Number:	( ) -
Psychiatrist	_____	Phone Number:	( ) -
Psychologist	_____	Phone Number:	( ) -
Counselor	_____	Phone Number:	( ) -
Hospital Staff (Please list Hospital)	_____	Phone Number:	( ) -
Agency Staff (Please list agency- FACT, CMO, DCP&P, etc.)	_____	Phone Number:	( ) -
Probation Officer (Please include County)	_____	Phone Number:	( ) -
Other (Please specify agency)	_____	Phone Number:	( ) -
Other (Please specify agency)	_____	Phone Number:	( ) -

I understand that this list is not exhaustive and may change during the course of my child's enrollment. I consent that Green Brook Academy Staff may add/delete professionals from this list as a means of maintaining communication with relevant service providers. I understand that this consent will remain in effect as long as my child is enrolled at Green Brook Academy. Further, I am aware that I may revoke this consent at any time by providing written notice to Green Brook Academy Administration.

Parent/Guardian Signature:_____Date:_____

Student Signature:_____Date:_____
(Required if student is 18 years old or older)

Witness Signature:_____Date:_____

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Prescribed Medical Authorization Form

Students' Name:

Last Name First Name Middle Name

I hereby request the school nurse to administer medication to my child as directed by the physician's orders below. I release Green Bro Academy from any liability concerning administration of medication to my child.

Parent/Guardian Signature:_____	Date:_____

Medication must be in the original pharmacy labeled bottle and be delivered to the school nurse by the parent/guardian.

PHYSICIAN PERMISSION FOR ADMINISTRATION OF PRESCRIBED MEDICATION DURING SCHOOL DAY

Physicians Orders:
(To be completed by Child's Physician)

Please administer the following medication(s) to above stated student as detailed below:

1. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

2. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

3. _____

Dosage: _____ Time of administration:_____

Duration of administration: (i.e.: 10 days, school year, etc.)

_____

Diagnosis:

_____

Possible side effects:

_____

Physician's Signature (Required):	Date:

Physician Stamp

PLEASE NOTE:

Requests are effective for one school year only and must be renewed annually. Parent must notify the school nurse in writing when medication is no longer required. If there is a change in dosage a physician's order is required.

Self-Medication by Pupils- Asthma

P.L. 2001 Chapter 61, Authorizes Parents/Guardians to allow their children to self-medicate for Asthma

Students' Name:

Last Name First Name Middle Name

To: Parent/Guardians

Re: Signed Authorization for Self-Medication

I authorized my son/daughter to self-administer the necessary medication for his/her asthma condition. He/she shall be permitted to carry an inhaler. I understand the school shall not incur any liability as a result of any injury arising from the self-administration of medication. I hold harmless the school and its employees against any claims arising out of self-medication by my child.

Parent/Guardian Signature:_____ Date:_____

P.L. 2001 CHAPTER 61, WRITTEN CERTIFICATION FROM PHYSICIAN ALLOWING SELF-MEDICATION - ASTHMA

To: Student's Physician

Re: Self-Medication by a Pupil with Asthma

Please be advised that the student stated above has asthma and is capable of, and has been instructed in the proper use and administration of his/her medication.

The student ___ may ___ may not carry the inhaler with him/her at all times.

Please indicate severity of asthmatic condition: _____ Mild _____ Moderate _____ Severe

Physician Signature:_____ Date:_____

Physician Stamp:

GREEN BROOK ACADEMY

Founded 1979

Your Key To The Future

Proudly Serving The Special Education Community Since 1979

June 27, 2019

RE: Household Survey for School Lunches

Dear GBA Families:

I have enclosed for you a Household Survey that is now a requirement from the State of New Jersey's Department of Education for all students who receive "meals".

If you could please complete the attached document and return it to the school, we would appreciate it.

Green Brook Academy will continue to provide your child with a daily lunch, however, to support the costs of lunches, we must collect these documents.

If the State determines that you are "not eligible" for a FREE meal, we will contact you to determine the costs (which will not exceed $4.25) that you are responsible for.
Thank you for your support and understanding.

If you have ANY questions, please don't hesitate to call me at the school. I will be more than happy to answer your questions or assist you in any way possible.

Sincerely,

Colleen D. Motzel
Principal

151 Vosseller Avenue • P.O. Box 947 • Bound Brook • New Jersey • 08805
Phone: (732) 469-5892 x22 ● Fax: (732) 469- 0035 ● E-Mail: cmotzel@greenbrookacademy.com
Visit Our Website At: www.greenbrookacademy.org

New Jersey Department of Education

Household Information Survey 2019 – 2020

COUNTY: Somerset DISTRICT: SCHOOL: Green Brook Academy

Please complete, sign, and return this form to your child's school.

Part A. Household Members - Fill in the information for every person living in your household (adults & children)
For help determining who should be included in the household, see instructions on the second page.

List all who live in the household: Names (*Last Name, First Name*)	Date of Birth XX-XX-XXXX	Name of School the Student Attends (if applicable)	Grade Level	Student Information (mark as applicable)			
				Migrant	Homeless	Foster	In Head Start
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

* **If household size is greater than 8**, list additional household members on a separate paper, and **follow special instructions in Part C**.

Part B. Benefits Received (if applicable)

1) If anyone in the household receives FDPIR, TANF, or SNAP, check the appropriate box(es): ☐ FDPIR ☐ TANF ☐ SNAP (formerly "food stamps")

2) If you checked a box, write the full name (Last, First) and 10-digit case number of any one person receiving the benefit and skip to Part D.
Name: _____ Case #: _____-_____-_____-_____

Part C. Household Size and Gross Income (before deductions). For help determining your annual income, see page 2 of the survey.

- Households with 8 or fewer people: Check a box below for the Annual Income Range that reflects your total annual household income.
- If Household Size is greater than 8, DO NOT check an income range, but follow the special instructions below boxes 1 through 17.

Annual Household Income Ranges*

1. ☐ $0 - $15,678	5. ☐ $26,547 - $30,044	9. ☐ $37,778 - $42,848	13. ☐ $53,244 - $53,716
2. ☐ $15,679 - $21,112	6. ☐ $30,045 - $31,980	10. ☐ $42,849 - $45,510	14. ☐ $53,717 - $60,976
3. ☐ $21,113 - $22,311	7. ☐ $31,981 - $37,414	11. ☐ $45,511 - $48,282	15. ☐ $60,977 - $68,709
4. ☐ $22,312 - $26,546	8. ☐ $37,415 - $37,777	12. ☐ $48,283 - $53,243	16. ☐ $68,710 - $76,442
			17. ☐ $76,443+

*** Special Instructions for households with more than 8 people:** DO NOT check the boxes above. Instead, fill in items below:
Household size (# people): _____ Total annual Income: $ _____

Part D: Certification - The head of household or adult designee who completed this form must complete this certification section.

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

Sign Here: **X**_____ Print Name: _____ Date:_____

Last Four (4) Digits of Social Security Number (Optional): XXX-XX- __ __ __ __ (may be used to verify the accuracy of the information provided)

Address	City	Zip

Home Phone	Work Phone	Email (optional)

Do NOT fill out this section. This is for school use only.

Status: F _____ R _____ N _____

Reason for ineligibility:_____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

New Jersey Department of Education

Household Information Survey

This survey is used to determine eligibility for state benefits for which your child(ren)'s school may qualify. Please complete, sign, and return this form to your child's school.

Part A: Who should I include in "Household"?

You must include yourself and all people living in your household, related or not (for example, children, grandparents, other relatives, or friends) who share income and expenses. If you live with other people who are economically independent (they do not share income with you/your children and they pay a share of the expenses), do not include them.

Part B: What are benefits received?

TANF: NJ's Temporary Assistance for Needy Families (WorkFirst NJ)
SNAP: Supplemental Nutrition Assistance Program (formerly food stamps)
FDPIR: Food Distribution Program on Indian Reservations

Part C: What is included in "Annual Household Income"?

Annual Household Income includes the following:

- **Gross earnings from work**: Use your gross income, not your take-home pay. Gross income is the amount earned before taxes and other deductions. This information can be found on your pay stub or, if you are unsure, your supervisor can provide this information. Net income should only be reported for self-owned business, farm, or rental income.
- **Welfare, Child Support, Alimony**: Include the total amount everyone in your household receives from these sources. Do not include SNAP or FDPIR payments.
- **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits**: Include the amount everyone in your household receives from these sources.
- **All Other Income**: Include for everyone in the household: worker's compensation, unemployment or strike benefits, rental income, interest and dividends, regular contributions received from who do not live in your household, and any other income received. Do not include income from WIC, federal education benefits and foster payments received by your household.
- **Military Housing Allowances and Combat Pay**: Include off-base housing allowances, and food or clothing allowances. Do not include Military Privatized Housing Initiative or combat pay.
- **Overtime Pay**: Include overtime pay ONLY if it is received on a regular basis.

How do I calculate total household income received from multiple sources and/or on a weekly, every two weeks, twice a month, or monthly basis?

1) Annualize pay for each source of income based on the above definitions for every household member.
   a. Use the table below to convert your pay to an Annual Income amount.

Frequency of payment	Annual Income Conversion Amount
Weekly	= 52 x weekly gross (not take-home) income
Bi-Weekly (every two weeks)	= 26 x bi-weekly gross (not take-home) income
Twice per Month	= 24 x gross (not take-home) amount received twice per month
Monthly	= 12 x monthly gross (not take-home) income

2) Add together the annualized pay from every person in the household for the total annual household income for Part C.

3) If your household has 8 or fewer people, check the box that shows the range for your total income. If your household has more than 8 people, do not check a box; instead, write household size and total annual household income in the space provided.

If your income fluctuates, include the wages/salary that you regularly receive. For example, if you normally make $1,000 each month, but you missed some work last month and made $900, use $1,000/month as the basis for your annual income. If you have lost your job or had your hours or wages reduced, enter zero or your current reduced income.

Additional information about this survey is available at: http://www.state.nj.us/education/finance/cep/.