Welcome to the Caesar Rodney School District!

Home of the Riders

There are many opportunities within Caesar Rodney School District for your student to excel and we are excited to begin your child's registration process. Please visit our website:


*To ensure a successful registration, the following information is required:

1. Student's Birth Certificate
2. Proof of residency with parent/guardian name – mortgage statement or lease agreement w/landlord and parent/guardian's name*. If a mortgage statement or lease agreement is not available, the school will need a copy of the electric, gas, or water bill.
3. Immunization records and current physical (within the last two years)
4. Photo identification of the parent and/or guardian
5. Custody documentation (if applicable)
6. IEP documentation (if appropriate)
7. 504 documentation (If appropriate)

If you are transferring to Caesar Rodney School District from another school district, please provide the following:

1. Withdrawal papers from the former school
2. Transcript of grades or report cards from former school
3. Standardized testing results (if available)

Kindergarten: In Delaware, students must be five years old by August 31st of the current school year to attend kindergarten.

*The lack of information will not serve as a barrier to registration and placement for those students who are eligible for services under the McKinney Vento Homeless Education Act.

The Caesar Rodney School District is an Equal Opportunity Employer and does not discriminate in employment or educational programs, services or activities based on race, color, religion, national origin, gender, age, veteran or marital status, disability, sexual orientation, gender identification or genetic information in accordance with State and Federal laws. Inquiries about compliance should be made to the Title IX, District 504 and ADA Compliance Coordinators. The following have been appointed to serve as the District's Compliance Coordinators. These coordinators can be contacted at the Paul L. Dunbar Administration Building at 7 Front Street, Wyoming, DE 19934 or at (302) 698-4800.
Caesar Rodney School District
Student Registration Checklist

Student Name ____________________________________________

Grade ___________________ Homeroom ___________________

<table>
<thead>
<tr>
<th>Items Required for Registration</th>
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<tbody>
<tr>
<td>Registration Form</td>
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<tr>
<td>Emergency Treatment Information</td>
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<tr>
<td>Student Residency Form</td>
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<tr>
<td>Delaware DOE Home Language Survey</td>
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<tr>
<td>Agriculture Work Survey</td>
</tr>
<tr>
<td>Birth Certificate</td>
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<tr>
<td>proof of Residency w/parent/guardian’s name *</td>
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<tr>
<td>Immunization Records and current physical (within the last two years)</td>
</tr>
<tr>
<td>Proof of parenthood/guardianship – may require custodial papers and primary placement papers</td>
</tr>
<tr>
<td>Picture identification</td>
</tr>
<tr>
<td>Caesar Rodney School District Student History (2 Pages)</td>
</tr>
<tr>
<td>Delaware Student Health Form (one of the below)</td>
</tr>
<tr>
<td>Children – PreK to Grade 6 (4 pages)</td>
</tr>
<tr>
<td>Adolescent – Grades 7-12 (4 pages)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Items Required for Kindergarten / PreK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Information Form (2 pages)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Transferring from Another District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal papers from former school</td>
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<tr>
<td>Transcript of grades or report cards from former school</td>
</tr>
<tr>
<td>IEP/504 Documentation (if applicable)</td>
</tr>
<tr>
<td>Standardized Assessment results</td>
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Caesar Rodney School District Registration Form

School ____________________________  Grade _______ Date ____________

Transferring from ____________________________

Is this child currently attending or is there a contract
signed with a charter school?

Yes ___   No ___   Where ____________________________

Has this child ever attended Caesar Rodney School District before?

Yes ___   No ___   When ____________________________

Student Information

Legal Name of Child ____________________________  Age _______

Nickname(s) ____________________________  Has Child Been Retained? : ☐ Yes ☐ No  Grade(s) _______

Birth Date: _____________  Gender: ☐ Male ☐ Female  Active Military: ☐ Yes ☐ No

Hispanic: ☐ Yes ☐ No  Race: ☐ American Indian/AK  ☐ Black/African American  ☐ Caucasian  ☐ Asian

☐ Native Hawaiian/Pacific Islander

Child’s Home Language: ____________________________  Child’s Complete Physical Address (If Different):

PO Box / Street ____________________________  Street ____________________________

City/State/Zip ____________________________  City/State/Zip ____________________________

Development ____________________________  Development ____________________________

Home Phone: ____________________________  Home Phone: ____________________________

*Check if Applicable: ☐ Homeless ☐ Foster Care ☐ Speech ☐ Title I ☐ Gifted ☐ 504 Plan ☐ IEP ☐ Other

Special Programs Needed:

Parent / Guardian Information

☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian  ☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian

☐ Other ☐ Other

Name: ____________________________________________  Name: ____________________________________________

Address: ____________________________________________  Address: ____________________________________________

Home Phone: ____________________________  Home Phone: ____________________________

Work Phone: ____________________________  Work Phone: ____________________________

Cell Phone: ____________________________  Cell Phone: ____________________________

Email: ____________________________________________  Email: ____________________________________________

Lives with: ☐ Yes ☐ No  Lives with: ☐ Yes ☐ No

Legal Custody: ☐ Joint ☐ Relative Caregiver  ☐ Joint ☐ Relative Caregiver

☐ Other ☐ Other

Emergency Contact:

Home Phone: ____________________________  Work Phone: ____________________________

Cell Phone: ____________________________

Siblings in Present Household Under Age 18:

Name ____________________________________________  Age _______  Grade _______

Name ____________________________________________  Age _______  Grade _______

Name ____________________________________________  Age _______  Grade _______

This is to confirm to Caesar Rodney School District Officials that I am the parent or legal guardian of the above child and that this is my legal address

Please Print Your Name ____________________________________________  Signature / Date ____________________________

FOR OFFICE USE ONLY

BUS ____________________________  SPECIAL ED. CLASS ____________________________  LUNCH ____________________________

CHROMEBOOK ____________________________  RECORDS REQUESTED ____________________________  TEACHER ASSIGNED ____________________________

Revised 02/06/2023
Caesar Rodney School District Emergency Treatment and Contact Information

Student Name: ___________________________ School: ___________________________

Child Resides with: ___________________________ Relationship: ___________________________
Address: __________________________________ Relationship: ___________________________

Bus No. To School: ___________________________ Grade: ___________________________
Bus No. From School: ___________________________ Birth Date: ___________________________
Daycare/ Sitter Name: ___________________________ Gender (M/F): ___________________________
Daycare Phone: ___________________________

<table>
<thead>
<tr>
<th>Guardian 1 Information</th>
<th>Guardian 2 Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
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<tr>
<td>Date of Birth:</td>
<td>Date of Birth:</td>
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<tr>
<td>Home Address:</td>
<td>Home Address:</td>
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<td>Home Phone:</td>
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<td>Cell Phone:</td>
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<td>Business Phone:</td>
<td>Business Phone:</td>
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<tr>
<td>Place of Employment:</td>
<td>Place of Employment:</td>
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<tr>
<td>E-mail Address:</td>
<td>E-mail Address:</td>
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<tr>
<td>Step-parent/Spouse Name:</td>
<td>Step-parent/Spouse Name:</td>
</tr>
<tr>
<td>Place of Employment:</td>
<td>Place of Employment:</td>
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<tr>
<td>Business Phone:</td>
<td>Business Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
</tbody>
</table>

Guardian 1 Information

Guardian 2 Information

IF PARENTS/GUARDIANS CANNOT BE REACHED, CALL:

Name | Relationship | Work Phone | Home Phone
--- | --- | --- | ---
1 | | | 
2 | | | 
3 | | | 

Student’s Physician: ___________________________ Phone ___________________________
Student’s Dentist: ___________________________ Phone ___________________________

Insurance Information:
Provider: ___________________________ Group #: ___________________________ Policy #: ___________________________ Medicaid #: ___________________________

Indicate student’s medical problems: __________________________________________________________
Medication student takes regularly: __________________________________________________________
ALLERGIES (food, medication, environmental) __________________________________________________

SCHOOL EMERGENCY PROCEDURES

In case of illness or injury, the school will attempt to contact both parents at all numbers available. If the parent is unable to be reached the emergency contacts will be called in the order they are listed. If no emergency contact is reached, appropriate medical care will be provided, including contacting the student’s physician and transfer by ambulance (if necessary) to a medical facility for further care and evaluation. The school will continue to call the parents, guardians or physician until one is reached.

I have read and understand the School Emergency Procedure and I agree to its implementation. If I cannot be reached, I agree to assume responsibility for the cost of emergency care including transportation by ambulance if necessary. I consent to emergency care, treatment, surgery, diagnostic procedure, or the administration of anesthesia which may be carried out based on the medical judgement of the attending physician to ensure my child’s health, safety and welfare.

Parent/Guardian Signature ___________________________ Date ___________________________

This information may be shared with school personnel on a “need to know” basis

Revised 02/06/2023
Delaware McKinney-Vento Student Residency Questionnaire

This Student Residency Questionnaire is intended to address the McKinney-Vento Act. Your answers will help the school personnel determine residency documents necessary for enrollment of this student. Information provided on this form is confidential.

Name of Student: ___________________________ D.O.B.: __________ Grade: _____ □ Male □ Female

Name of Current School: ___________________________ Name of Last School: ___________________________

Is your current address a temporary living arrangement? Yes □ No □

If you answered ‘YES’, please complete all questions on this form.
If you answered ‘NO’, please skip questions 1 – 4 and complete the bottom section.

1. Do you live in any of these following situations?
   □ Sharing the housing of other persons due to: (check one)
     □ Loss of housing, economic hardship or a similar reason (example: evicted, lost job, etc.)
     Explain: _____________________________________________________________
     □ Long-term, cooperative living arrangement to save money or a similar reason
     □ Other (please specify): _______________________________________________________________________________________
   □ In a motel, hotel, campground or similar setting due to: (check one)
     □ Lack of alternative adequate accommodations,
     Explain:  _____________________________________________________________________________________________
     □ A convenient living arrangement or waiting for apartment or house to be ready
     □ Other (please specify): _________________________________________________________________________________
   □ In an emergency or transitional shelter such as a domestic violence shelter or a homeless shelter or transitional housing or other shelter
   □ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans
   □ In a car, park, public space, abandoned building, substandard housing, bus or train station, or similar setting
   □ None of the above

2. How long do you anticipate living at this location? ____________________________________________

3. The student lives with:
   □ Parent(s) or legal guardians(s)
   □ Relative(s), friend(s), or other adults(s) who are not the parent or the legal guardian
   □ Alone with no adults

4. Please list the name and ages of any children living with you that you have guardianship of:
   A. ________________________________________________________________  C. ________________________________________________
   B. ________________________________________________________________  D. ________________________________________________

I am the parent/legal guardian of ________________________________, who is of school age and who is seeking enrollment in the school district.

I understand that presenting a false record of falsifying records is an offense under Federal and state laws and enrollment of the child under false documents subjects the person to liability for tuition and other costs.

Printed Name: __________________________________________________________________
Signature: ___________________________________________ Date: _______________ Email: _____________________________
Address: __________________________________________________________________________
Phone Number with Area Code: __________________________ Emergency contact Phone Number with Area Code: ___________________________

(Rev 8/2019)
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.

<table>
<thead>
<tr>
<th>Student Information</th>
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</thead>
<tbody>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>Birthdate:</td>
</tr>
</tbody>
</table>

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.)
Dear Parent/Guardian,

In order to serve your child, __________________________, the __________________________ District/Charter School is 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 within 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:

<table>
<thead>
<tr>
<th>First / Last name</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
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Parent/Guardian: __________________________________________

Address: __________________________________________ Apt. No. _______ City: _______ Zip: _______

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

DISTRICTS: The ORIGINAL document 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.

Revised - January 2023
Estimado Padre/Madre o Adulto responsable del estudiante,

Con el fin de servir mejor a su niño, ____________________________, el distrito escolar ____________________________
(Inser District/Charter School Name)

está asistiendo al estado de Delaware a identificar estudiantes elegibles para recibir beneficios y apoyos. La información proporcionada es confidencial y será utilizada por el Departamento de Educación para fines de planeación únicamente. Por favor, conteste las siguientes preguntas y devuelva este formulario a la escuela de su hijo.

1. ¿En los últimos 3 años, su familia se ha cambiado de: a) un distrito escolar a otro; b) un estado a otro; c) otro país a Estados Unidos?
   _______ SÍ _______ NO

Si es "NO", no complete el resto de esta encuesta. Si es "SI", por favor continúe.

2. ¿El motivo de este cambio ha sido por buscar o aceptar un empleo en una actividad agrícola o de pesca, o en alguna de las actividades enlistadas abajo? Conteste aunque tenga otro tipo de trabajo actualmente.
   _______ SÍ _______ NO

Si es "SI", por favor marque todo lo que corresponda si usted, su esposo/a u otro miembro del hogar ha trabajado en/con:

- Granja
- Rastro/ Carnicería
- Cultivar Césped
- Invernadero
- Lechería
- Procesar carne/pescado
- Empacar carne/alimentos
- Plantar y cultivar árboles
- Rancho
- Cultivo de Arándanos
- Granja de Hongos
- Procesar alimentos
- Enlatadora
- Jugo Fresco/ Congelado
- Plantar, pizar o empaquetar
- Procesar limento para mascota
- Gallineros
- Pescado y Marisco
- Frutas, vegetales, semillas, nueces
- Desyerbar o preparar el terreno para plantar
- Planta de Pollo/Pollera
- Frutas secas/especias
- Gallineros
- Planta de Pollo/Pollera

Favor de anotar otro trabajo/actividad agrícola o de pesca que usted, su esposo/a u otro miembro del hogar haya realizado:
___________________________________________________________________________________

Anote todos los niños y jóvenes entre 3-21 años de edad en el hogar, incluyendo los que no asisten a la escuela:

<table>
<thead>
<tr>
<th>Nombre y Apellido</th>
<th>Fecha de Nacimiento</th>
<th>Edad</th>
<th>Grado</th>
<th>Escuela</th>
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Padre/Madre o Adulto responsable del estudiante: ____________________________________________

Dirección: ___________________________________ Ciudad __________________ Zip

Teléfono 1: ___________________ Teléfono 2 ___________________ Hora: ________________ AM/PM

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Dear Parent/Guardian,

In order to serve your child, _______ the _______ District/Charter School is 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:

   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:

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</tbody>
</table>

Parent/Guardian: ________________________________ Date: ________________________________

Address: ___________________________________________ Apt. No. ______ City: ___________ Zip: ___________

Phone: __________________ Best time to be reached __________ AM / PM Alternate or cell phone number: _______

DISTRICTS: The ORIGINAL document must be submitted to the Delaware Department of Education Migrant Education Program Office within 10 days of the student’s enrollment by State
Chè Paran(yo),

Dat: _____________

Nan lide pou li sevi pitit ou a, ____________________________________la ________________________________Distri Lekòl

(Insert District/Charter School Name)
yo ap ede Eta Delaware idantifye elèv ki kapab kalifye pou resevwa plis edikasyon ak sèvis sipò.

Enfòmasyon ke w bay pi ba ap rete konfidsanyèl. Tanpri reponn kesyon sa yo epi retounen fòm sa a nan lekòl pitit ou .

1) Nan twa (3) dènye ane yo, eske fanmi ou te chanje soti nan: a) yon distri lekòl pou al nan yon lòt ; b) yon eta pou ale nan yon lot eta ; c) yon lòt peyi pou vin nan US

____________Wi ________________Non

Si w repon « Non » ou pa bezwen kontinye rès sondaj la. Si w repon « Wi » tanpri kontinye.

2) Eske rezon kifè chanjman sa yo sete pou w chache si w jwen oswa aksepte yon djob nan jaden oswa nan yon nan aktivite sa yo ki nan lòs anba a. Reponn kesyon sa a mem si w gen yon lòt kalite travay ki diferan kounye a.

____________Wi ________________Non

Si "wi". tanpri ansèkle tout sa ki aplike pou oumenm oswa mari ou / madanm, oswa yon moun lakay ou ki te travay nan youn nan sa yo:

fèm Usine ki prepare poul Fwi a kepis sech epi santibon Pepinyè / lakòz efè tèmik
letye Usine kote yo prepare vyann / Kote yo van sèl pwason Kote yo plante pye bwa oswa rekòlòte

pwason
elvaj Kote ki gen Cseriz Usine Kote yo anbale vyann ak manje Faktory kote yo met manje nan mamit
konsèrveri Ji fresh / jele dyondyon Preparasyon manje pou bet
Kay Poul Lapèch Plante , ranmase, anbale fwi, legim, vyan, nwa Netwayaj, saklay te plantasyon

Tanpri ajoute nenpòt lòt travay ki gen rapò ak aktivite agrikòl oswa lapèch ke w ka fè :

___________________________

Tanpri fè lis tout ti moun lakay ou ki gen laj 3-21 ane. Mete sak pako ale lekòl tou

<table>
<thead>
<tr>
<th>Non/sinyati</th>
<th>Dat timoun nan fèt</th>
<th>Laj li</th>
<th>Clas li</th>
<th>Lekòl li</th>
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</table>

Paran/ moun responsab : ___________________________________________ Dat: _________________________

Apt. No ______________ Katye __________________________ Kòd __________________________

Phone _____________________ Pi bon lè pou rele w __________ AM/PM Lòt telefòn/ selilè Nîmero telefòn li __________________________

DISTRICTS: The ORIGINAL document 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.
Date_________________________ School_____________________________________

Child’s Name_________________________ (Last)_________________________ (First)_________________________ (Middle)_________________________

Birth Date_________________________ Race_________________________ Sex  □ M  □ F

PLEASE READ EACH QUESTION CAREFULLY AND FILL IN THE BLANKS COMPLETELY AND ACCURATELY.

1. Birth weight of child?__________ Born early? □ Yes  □ No  If yes, how many weeks early?__________

2. Were there any unusual difficulties for the mother or baby during pregnancy or birth of this child?  □ Yes  □ No
   If yes, please explain:__________________________________________

   Did your child need oxygen at time of birth? □ Yes  □ No

3. Does your child have asthma?  □ Yes  □ No  If yes, □ Mild  □ Moderate  □ Severe
   Medication at school?__________________________________________

4. Does your child have: Sickle Cell Anemia?  □ Yes  □ No

5. Does your child have: Diabetes?  □ Yes  □ No

6. Does your child have allergies (medicine, food, environment, insect bites, latex, etc)?  □ Yes  □ No
   If yes, list them and describe in detail what happens to the child.__________________________________________

   ____________________________________________________________

7. Does your child take medicine for allergies?  □ Yes  □ No  Medication__________________________________________
   Would it be necessary to have this medicine on hand at school in case of a sudden allergic reaction? □ Yes  □ No

8. Has this child ever been admitted overnight to a hospital?  □ Yes  □ No  Why?__________________________

9. Has this child ever been on any long-term medication?  □ Yes  □ No
    If yes, what kind?__________________________________________

10. Has this child experienced any of the following?
    □ Seizures  □ Feeding Problems  □ Physical Problems
    □ Persistent High Fever  □ Sleeping Problems  □ Chronic Illness
    □ Head Injury  □ Toileting Problems

    If yes to any of the above, please explain:
    _________________________________________________________
11. Speech Problems? □ Yes □ No  Evaluation? □ Yes □ No  Therapy? □ Yes □ No
If yes, where? ________________________________________________________________

12. Hearing problems? □ Yes □ No
Doctor’s Name__________________________ Date of Last Visit_________________________

13. Vision Problems? □ Yes □ No  □ Glasses  □ Contacts
Doctor’s Name__________________________ Date of last visit_________________________

14. Has this child ever had chickenpox? □ Yes Date______________ □ No

15. At about what age did the child begin the following?
   Sit alone________  Crawl_______  Walk________  Say simple words________

16. Have you had concerns that your child might experience difficulty adjusting or achieving in school? □ Yes □ No
   Explain:____________________________________________________________________

17. Has the child had any previous school or nursery experiences? □ Yes □ No
   If yes, where?________________________ When?______________________________

18. Do you believe your child has a special need: Please check all your concerns from the following list.
   Behavior: □ Has Tantrums  □ Is not able to accept limits
              □ Resists rules or refuses to comply with requests  □ Is destructive with toys
   Socialization: □ Does not play with other children  □ Does not separate from me easily
   Speech/Language: □ Has unclear or garbled speech  □ Has difficulty expressing wants
                    □ Uses incomplete sentences  □ Needs instructions repeated often
   Attention: □ Is easily distracted  □ Has a short attention span
              □ Darts from one task to another  □ Persists when asked to stop
   Developmental Abilities: □ Does not appear to be learning at an average rate
                            □ Acts much younger than his or her age
                            □ Has had delays in developmental milestones
                            □ Seeks much younger friends
   Motor: □ Is clumsy  □ Has difficulty using pencils, crayons or scissors
           □ Has difficulty buttoning or zipping

19. Is English the primary language in the home? □ Yes □ No  Primary Language________________________

20. Please write here any concerns you have regarding your child's physical, mental, and/or emotional health.
______________________________________________________________________________
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 4\(^{th}\) dose was prior to the 4\(^{th}\) birthday, a 5\(^{th}\) dose is required.
- **Polio**: 3 or more doses. If the 3\(^{rd}\) dose was prior to the 4\(^{th}\) birthday, a 4\(^{th}\) dose is required.
- **MMR**: 2 doses. The 1\(^{st}\) dose should be given on or after the 1\(^{st}\) birthday. The 2\(^{nd}\) dose should be given after the 4\(^{th}\) birthday.
- **Hep B**: 3 doses.
- **Varicella**: 2 doses. The 1\(^{st}\) dose should be given on or after the 1\(^{st}\) birthday and the 2\(^{nd}\) dose after the 4\(^{th}\) birthday.

**GRADES 1-6**:

- **DTaP/DTP**: 4 or more doses. If the 4\(^{th}\) dose was prior to the 4\(^{th}\) birthday, a 5\(^{th}\) 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 3\(^{rd}\) dose was prior to the 4\(^{th}\) birthday, a 4\(^{th}\) dose is required.
- **MMR**: 2 doses. The 1\(^{st}\) dose should be given on or after the 1\(^{st}\) birthday. The 2\(^{nd}\) dose should be given after the 4\(^{th}\) birthday.
- **Hep B**: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- **Varicella**: 2 doses. The 1\(^{st}\) dose must be given on or after the 1\(^{st}\) birthday and the 2\(^{nd}\) dose after the 4\(^{th}\) 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.
# 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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gender:</th>
<th>DOB:</th>
<th>Date:</th>
<th>Examiner:</th>
</tr>
</thead>
</table>

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

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

Parent/Guardian

Signature: __________________________ Date: __________________________

November 2016
**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.

<table>
<thead>
<tr>
<th>DTaP/DT</th>
<th>DTaP/DT</th>
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<td>OPV/IPV</td>
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<td>PCV7/PCV13</td>
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<tr>
<td>MMR</td>
<td>MMR</td>
<td>HepB/HepB-2</td>
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<td>VAR</td>
<td>VAR</td>
<td>RV-2/ RV-3</td>
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<tr>
<td>Hep A</td>
<td>Hep A</td>
<td>Td/ Tdap</td>
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<tr>
<td>Influenza</td>
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<td>PPSV23</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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<td>Other:</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Screen</th>
<th>Height: _____</th>
<th>Weight: _____</th>
<th>BMI: _____</th>
<th>BMI Percentile: _____</th>
<th>BP: _____</th>
<th>Pulse: _____</th>
<th>Other: _____</th>
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<tbody>
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<td>(inches)</td>
<td>(pounds)</td>
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</table>

□ 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.

<table>
<thead>
<tr>
<th>Risk Assessment:</th>
<th>Date ________</th>
<th>Results: □ Test Required  □ Test Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mantoux Skin Test:</td>
<td>Date ________</td>
<td>Results: __________ MM</td>
</tr>
<tr>
<td>Other: (type):</td>
<td>Date ________</td>
<td>Results: __________ MM</td>
</tr>
</tbody>
</table>

**Lead Test**

Blood lead test required for children age 6 months through 6 years

Date: __________ | Results: ________________________________

**Hearing**

Date: __________ | Results: ________________________________ | Referral: □ No  □ Yes __________

**Vision**

Date: __________ | Results: ________________________________ | Referral: □ No  □ Yes __________

**Other Screen**

Date: __________ | Results: ________________________________ | Referral: □ No  □ Yes __________
# PART IV – COMPREHENSIVE EXAM

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

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>REFERRAL</th>
<th>HEALTHCARE PROVIDER COMMENT</th>
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</thead>
<tbody>
<tr>
<td>General Appearance</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Eyes</td>
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<tr>
<td>Ears</td>
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<tr>
<td>Nose/Throat</td>
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<tr>
<td>Mouth/Dental</td>
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<tr>
<td>Cardiovascular</td>
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<td>Respiratory</td>
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<td>Gastrointestinal</td>
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<td>Genito-Urinary</td>
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<td>Neurological</td>
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<td>Musculoskeletal</td>
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<tr>
<td>Spinal examination</td>
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<tr>
<td>Nutritional status</td>
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<tr>
<td>Mental health status</td>
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</tbody>
</table>

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**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:**
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

---

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>EMERGENCY PLAN ATTACHED</th>
<th>CARE PLAN OR PRESCRIPTION PLAN ATTACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
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Print Name: __________________________   Signature: ____________________________ Date: ______

- [ ] Physician (MD or DO)  - [ ] Clinical Nurse Specialist (APN)  - [ ] Advanced Practice Nurse (APN)  - [ ] Physician Assistant (PA)

Address: ______________________________________ Phone: __________________________
Child’s Name:_________________________________________________________ Date of Birth:__________

□ Male □ Female School:____________________________________________________

Pre-Kindergarten Experience (Required)

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

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

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

4. During the day, my child:
   □ Attends preschool: □ full day □ half day □ occasionally
   □ Attends a daycare center: □ full day □ half day □ occasionally
   □ Is home with a sitter: □ full day □ half day □ occasionally
   □ Is home with a parent: □ full day □ half day □ occasionally
   Other: ____________________________________________________________

5. My child uses:
   □ Crayons □ Scissors □ Telephone □ DVD Player
   □ Pen/pencil □ Blocks □ Videogames □ iPad/iPod
   □ Refrigerator □ Computer □ Paper □ Computer/ laptop
   □ Glue/paste □ Fingerpaint □ TV

6. The things my child does that please me most are:________________________

   _________________________________________________________________

7. The things my child does (or does not do) that worry me most are:_____________

   _________________________________________________________________

8. My child prefers the following toys and activities:_________________________

   _________________________________________________________________

9. The activities my child and I do together are:______________________________

   _________________________________________________________________

10. When my child disobeys me, I__________________________________________

   _________________________________________________________________
11. My child speaks in: □ single words □ phrases □ sentences

12. He or she began to talk at ______ months.

13. My child was: □ full term □ premature (by ________ weeks)

14. My child has the following medical problem(s):

15. When I leave my child for a short time or with a sitter, he or she will:

16. When my child and I look at a book, he or she will:

17. My child: □ sleeps through the night □ frequently wakes up

18. My child is: □ independent □ dependent for his/her age

**Parental Concerns**

1. **Behavior.** My child:
   - □ Has tantrums
   - □ Is not able to accept limits
   - □ Resists rules or refuses to comply with request
   - □ Is destructive with toys
   - □ Clings to an adult
   - □ Appears sluggish or lacks energy
   - □ Is fearful or worries a lot
   - □ Rarely smiles, giggles or laughs

2. **Socialization.** My child:
   - □ Does not play with other children
   - □ Does not separate from me easily
   - □ Will not work in a group
   - □ Is left out of activities with other children

3. **Speech/Language.** My child:
   - □ Has unclear or garbled speech
   - □ Has difficulty expressing wants
   - □ Uses incomplete sentences
   - □ Needs instructions repeated often
   - □ Repeats what he or she says
   - □ Doesn’t remember simple information from day to day
   - □ Gives inappropriate answers to questions

4. **Self-Help.** My Child:
   - □ Has toileting difficulties
   - □ Has difficulty feeding or dressing him/her self
   - □ Has difficulty following routines

5. **Attention.** My Child:
   - □ Is easily distracted
   - □ Has a short attention span
   - □ Darts from one task to another
   - □ Persists when asked to stop

6. **Developmental Abilities.**
   - My child:
     - □ Does not appear to be learning at an average rate
     - □ Has had delays in developmental milestones
     - □ Does not seem to understand well
     - □ Acts much younger than his/her age
     - □ Seeks much younger friends

7. **Motor.** My child:
   - □ Is clumsy
   - □ Has difficulty using pencils, crayons, or scissors
   - □ Has difficulty buttoning or zipping
   - □ Has hand/eye coordination problems
   - □ Has poor control of body movements

8. **Hearing.** My child:
   - □ Has trouble hearing
   - □ Asks people to repeat or talk louder
   - □ Favors one ear over the other
   - □ Is startled at sudden noises
   - □ Has earaches
   - □ Speaks loudly
   - □ Watches a person’s face when that person talks

9. **Vision Problems.** My child:
   - □ Has eyes that turn in or out
   - □ Squints
   - □ Tilts his or her head
   - □ Wants to sit too close to the TV
   - □ Holds books very close to his/ her face
   - □ Blinks a lot
   - □ Rubs his/her eye

10. **Medical/Health Related.**
    - My child:
      - □ Has been to the hospital _______ times
      - □ Has had serious illnesses
      - □ Has had accidents

If you have a concern that is not listed, please write it here:______________________________

Revised 02/06/2023
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. Additionally, a current (within 2 years) health examination is required upon school entry and prior to ninth (9th) grade.

Talk with your health care provider about important issues1 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: 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.
☐ MMR2: 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 B2: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.

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 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.
**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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gender:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Examiner:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PARENT</strong></th>
<th><strong>HEALTHCARE PROVIDER COMMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental delay (speech, ambulation, other)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Serious injury or illness?</td>
<td></td>
</tr>
<tr>
<td>Medication?</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations?</td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td>What for?</td>
</tr>
<tr>
<td>Surgery? (List all)</td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td>What for?</td>
</tr>
<tr>
<td>Ear/Hearing problems?</td>
<td></td>
</tr>
<tr>
<td>Heart problems/Shortness of breath?</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
</tr>
<tr>
<td>Allergies (food, insect, other)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Family history of sudden death before age 50?</td>
<td>Yes</td>
</tr>
<tr>
<td>Child wakes during the night coughing?</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnosis of asthma?</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood disorders (hemophilia, sickle cell, other)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Excessive weight gain or loss?</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
</tr>
<tr>
<td>Loss of function of one or paired organs (eye, ear, kidney, testicle)?</td>
<td></td>
</tr>
<tr>
<td>Seizures?</td>
<td>Yes</td>
</tr>
<tr>
<td>Head injuries/Concussion/Passed out?</td>
<td>Yes</td>
</tr>
<tr>
<td>Muscle, Bone, or Joint problem/Injury/Scoliosis?</td>
<td>Yes</td>
</tr>
<tr>
<td>ADHD/ADD?</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavior concerns?</td>
<td>Yes</td>
</tr>
<tr>
<td>Eye/Vision concerns?</td>
<td>Yes</td>
</tr>
<tr>
<td>□Glasses □Contacts</td>
<td></td>
</tr>
<tr>
<td>□Other</td>
<td></td>
</tr>
<tr>
<td>Dental concerns?</td>
<td>Yes</td>
</tr>
<tr>
<td>□Braces □Bridge □Plate □Other?</td>
<td></td>
</tr>
<tr>
<td>Date of exam</td>
<td></td>
</tr>
<tr>
<td>Other diagnoses?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your child have health insurance?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your child have dental insurance</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

**Parent/Guardian**

**Signature**

**Date**

Page 1

April 2014
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

<table>
<thead>
<tr>
<th>DTaP/DT</th>
<th>DTaP/DT</th>
<th>DTaP/DT</th>
<th>DTaP/DT</th>
<th>DTaP/DT</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPV/IPV</td>
<td>OPV/IPV</td>
<td>OPV/IPV</td>
<td>OPV/IPV</td>
<td>OPV/IPV</td>
</tr>
<tr>
<td>PCV7/PCV13</td>
<td>PCV7/PCV13</td>
<td>PCV7/PCV13</td>
<td>PCV7/PCV13</td>
<td>PCV7/PCV13</td>
</tr>
<tr>
<td>Hib</td>
<td>Hib</td>
<td>Hib</td>
<td>Hib</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>MMR</td>
<td>HepB/HepB-2</td>
<td>HepB/HepB-2</td>
<td>HepB</td>
</tr>
<tr>
<td>VAR</td>
<td>VAR</td>
<td>RV-2/RV-3</td>
<td>RV-2/RV-3</td>
<td>RV-3</td>
</tr>
<tr>
<td>MCV4</td>
<td>MCV4</td>
<td>HPV</td>
<td>HPV</td>
<td></td>
</tr>
<tr>
<td>Hep A</td>
<td>Hep A</td>
<td>Td/Tdap</td>
<td>Td/Tdap</td>
<td>Td</td>
</tr>
<tr>
<td>Influenza</td>
<td>Influenza</td>
<td>PPSV23</td>
<td>PPSV23</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Screen</th>
<th>Height: _______</th>
<th>Weight: _______</th>
<th>BMI: _______</th>
<th>BMI Percentile: _______</th>
<th>BP: _______</th>
<th>Pulse: _______</th>
<th>Other: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Screen</td>
<td>□ Problem Identified:</td>
<td>Referred for treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No Problem:</td>
<td>Referred for prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No Referral:</td>
<td>Already receiving dental care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis Screen</td>
<td>All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Date: _______</td>
<td>Results: □ Test Required  □ Test Not Required</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Mantoux Skin Test:</td>
<td>Date: _______</td>
<td>Results: _______ MM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: (type):</td>
<td>Date: _______</td>
<td>Results: _______ MM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Screen</td>
<td>Hearing: Type:</td>
<td>Date: _______</td>
<td>Results: _______</td>
<td>Referral: □ No  □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision: Type:</td>
<td>Date: _______</td>
<td>Results: _______</td>
<td>Referral: □ No  □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other: Type:</td>
<td>Date: _______</td>
<td>Results: _______</td>
<td>Referral: □ No  □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# PART IV – COMPREHENSIVE EXAM

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

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>Check (✓)</th>
<th>HEALTHCARE PROVIDER COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NORMAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABNORMAL</td>
<td></td>
</tr>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose/Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Dental</td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular</td>
<td></td>
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<tr>
<td>Respiratory</td>
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</tr>
<tr>
<td>Endocrine</td>
<td></td>
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</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genito-Urinary</td>
<td></td>
<td></td>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
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<tr>
<td>Spinal examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

Please provide the parent with information on Special Needs Alert Program (SNAP) for EMS.

**Recommendations or Referrals:**

________________________________________________________________________

________________________________________________________________________

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>EMERGENCY PLAN ATTACHED</th>
<th>CARE PLAN OR PRESCRIPTION PLAN ATTACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

**Print Name:** __________________________   **Signature:** ____________________________ **Date:** ______

[ ] Physician (MD or DO)   [ ] Clinical Nurse Specialist (APN)   [ ] Advanced Practice Nurse (APN)   [ ] Physician Assistant (PA)

**Address:** __________________________   **Phone:** __________________________
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.

Date__________________________________ Parent/Guardian’s Signature ______________________________

Student__________________ DOB:__________ Grade______ Teacher__________________________

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1. [ ] ADD/ADHD [ ] Bone/Spine [ ] Heart [ ] Speech
   [ ] Allergies [ ] Bowel/Bladder [ ] Infections [ ] Surgery
   [ ] Asthma [ ] Diabetes [ ] Kidney [ ] Vision
   [ ] Blood Disorder [ ] Emotional [ ] Physical Disability
   [ ] Body Piercing/Tattoo [ ] Hearing [ ] Seizures
   [ ] OTHER__________________________________________________________

   Comments:_________________________________________________________________

2. Does your child have allergies to medicine, food, latex or insect bites?
   NO [ ] YES [ ] To What________________________ What happens?________________________

   Treatment____________________________________________________________

3. Has your child had any illnesses since school last ended?
   NO [ ] YES [ ] Type of illness, with date(s)__________________________________________

4. Has your child had surgery since school last ended?
   NO [ ] YES [ ] Type of surgery, with date(s)__________________________________________

5. Has your child received any immunizations since school last ended?
   NO [ ] YES [ ] List immunizations, with dates________________________________________

6. Is your child being treated or evaluated for any health conditions?
   NO [ ] YES [ ] List condition________________________________________________________________

7. Is your child on any medication or treatment?
   NO [ ] YES [ ] Name of medication and/or treatment________________________________________

   Does your child need medicine during school hours?
   NO [ ] YES [ ] *If yes, please contact the school nurse to make arrangements.

8. Has your child ever been examined by an eye doctor?
   NO [ ] YES [ ] Date of last exam________________________________________________________

   NO [ ] YES [ ] Glasses Prescribed

   If your child wears glasses or contact lenses, when was the prescription last changed______________

9. What is the name of your child’s dentist?_______________________________________________

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

10. What is the name of your child’s primary healthcare provider?____________________________

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

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?
    NO [ ] YES [ ] *If yes, please contact your School Nurse or School Counselor.

12. Have you, your child or anyone in your household tested positive for COVID-19?
    NO [ ] YES [ ] *If yes, please contact the school nurse.

Revised 7/17/2020