



**Raritan Valley YMCA**

**2025-2026**

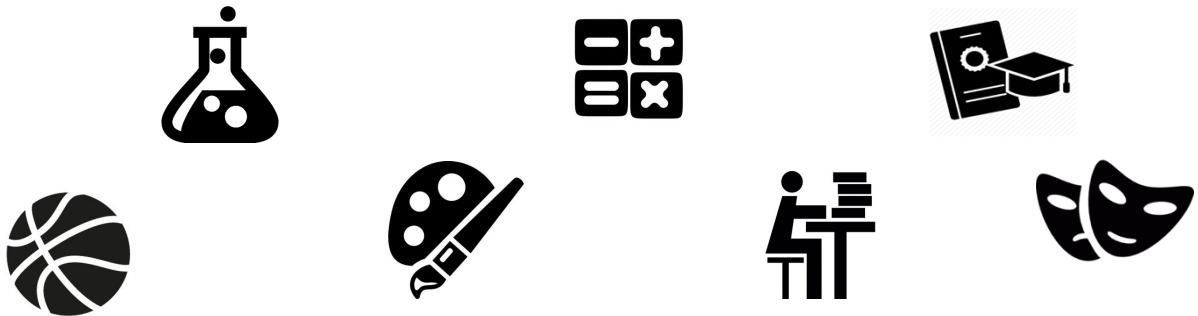


# **Spotswood Before & After School OPEN ENROLLMENT**

**Schoenly Elementary School**, Spotswood  
80 Kane Ave., Spotswood, NJ 08844

**Appleby Elementary School**, Spotswood  
23 Vilet St., Spotswood, NJ 08884

Healthy Snacks and Enrichment Included  
Before Care 7:00am until School Begins  
Dismissal until 6:00pm—Early Dismissal Included



- Licensed, Accredited, Quality Care
- Adventurous Program with Indoor/Outdoor Play Activities
- Academic and Enrichment Activities
- Caring, Trained, Dependable Year-Round Staff

**For more information**

**Call or Email**

**Preeti Srivastava, Associate Executive Director**

at

[psrivastava@raritanvalleymca.org](mailto:psrivastava@raritanvalleymca.org)

**732.257.4114**



# 2025-26 School Year Tuition Schedule AFTER SCHOOL ENRICHMENT

Spaces will be filled in the order they are received.

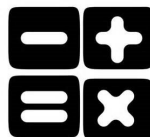
All paperwork must be returned no later than August 25th to start the program on the first week of school, pending space availability. Two (2) business days' notice is required to begin after the first week of school. Register early. Snacks, and early dismissals included. Monthly fees are based on 180 days of school and includes early dismissals.

**Schoenly School- 7am-8:35am, 2:30pm-6pm**

**Appleby School 7am-8:20am, 2:45pm-6pm**

Preschool Tuition	
2025-2026	
AM CARE TUITION MONTHLY	
# of Days	Tuition Rate
5 days a week per month	\$134
4 days a week per month	\$113
3 days a week per month	\$93
2 days a week per month	\$67
1 days a week per month	\$47
PM CARE TUITION MONTHLY	
# of Days	Tuition Rate
5 days a week per month	\$330
4 days a week per month	\$268
3 days a week per month	\$206
2 days a week per month	\$165
Drop-in daily rate	\$ 62

\*\$80 per child yearly membership fee and 1 month deposit due at registration





Elementary School Tuition	
2025-2026	
AM CARE TUITION MONTHLY	
# of Days	Tuition Rate
5 days a week per month	\$113
4 days a week per month	\$93
3 days a week per month	\$72
2 days a week per month	\$52
1 days a week per month	\$31
PM CARE TUITION MONTHLY	
# of Days	Tuition Rate
5 days a week per month	\$309
4 days a week per month	\$252
3 days a week per month	\$198
2 days a week per month	\$155
Drop-in daily rate	\$52

\*\$80 per child yearly membership fee and 1 month deposit due at registration

Financial Assistance is available; please see our handbook for more information.

The Y's Afterschool Care Program is for students in Preschool thru 5th Grade We strive to provide the best experience and make the greatest impact with quality programming.





**Raritan Valley YMCA  
After School Care  
and Vacation Camp  
2025-26 Registration**

Choose One:

AM Care ( 5, 4, 3, 2, 1 Days)

PM Care ( 5, 4, 3, 2 Days)

PM Drop In

Days- M T W Th F

Child \_\_\_\_\_ M / F

Birthdate \_\_\_/\_\_\_/\_\_\_\_\_ Grade (entering in Fall) \_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ NJ \_\_\_\_\_

School Attending \_\_\_\_\_ Room # \_\_\_\_\_

Enroll Date \_\_\_/\_\_\_/\_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_\_\_

**PARENT/GUARDIAN CONTACT INFORMATION**

Parent/Guardian #1 \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

**ALTERNATE PICK-UP AUTHORIZATION CONTACT INFORMATION**

Emergency Contact #1 \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Phone \_\_\_\_\_ - Alternate Phone \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Phone \_\_\_\_\_ - Alternate Phone \_\_\_\_\_

**Who may NOT pick up your child, if any? (Please provide legal documentation if a parent.)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Reason \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Reason \_\_\_\_\_

**Registrations are not considered active until all forms and fees have been processed**

School Age Care Registration Form

Medical Release Form

Parent /Guardian Agreement Form

All Registration and Tuition Fees

Auto-Draft Payment Form (optional)

AS NEEDED FORMS:

Permission to Medicate Form

Sign-In/Out Waiver

(Walking home alone)

**REGISTRATION FEE SUMMARY**

\$ \_\_\_\_\_ . Annual Membership (thru June)

\$ \_\_\_\_\_ . 1 Month Deposit

\$ \_\_\_\_\_ . 1st Month Tuition

**Sorry-No cash during enrollment period.**

**Checks** to YMCA are processed at registration.

**Auto-Draft Forms** will charge deposit now and future months on the 1st of each month. We accept: Visa, MC, Discover, Amex, or electronic bank drafts

\$ \_\_\_\_\_ . TOTAL DUE at Registration

Staff Reviewing/Accepting Forms \_\_\_\_\_ Date \_\_\_\_\_

Staff Processing Registration \_\_\_\_\_ Date \_\_\_\_\_



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

Child's Name \_\_\_\_\_

## School Age Care Medical Release Form

Child Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Chronic Illness / Bloody Nose History? \_\_\_\_\_

Asthma History? \_\_\_\_\_ Seizure History? \_\_\_\_\_

Food Reactions \_\_\_\_\_ Insect Reactions \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Medications Being Taken \_\_\_\_\_

(The Y does not dispense any medication without a completed Permission to Administer Medication Form provided the medication is in its original container and labeled with the child's full name, doctor, and dosage. All medication dispensing requests must be approved by the Child Care Director.)

Any physical, educational, emotional, medical, or special needs we should be aware of?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This health history is correct as far as I know, and the child herein described has vaccination records on file with the Board of Education, is in good health and has permission to engage in all the normal activities of the School Age Child Care Program OR I exempt my child from vaccinations due to the following reasons: \_\_\_\_\_.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the medical personnel selected by the Y, to transport, hospitalize, and secure proper treatment, order x-rays, injections, anesthesia, or surgery, and to release any records necessary for insurance purposes for my child as named above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

I agree that the YMCA shall not be responsible for any personal injuries or losses sustained by me or my family on any YMCA premises, or as a result of any YMCA sponsored activities. I further agree to indemnify and hold harmless the Y from any claims or demands arising out of any such injuries or losses. The undersigned hereby releases, waives, discharges, and covenants do not sue the Y, its directors, officers, employees, and agents from any claims for injury, illness, death, loss or damage that may be suffered as a result of participation in these activities. The undersigned acknowledges that a physician should be consulted prior to participating in any physical activity or program.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

Child's Name \_\_\_\_\_

## School Age Care Parent/Guardian Agreement Form

Please read and retain the Parent Handbook available on our website at [www.RaritanValleyYMCA.org](http://www.RaritanValleyYMCA.org) under After School / Child Care Handbook. Registration is not complete until completed forms and fees are processed.

### I acknowledge the following:

I have received and read the Parent Handbook and I am fully aware of the policies of the Raritan Valley YMCA Child Care programs and any questions have been answered to my satisfaction by the YMCA staff. I also agree to complete additional forms from the website, as necessary, including Permission to Administer Medication Form. By signing below, I understand and agree to accept the terms and conditions of the policies in the Parent Handbook (revised July 2024) including:

### PLEASE CHECK ALL BOXES

- Information to Parents Statement prepared by the NJ Bureau of Licensing
- Policy on the Release of Children
- Behavior Management, Positive Guidance, Discipline and Expulsion Policy
- Policy on Methods of Parent Communication
- Babysitting Policy
- Health Policy & Communicable Disease Management
- Absences and Tuition Credits Policy
- Technology & social media Policy
- YMCA Parent Handbook

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### I understand the following:

- Monthly fees are based on 180 days of school and include early dismissals.
- I must give 30 days' notice, in writing, prior to the first (1st) of the month I want to cancel.
- Deposits will be applied to the last month once 30 days' notice has been received, in writing.
- Membership Fees are non-refundable/transferable.
- I must communicate any changes in contact information, emergency contacts, or medical needs, in writing.
- I will request a Permission to Administer Medication and follow all guidelines, if needed.
- My child needs to complete homework in the provided time or do so at home. Assistance will be provided.
- The Y provides one serving size snack each day and I may send additional snacks in his/her backpack.
- The Y is not responsible for any lost or stolen personal belongings and I should label all belongings.
- A late pick-up fee of \$15 for each 15-minute interval is charged after your pre-arranged pick up time.
- It is my responsibility to communicate my child's participation in the Y's program to his/her school to ensure my child is placed in the appropriate bus line.

Parent/Guardian Signature \_\_\_\_\_

### I give the Y permission for the following:

- To have my child to participate in walking trips within the center's neighborhood.
- To transport my child on occasional trips, with advance communication.
- To use any media footage of my child for publicity purposes. (Cross off if not authorized.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## LATE PICK-UP FEE POLICY

The YMCA Afterschool Program ends promptly at 6:00pm. We understand that emergencies occur. We kindly ask you to consider your child's well-being and our staff's responsibilities outside of the YMCA. Their time is also valuable, and they may have other obligations.

Please call the center if you anticipate being late on any given day. Calling does not waive the late fees but does allow the YMCA to make arrangements for supervision of the child until the parent /guardian arrives. We also ask that you contact your alternate authorized contacts to arrange to pick-up your child timely to avoid late fees.

Parents/guardians must pay a considerable late fee if the child is picked up after the program ends. A fee of \$15.00 for up to every fifteen (15) minutes is charged and payable before you sign your child in again. **(Examples 6:01-6:15pm=\$15.00, 6:16 – 6:30=\$30.00, 6:31-6:45pm=\$45.00 etc.)**

### **AFTER 3 LATE PICK UPS, YOUR CHILD MAY BE SUSPENDED FROM THE PROGRAM.**

If the parents or persons authorized by parents fail to pick-up a child at the time of the center's daily closing, the procedure shall require:

- The child is always supervised.
- Staff attempt to contact the parents or persons authorized by the parents.
- An hour or more after closing time, provided that other arrangements for releasing the child to his/her parents or additional authorized contacts have failed, and staff cannot continue to supervise the child at the center, staff shall call the Division's 24-hour Child Abuse Hotline (1-800-792-8610) to seek assistance in caring for the child until the parents/authorized contact is able to pick up the child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SUNSCREEN POLICY

The childcare participants spend a great deal of time in the outdoors and are thereby exposed to the sun's harm-full rays. Since it is our commitment to promote healthy spirits, minds, and bodies, we have made the following policies in this regard:

- It is suggested that all children and staff wear sunscreen with an SPF of at least 15 on all exposed skin.
- Parents or legal guardian will be responsible for applying the first layer of sunscreen prior to drop off.
- Parents or legal guardians will be responsible for providing the children with enough sunscreen (in a sealed container) to take with them for later applications. One container per child, please.
- Childcare staff will be responsible for ensuring thorough follow-up applications after one hour in the water, after 2 hours of activity in the sun (due to perspiration), and/or any other time that it is needed. Please note, this will mean your child will have the sunscreen applied for them by the childcare staff. Please explain this to your child before attending.

• For children who have fair skin, freckles, or numerous moles, have blonde, red or light brown hair; have blue, green, or gray eyes; tend to burn easily and tan little or not at all; and have a family history of skin cancer, we recommend an extra t-shirt and hat be brought to wear in the water for extra protection.

**I understand the Y reserves the right to disallow anyone to participate in the childcare program at any time for failure to comply with this policy.** Please note that these decisions were made to protect your child. Furthermore, our staff members have been trained on this subject and understand their responsibilities and the consequences for failure in observing this policy.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# **Minor Participant Waiver, Release, Indemnification of All Claims & Covenant Not to Sue**

**PLEASE READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT, YOU ARE RELEASING RARITAN VALLEY YMCA FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFOR**

## **Assumption of Risk**

I, in my legal capacity as parent/guardian of the minor named below (“Minor”), acknowledge and agree that any use of Raritan Valley YMCA facilities, services, equipment and premises (“Facilities”) and any participation in Raritan Valley YMCA programs and activities (“Programs”) comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily, for myself and Minor, accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

## **Waiver, Release, Indemnification & Covenant Not to Sue**

In consideration of Minor’s use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that Raritan Valley YMCA, its officers, directors, agents, employees, volunteers, insurers and representatives (“Releasees”) will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, arising out of or in any way related to the use of Facilities and participation in Programs.

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Minor Name (Print Clearly)

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Date

---

Parent/Guardian Signature

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Parent/Guardian Name (Print Clearly)



# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____ / _____ / _____	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	
<b><i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i></b>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		_____	
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <b><i>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.</i></b>					
Name of Health Care Provider (Print) _____			Health Care Provider Stamp: _____		
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](http://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](http://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 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.