RED CLAY SCHOOLS

Red Clay Enrollment Document Checklist

Please complete the forms included in this packet and return to your assigned school.

- ☐ Birth Certificate: A valid birth certificate. A copy of the birth certificate sent directly to the school by the previous school may be accepted. If the birth certificate does not contain the name of the parent who is registering the child, additional guardianship verification is required. A legal document (from the court system) may be accepted with the birth certificate if it states the parent's name, relationship to the child and the child's date of birth
- ☐ Record of physical examination (completed within the last 24 months)
- ☐ Current immunization record
- ☐ Tuberculosis Risk Assessment
    - ☐ Kindergarten students only: Lead Screening
- ☐ Most recent student report card (grades K-8), most recent transcript (grades 9-12)
- ☐ IEP (Individualized Education Plan) documentation (if applicable)

Two Proofs of Residence - Parent, legal guardian or relative caregiver of the child being registered is required to provide at least two documents from the list below. Addresses must be the same on both documents.

At least one item from group A and one item from group B must be provided.

Group A:

- ☐ Copy of the most recent month's mortgage statement (copy of home settlement statement may be accepted in lieu of mortgage statement if the home was recently purchased and a mortgage statement has not been received)
- ☐ Rental agreement (showing legal parent, legal guardian, or relative caregiver as an occupant)
- ☐ Sewer bill (current year)
- ☐ Real estate tax receipt (current year)
- ☐ A recent original gas or electric bill

Group B:

- ☐ Current automobile registration card or automobile insurance policy statement
- ☐ Rental insurance policy statement
- ☐ Most current year's tax documents
- ☐ Paycheck or pay stub (dated within the past 30 days)
- ☐ Two consecutive bank statements (dated within the past 90 days)
- ☐ Official US Postal Service change of address notification on returned mail (yellow label with new address should be attached to envelope next to the old address)
- ☐ Correspondence from a DE state agency such as Delaware Health and Social Services, Department of Services for Children, Youth and their Families, Department of Labor, or Delaware Division of Social Services

If living in the residence of another person, please complete the "Red Clay Consolidated School District Owner/Renter Affidavit of Multiple Occupancy" and the "Red Clay Consolidated School District Affidavit of Multiple Occupancy".

Please direct any questions to your assigned Red Clay school.

Red Clay Consolidated School District

STUDENT DATA CARD

School Year: 2022-2023			
For Office Use Only:			
School:			
ID:			
Grade:		*Hmrm:*	

STUDENT INFORMATION

First Name:		2022-2023 Grade:	
Middle Name:		Birth Date:	
Last Name:		Nickname/Preferred Name:	
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Gender: ☐ Male ☐ Female	Primary Phone:

RACE and ETHNICITY DESIGNATION

Is this student Hispanic or Latino? (Select one answer.) Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino ☐ Yes ☐ No

Indicate this student's race below. You must select at least one race, regardless of ethnicity designation. More than one response may be selected.

☐ American Indian or Alaskan Native American ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Pacific Islander

ADDRESS Please indicate Physical (home) and Mailing address if they are different.

Physical Address		Mailing Address Same as Physical? ☐ Yes ☐ No	
Apt #:		Apt #:	
Address:		Address:	
Development:		Development:	
City, State, Zip:		City, State, Zip:	

SPECIAL CUSTODY INFORMATION If child lives with anyone other than mother or father listed on birth certificate please indicate:

Name:	
Relationship:	
Custodial Papers on file with school?:	☐ Yes ☐ No

ADDITIONAL INFORMATION

Has the student been expelled? ☐ Yes ☐ No

Does your child have (documentation required):

IEP (Individualized Education Plan)? ☐ Yes ☐ No	Learning Difficulties ☐ Yes ☐ No
504 Accommodation Plan? ☐ Yes ☐ No	Physical Difficulties: ☐ Yes ☐ No

EDUCATION BACKGROUND INFORMATION Name and address of previous school, pre-school, or day care

Name:			
Address:			
City, State, Zip:			
Phone:		Fax:	

SCHOOL AGE SIBLING INFORMATION

Name:				Name:			
School:		Grade:		School:		Grade:	
Name:				Name:			
School:		Grade:		School:		Grade:	

For Office Use Only:	Student:	ID:

Student Health History Update: **This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.**

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADD/ADHD	☐ Bleeding/Blood Disorder	☐ Concussion	☐ Heart	☐ Seizures
☐ Allergies	☐ Body Piercing/Tattoo	☐ Diabetes	☐ Infections	☐ Speech
☐ Asthma	☐ Bone/Spine	☐ Emotional	☐ Kidney	☐ Surgery
☐ Behavior	☐ Bowel/Bladder	☐ Hearing	☐ Physical Disability	☐ Vision

☐ Other: _____

Comments: _____

( ) Yes ( ) No **2. Does your child have allergies to medicine, latex or insect bites?**

To What? _____ What Happens? _____

Treatment _____

( ) Yes ( ) No **3. Does your child have a food allergy?**

To What? _____ What Happens? _____

Treatment _____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy. Please provide an Emergency Action Plan and ALL emergency medications to the School Nurse.

( ) Yes ( ) No **4. Will your child require an individualized, allergen-free menu designed by Nutrition Services?**

Note: Meals provided from home provide the safest food options at school for food-allergic students.

☐ **No.** I will take full responsibility for providing my child with allergen-free school meals.

☐ **Yes.** I will provide the School Nurse with a Food Allergy Plan completed by a licensed healthcare provider.

( ) Yes ( ) No **5. Has your child had any illnesses since school last ended?**

Type of illness, with date(s): _____

( ) Yes ( ) No **6. Has your child had surgery since school last ended?**

Type of surgery, with date(s): _____

( ) Yes ( ) No **7. Has your child received any immunizations since school last ended?**

List of immunization(s), with date(s): _____

( ) Yes ( ) No **8. Is your child being treated or evaluated for any health conditions?**

List condition(s): _____

( ) Yes ( ) No **9. Is your child on any medication or treatment?**

Name of medication and/or treatment: _____

( ) Yes ( ) No Does your child need medicine during school hours? ***If yes, please contact the School Nurse to make arrangements.***

( ) Yes ( ) No **10. Has your child ever been examined by an eye doctor?**

Date of last _____ Glasses Prescribed: **( ) Yes ( ) No**

If your child wears glasses or contact lenses, when was the prescription last changed? _____

( ) Yes ( ) No **11. What is the name of your child's dentist?** _____

What is the date of his/her last dental exam? _____

12. What is the name of your child's primary healthcare provider? _____

What is the date of his/her last physical exam? _____

( ) Yes ( ) No **13. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year? *If yes, please contact your School Nurse or School Counselor.**

( ) Yes ( ) No **14. Have you, your child or anyone in your household tested positive for COVID-19? *If yes, please contact the School Nurse.***

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

Permission for Over the Counter Medication Administration

I give permission for my child to have the following; as determined by the nurse:

Acetaminophen (Tylenol®) ☐ Yes ☐ No Ibuprofen (Advil®) ☐ Yes ☐ No Tums® ☐ Yes ☐ No

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

For Office Use Only:	Student:	ID:

DELAWARE EMERGENCY/NURSING TREATMENT CARD

Medical Information

Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Indicate student's serious medical diagnoses: _____

Student is allergic to: Medicine: _____ Food: _____ Other: _____

Medical Insurance: Medicaid No.: _____

Other: Certificate No.: _____ Group No.: _____ Type: _____

The purpose of this form is to provide the school with information to be used for the care of a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures that will normally be followed in caring for your child when your child requires emergency assistance at school for either a medical or behavioral health concern. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.
7. The information on this form may be shared with emergency medical staff.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

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

For Office Use Only:	Student:	ID:

PARENT/GUARDIAN CONTACT INFORMATION

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
E-Mail:			

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
E-Mail:			

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
Email:			

EMERGENCY CONTACT INFORMATION: Must be 18 years of age or older.

Important: In the event of an emergency, individuals listed here will be contacted if parent/guardian **cannot** be reached.

First Name:		First Name:	
Last Name:		Last Name:	
Relationship:		Relationship:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	

Delaware Department of Education

DELAWARE DEPARTMENT OF EDUCATION
TITLE I, PART C
Agricultural Work Survey

English/Spanish

Dear Parent/ Guardian,

Date: _____

In order to serve your child, _____, the _____ District/Charter School is
(Insert District/Charter School Name)
helping the State of Delaware identify students who may qualify to receive additional education and support services.

The information provided below will be kept confidential with in the Department of Education and will be used for planning purposes only. Please answer the following questions and return this form to your child's school.

1. In the past 3 years, has your family changed from: a) one school district to another; b) one state to another state; c) another country to the U.S.?

_____ YES _____ NO

If "NO," do not complete the remainder of this survey. If "YES," please continue.

2. Was the reason for this change **to look for or to accept** a job in an agricultural or fishing activity such as those listed below? Answer this question even if you have a different type of job now.

_____ YES _____ NO

If "YES," please circle all that apply if you or your husband/wife, or someone in your household has worked with, on, or in a:

Farm	Chicken processing plant	Dried or dehydrated fruits/spices	Plant nursery/greenhouse
Dairy	Processing meat/fish	Sod farms	Tree growing or harvesting
Ranch	Cranberry bogs	Meat or food packing plant	Food processing
Cannery	Fresh/frozen juices	Mushrooms	Pet food processing
Chicken house	Fishery	Planting, picking, or packing fruits, vegetables, seeds, or nuts	Cleaning, weeding or preparing land for planting

Please add any other agricultural or fishing work/activity that you or your husband/wife or someone in your household has performed:

_____

Please list all children **ages 3-21 years old** in the home, including those not enrolled in school:

First / Last name	Date of Birth	Age	Grade	School

Parent/Guardian: _____

Address: _____ Apt. No. _____ City: _____ Zip: _____

Phone: _____ Best time to be reached _____ AM / PM Alternate or cell phone number: _____

DISTRICTS: All **ORIGINAL** copies of the survey with **"YES"** responses for **BOTH** questions 1 and 2 **MUST** be submitted to the Delaware Department of Education **Migrant Education Program Office** within 10 days of the student's enrollment by **State Mail Code N510** or by U.S. Postal Service to **35 Commerce Way, Suite 1, Dover, DE 19904**. A COPY of this form must be retained in the student's file to document compliance with the Title I, Part C federal program requirements.

Delaware Department of Education

DEPARTMENT OF EDUCATION

Townsend Building
401 Federal Street Suite 2
Dover, Delaware 19901-3639
DOE WEBSITE: http://www.doe.k12.de.us

Susan S. Bunting, Ed.D.
Secretary of Education
Voice: (302) 735-4000
FAX: (302) 739-4654

Delaware Department of Education Home Language Survey

Date: _____ **School:** _____

The Delaware Department of Education requires schools to determine the language(s) spoken at home by each student. The information provided will only be used to determine whether your student is eligible to begin the English as a Second Language process and will not be used for immigration matters or reported to immigration authorities.

Student Information				
First Name:			**Country of birth:**	
Last Name:			**Date of entry in the US:**	
Birthdate:			**Date student first enrolled in a US school:**	

Circle grades your child attended in US schools

PK K 1 2 3 4 5 6 7 8 9 10 11 12

How many total months has the student been enrolled in a US school? _____

1. What language did your child first learn?

   Language: _____ | Dialect: _____

2. What language does your child most often use at home?

   Language: _____ | Dialect: _____

3. What languages do you most often speak to your child?

   Language: _____ | Dialect: _____

4. What language(s) other than English are spoken in your home?

   Language: _____ | Dialect: _____

5. What language would you prefer to receive information from your school?

   Language: _____ | Dialect: _____

_____ Parent Name

_____ Parent Signature

_____ Date

LEA : Please have all families complete this home language survey at the student's initial enrollment in school. This form must be signed and dated by the parent or guardian and kept in the student's file. (If a language other than English or Non-US English is listed on questions 1-3, the LEA must continue with a records review, step 2 of the English learner identification process.)

THE DELAWARE DEPARTMENT OF EDUCATION IS AN EQUAL OPPORTUNITY EMPLOYER. IT DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, GENDER IDENTITY, MARITAL STATUS, DISABILITY, AGE, GENETIC INFORMATION, OR VETERAN'S STATUS IN EMPLOYMENT, OR ITS PROGRAMS AND ACTIVITIES

2022 – 2023 Military-Connected Youth Student Information Update Form

All Delaware public schools starting with the 2016 – 2017 school year are required to annually identify enrolled students who are "military-connected youth" pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014), and the reauthorized Every Student Succeeds Act (2015), 20 U.S.C. 6301 et seq. in order to possibly provide your student with additional supports and services if needed.

Please read the following statements and check the appropriate box below.

- If you are a parent or a step-parent, only check the box that specifically applies to you, your duty status and branch of the United States armed forces.
- If you are a parent or a step-parent meeting the definition of box one or two, and there is an immediate family member residing in the same household that meets the definition of box three, then both boxes should be checked.
- If your student is not a "military-connected youth", please check the fourth box, "Non-Applicable".

PARENTS OR STEP-PARENTS

☐ **"Active Duty"** - I am a parent or step-parent who is an **"active duty"** member of the Armed Forces (United States Army, United States Navy, United States Air Force, United States Marine Corps, or United States Coast Guard) pursuant to 10 U.S.C. §101(d) (2014), and the reauthorized Every Student Succeeds Act (2015), 20 U.S.C. 6301 et seq.

☐ **"Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action"** - A parent or step-parent ***residing in the same household***, who is on active duty, serving in the reserve component, identified as a disabled veteran, killed in action, or recently retired (within 18 months prior to September 30 of the current school year) from a branch of the United States armed forces. Such branches consist of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

IMMEDIATE FAMILY MEMBER OR ANY OTHER PERSON RESIDING IN SAME HOUSEHOLD

☐ **"Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action"** - An immediate family member, including a sibling or any other person ***residing in the same household***, who is on active duty, serving in the reserve component, identified as a disabled veteran, killed in action or recently retired (within 18 months prior to September 30 of the current school year) from a branch of the United States armed forces. Such branches consist of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

☐ **NON-APPLICABLE**

Student Name: _____ Grade: _____

School Name: _____

Homeroom Teacher Name: _____

Please return this form to your student's homeroom teacher on or before Monday, September 19, 2022.

Delaware
Department of Education

Kindergarten Registration Questionnaire

1. Did your child attend a preschool or child care program in Delaware this past year?
   Circle: Yes or No

2. If yes, in which county did your child attend the program?
   Circle: New Castle County / Kent County / Sussex County

3. If yes, what was the name of the program?

   _____

RED CLAY CONSOLIDATED SCHOOL DISTRICT

DAYCARE TRANSPORTATION REQUEST

Student Name _____ Date _____
Last *First* *M.I.*

Student I.D. _____ School _____ Grade _____

Home Address _____ Kindergarten – AM☐ PM ☐

Development _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Pager_____ Cell Phone _____

Emergency Contact _____ Telephone No. _____

Before-School Child Care: ☐ **Home** ☐ **Other**

Name of Provider _____

Street Address _____

Development _____

City _____ Zip _____ Telephone No. _____

After-School Child Care: ☐ **Home** ☐ **Other** ☐ **Same as above**

Name of Provider _____

Street Address _____

Development _____

City _____ Zip _____ Telephone No. _____

Parent/Guardian (*please print*) _____

Parent/Guardian Signature _____

Date _____

SCHOOL STAFF TO SEND COPIES TO TRANSPORTATION AND THE ELEMENTARY OFFICE

TO: Transportation Supervisor

FROM: _____
(PARENT / GUARDIAN)

RE: **AUTHORIZATION TO DISCHARGE A KINGERGARTEN STUDENT FROM A SCHOOL BUS AFTER SCHOOL WITHOUT ADULT SUPERVISION**

DATE: _____

I authorize the Red Clay Consolidated School District to drop off my kindergarten child at his/her bus stop without adult supervision.

I understand that I assume full responsibility for my child's safety and welfare and will NOT hold the driver, the District, or any employees of the District or it's contractors responsible for any mishap, which could occur after my child is released from the bus.

Parents with students having an IEP with transportation modifications must first contact the school personnel to change the IEP.

STUDENT'S NAME: _____

ADDRESS: _____

HOME PHONE #: _____

BUS #: _____

BUS STOP LOCATION: _____

EFFECTIVE DATE OF AUTHORIZATION: _____

_____ PARENT / GUARDIAN SIGNATURE

_____ DATE

Copies: Transportation Office
Driver
School

Revised: January 2002

DELAWARE STUDENT HEALTH FORM – CHILDREN
PreK- Grade 6

To be completed by licensed healthcare provider:
Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician's Assistant (PA)

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) and your health care provider (Parts I, II, and III). All students in Delaware public schools must provide documentation of current immunizations. Additionally, a current (within 2 years) health examination is required upon school entry.

Talk with your health care provider about important issues[1] regarding your child, such as:

- ☐ **School** (readiness or adaptation, after school, parent-teacher communication, maturity, performance, special services)
- ☐ **Mental and Physical Activity** (healthy weight, well-balanced diet, physical activity, limited screen time)
- ☐ **Emotional Well-Being** (family time, social interactions, self-esteem, resolving conflicts, friends)
- ☐ **Physical Growth & Development** (dental care, healthy eating, puberty)
- ☐ **Injury & Illness Prevention & Safety** (seat belt or booster seat, bicycle safety, swimming, abuse protection, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- ☐ **Immunizations**

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]:

- ☐ **DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
- ☐ **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR[3]**: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B[3]**: 3 doses.
- ☐ **Varicella[4]**: 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6:

- ☐ **DTaP/DTP**: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required. Students who start the series at age 7 or older only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTap, DTP, or DT dose was administered –whichever is later.
- ☐ **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR[3]**: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B[3]**: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- ☐ **Varicella[4]**: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

Immunizations *Strongly* Recommended by the Delaware Division of Public Health

- ☐ **Influenza (seasonal) vaccine:** *each year* for *all* children (6 months and up).
- ☐ **Tetanus-Diphtheria-Pertussis (Tdap):** booster at age 11 or five years after the last dose
- ☐ **Meningococcal (MCV4):** all children at 11 or 12 years, and a booster does at age 16
- ☐ **Human papillomavirus vaccine (HPV):** all girls and boys (ages 11 or 12)
- ☐ **Pneumococcal vaccine (PCV13):** children with specific risk factors
- ☐ **Pneumococcal vaccine (PPSV):** certain high risk groups
- ☐ **Hepatitis A:** unvaccinated children who are or will be at increased risk

[1] Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd ed.) AAP, 2008
[2] Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.
[3] Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
[4] Varicella disease history must be verified by a health care provider to be exempted from vaccination.

CHILD'S NAME_____

PART I – HEALTH HISTORY

To be completed by parent/guardian prior to exam
The healthcare provider should review and provide comments in the last column.

Name:_____ **Gender:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
Serious injury or illness?			
Medication?			
Hospitalizations? When? What for?			
Surgery? (List all) When? What for?			
Ear/Hearing problems?			
Heart problems/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Allergies (food, insect, other)?	Yes	No	
Family history of sudden death before age 50?	Yes	No	
Child wakes during the night coughing?	Yes	No	
Diagnosis of asthma?	Yes	No	
Blood disorders (hemophilia, sickle cell, other)?	Yes	No	
Excessive weight gain or loss?	Yes	No	
Diabetes?	Yes	No	
Loss of function of one or paired organs (eye, ear, kidney, testicle)?			
Seizures?	Yes	No	
Head injuries/Concussion/Passed out?	Yes	No	
Muscle, Bone, or Joint problem/Injury/Scoliosis?	Yes	No	
ADHD/ADD?	Yes	No	
Behavior concerns?	Yes	No	
Eye/Vision concerns? ☐Glasses ☐Contacts ☐Other_____	Yes	No	
Dental concerns? ☐Braces ☐Bridge ☐Plate ☐Other? Date of exam _____	Yes	No	
Other diagnoses?	Yes	No	
Does your child have health insurance?	Yes	No	
Does your child have dental insurance	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian
Signature **Date**

CHILD'S NAME_____

PART II – IMMUNIZATIONS

Entire section below to be completed by MD/DO/APN/NP/PA
Printed VAR form may be attached in lieu of completion.

Immunizations – Shaded *Vaccines Required. Regulations is located at Title 14 Section 804 Immunizations.*

DTaP/ DT / /	**DTaP/ DT** / /	**DTaP/ DT** / /	**DTaP/ DT** / /	**DTaP/ DT** / /
OPV/ IPV / /	**OPV/ IPV** / /	**OPV/ IPV** / /	**OPV/ IPV** / /	**OPV/ IPV** / /
PCV7/ PCV13 / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /
Hib / /	**Hib** / /	**Hib** / /	**Hib** / /	
MMR / /	**MMR** / /	**HepB /HepB-2** / /	**HepB /HepB-2** / /	**HepB** / /
VAR / /	**VAR** / /	**RV-2/ RV-3** / /	**RV-2/ RV-3** / /	**RV-3** / /
MCV4 / /	**MCV4** / /	**HPV** / /	**HPV** / /	**HPV** / /
Hep A / /	**Hep A** / /	**Td/ Tdap** / /	**Td/ Tdap** / /	**Td** / /
Influenza / /	**Influenza** / /	**PPSV23** / /	**PPSV23** / /	
Other: / /	**Other:** / /	**Other:** / /	**Other:** / /	**Other:** / /

Child is fully immunized per DPH/CDC recommendations (refer to cover page) ☐ Yes ☐ No

PART III – SCREENING & TESTING

Entire section below to be completed by MD/DO/APN/NP/PA

Screen	**Height:** _____ (inches) **Weight:** _____ (pounds) **BMI:** _____ **BMI Percentile:** _____ **BP:** _____ **Pulse:** _____ **Other:** _____
Dental Screen	☐ **Problem Identified:** Referred for treatment ☐ **No Problem:** Referred for prevention ☐ **No Referral:** Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry. **Risk Assessment:** **Date**_____ **Results:** ☐ Test Required ☐ Test Not Required **Mantoux Skin Test:** **Date**_____ **Results:**_____MM **Other:** (type)_____ **Date**_____ **Results:**_____MM
Lead Test	Blood lead test required for children age 6 months through 6 years **Date:**_____ **Results:**_____
Other Screen	**Hearing:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date **Vision:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date **Other:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	REFERRAL	HEALTHCARE PROVIDER COMMENT
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal examination				
Nutritional status				
Mental health status				

FOR CHRONIC & LIFE THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency care plan for school.

Please attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals:_____

_____

_____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO

Print Name: _____ **Signature:** _____ **Date:** _____

☐**Physician (MD or DO)** ☐**Clinical Nurse Specialist (APN)** ☐**Advanced Practice Nurse (APN)** ☐**Physician Assistant (PA)**

Address: _____ **Phone:** _____

DELAWARE STUDENT HEALTH FORM – ADOLESCENT
Grades 7-12

To be completed by licensed healthcare provider:
Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician's Assistant (PA)

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) and your health care provider (Parts I, II and III). All students in Delaware public schools must provide documentation of current immunizations. Beginning in August 2016, students entering Grade 9 must have had an adolescent booster dose of Tdap and one dose of meningococcal vaccine. Additionally, a current (within 2 years) health examination is required upon school entry and prior to Grade 9.

Talk with your health care provider about important issues[1] regarding your child, such as:

- ☐ **Physical Growth and Development** (physical and oral health; body image; healthy eating; physical activity)
- ☐ **Social and Academic Competence** (connectedness with family, peers, school, and community; interpersonal relationships; school performance)
- ☐ **Emotional Well-Being** (coping; mood regulation and mental health; self-esteem; sexuality)
- ☐ **Risk Reduction & Safety** (tobacco; alcohol or other drugs; pregnancy; STIs; infection; disaster planning)
- ☐ **Violence & Injury Prevention** (safety belt and helmet use; substance abuse and riding in a vehicle; abuse protection; guns; interpersonal violence [fights/dating violence]; bullying)
- ☐ **Immunizations**

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

GRADES 7-12:

- ☐ **DTaP/DTP, Td/Tdap**: Completion of the primary series plus an adolescent booster dose of Tdap administered at age 11-12 or prior to entry into Grade 9.
- ☐ **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR**[2]: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B**[2]: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- ☐ **Varicella**[3]: 2 doses. The 1st dose must be given on or after the 1st birthday.
- ☐ **Meningococcal:** 1 dose is required for entry into Grade 9. A second dose is recommended by the Division of Public Health for all adolescents.

Immunizations *Strongly* Recommended by the Delaware Division of Public Health

- ☐ **Influenza (seasonal) vaccine:** *each year* for *all* children (6 months and up).
- ☐ **Human papillomavirus vaccine (HPV):** all girls and boys (ages 11 or 12)
- ☐ **Pneumococcal vaccine (PCV13):** children with specific risk factors
- ☐ **Pneumococcal vaccine (PPSV):** certain high risk groups
- ☐ **Hepatitis A:** unvaccinated children who are or will be at increased risk

[1]Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd Ed.) AAP, 2008
[2]Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
[3]Varicella disease history must be verified by a health care provider to be exempted from vaccination.
[4]A new school enterer is a child entering a Delaware school district for the first time.

CHILD'S NAME_____

PART I – HEALTH HISTORY

To be completed by parent/guardian prior to exam
The healthcare provider should review and provide comments in the last column.

Name:_____ **Gender:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
Serious injury or illness?			
Medication?			
Hospitalizations? When? What for?			
Surgery? (List all) When? What for?			
Ear/Hearing problems?			
Heart problems/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Allergies (food, insect, other)?	Yes	No	
Family history of sudden death before age 50?	Yes	No	
Child wakes during the night coughing?	Yes	No	
Diagnosis of asthma?	Yes	No	
Blood disorders (hemophilia, sickle cell, other) ?	Yes	No	
Excessive weight gain or loss?	Yes	No	
Diabetes?	Yes	No	
Loss of function of one or paired organs (eye, ear, kidney, testicle)?			
Seizures?	Yes	No	
Head injuries/Concussion/Passed out?	Yes	No	
Muscle, Bone, or Joint problem/Injury/Scoliosis?	Yes	No	
ADHD/ADD?	Yes	No	
Behavior concerns?	Yes	No	
Eye/Vision concerns? ☐Glasses ☐Contacts ☐Other_____	Yes	No	
Dental concerns? ☐Braces ☐Bridge ☐Plate ☐Other? Date of exam _____	Yes	No	
Other diagnoses?	Yes	No	
Does your child have health insurance?	Yes	No	
Does your child have dental insurance	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature **Date**

CHILD'S NAME_____

PART II IMMUNIZATIONS

Entire section below to be completed by MD/DO/APN/NP/PA
Printed VAR form may be attached in lieu of completion.

Immunizations – *Shaded Vaccines Required. Regulation is located at Title 14 Section 804: Immunizations*

DTaP/ DT / /	**DTaP/ DT** / /	**DTaP/ DT** / /	**DTaP/ DT** / /	**DTaP/ DT** / /
OPV/ IPV / /	**OPV/ IPV** / /	**OPV/ IPV** / /	**OPV/ IPV** / /	**OPV/ IPV** / /
PCV7/ PCV13 / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /	**PCV7/ PCV13** / /
Hib / /	**Hib** / /	**Hib** / /	**Hib** / /	
MMR / /	**MMR** / /	**HepB /HepB-2** / /	**HepB /HepB-2** / /	**HepB** / /
VAR / /	**VAR** / /	**RV-2/ RV-3** / /	**RV-2/ RV-3** / /	**RV-3** / /
MCV4 / /	**MCV4** / /	**HPV** / /	**HPV** / /	**HPV** / /
Hep A / /	**Hep A** / /	**Td/Tdap** / /	**Td/ Tdap** / /	**Td** / /
Influenza / /	**Influenza** / /	**PPSV23** / /	**PPSV23** / /	
Other: / /	**Other:** / /	**Other:** / /	**Other:** / /	**Other:** / /

Child is fully immunized per DPH/CDC recommendations (refer to cover page) ☐ Yes ☐ No

PART III – SCREENING & TESTING

Entire section below to be completed by MD/DO/APN/NP/PA

Screen	**Height:** _____ (inches) **Weight:** _____ (pounds) **BMI:** _____ **BMI Percentile:** _____ **BP:** _____ **Pulse:** _____ **Other:** _____
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Other Screen	**Hearing:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date **Vision:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date **Other:** **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	HEALTHCARE PROVIDER COMMENT
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Ears			
Nose/Throat			
Mouth/Dental			
Cardiovascular			
Respiratory			
Endocrine			
Gastrointestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Spinal examination			
Nutritional status			
Mental health status			

FOR CHRONIC & LIFE THREATENING CONDITIONS:

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Please attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals:_____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO

Print Name: _____ **Signature:** _____ **Date:** _____

☐ **Physician (MD or DO)** ☐ **Clinical Nurse Specialist (APN)** ☐ **Advanced Practice Nurse (APN)** ☐ **Physician Assistant (PA)**

Address: _____ **Phone:** _____