McIlvaine Early Childhood Center
Chinese & Spanish Immersion Program
Lottery Application
2020 - 2021

McIlvaine Early Childhood Center in the Caesar Rodney School District is pleased to offer the Chinese and Spanish Immersion programs during the 2020 – 2021 academic year.

- The Chinese Immersion program is limited to 100 students, which will be selected from all six elementary schools in the Caesar Rodney School District (Simpson, Stokes, Brown, Frear, Star Hill, and Welch).
- The Spanish Immersion program is limited to 100 students, which will be selected from all six elementary schools in the Caesar Rodney School District (Simpson, Stokes, Brown, Frear, Star Hill, and Welch).

Students in the immersion program will split their day between two classrooms with two different teachers. The Chinese and Spanish teachers will only speak the target language (Chinese or Spanish) to the children, and will instruct math, science, and social studies. The students will learn to read, write, and speak the target language (Chinese or Spanish). The English teacher will teach reading, writing, and bridge lessons to support math, science, and social studies concepts.

Due to limited space in the immersion program, parents are encouraged to complete the lottery application below for their child to be considered for this academic opportunity. Children selected for either the Chinese or Spanish immersion programs will be contacted by the McIlvaine ECC school administrators during the summer of 2020.

<table>
<thead>
<tr>
<th>If my child is in the immersion program, where will he/she go to school beyond McIlvaine ECC?</th>
<th>Elementary School (grades 1–5)</th>
<th>Middle School (grades 6–8)</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chinese</td>
<td>Spanish</td>
<td>Chinese</td>
</tr>
<tr>
<td>Simpson, Stokes, or Brown elementary schools</td>
<td>W.B. Simpson Elementary School</td>
<td>W. Reily Brown Elementary School</td>
<td>Fifer Middle School</td>
</tr>
<tr>
<td>Frear, Star Hill, or Welch elementary schools</td>
<td>Allen Frear Elementary School</td>
<td>Star Hill Elementary School</td>
<td>Postlethwait Middle School</td>
</tr>
</tbody>
</table>

Child’s Name ____________________________

Child’s Home School (grades 1-5) ____________________________

Parent / Guardian’s Name ____________________________

Parent / Guardian’s Contact Information
(cell) ____________________________
(home) ____________________________
(work) ____________________________

Yes, I am interested in my child being considered for placement in the Immersion program at McIlvaine ECC. My child will also continue in the Immersion program for grades 1-5.

My child’s sibling is currently in a CR immersion program (sibling’s name/grade/school) ____________________________

I am interested in EITHER the Chinese or Spanish immersion programs. I want my child to have a dual language experience. ____________________________

I am ONLY interested in the Chinese Immersion Program. ____________________________

I am ONLY interested in the Spanish Immersion Program. ____________________________

No, I am not interested in the Immersion program at this time. ____________________________
ENROLLMENT FORM

Student Information

Last Name: ___________________________ First Name: ___________________________ Middle Name: ___________________________

Birth Date: ___________________________ Place of Birth: ___________________________

Grade: ______ Gender: □ Male □ Female Hispanic/Latino Ethnicity: □ Yes □ No
Race: (Choose one or more) □ American Indian □ Black □ White □ Asian □ Native Hawaiian or Pacific Islander

911 Street Address: ___________________________ Mailing Address: ___________________________

City, State, Zip Code: ___________________________ City, State, Zip Code: ___________________________

Residency Documented By: □ Current Utility Bill(s) □ Mortgage/Lease Agreement □ Other: ___________________________

Home Telephone #: ___________________________ Military Base Housing: □ Yes □ No
Previous School: ___________________________
Mailing Address: ___________________________

School Choice: □ Yes □ No
Resident School: ___________________________
Resident District: ___________________________

Special Program Enrollment: □ Special Education □ Speech □ Title I □ Other: ___________________________

Parent/Guardian Information

□ Parent □ Step-Parent □ Foster Parent □ Guardian □ Other
Name: ___________________________
Address: ___________________________

Home Telephone: ___________________________ Date of Birth: M ______ Day _____ Year ______
Employer: ___________________________
Work Telephone: ___________________________
Cellular Telephone: ___________________________
E-Mail Address: ___________________________
Emergency Contact: ___________________________
Emergency Telephone: ___________________________

□ Parent □ Step-Parent □ Foster Parent □ Guardian □ Other
Name: ___________________________
Address: ___________________________

Home Telephone: ___________________________ Date of Birth: M ______ Day _____ Year ______
Employer: ___________________________
Work Telephone: ___________________________
Cellular Telephone: ___________________________
E-Mail Address: ___________________________
Emergency Contact: ___________________________
Emergency Telephone: ___________________________

Siblings in Household Under Age 18:

Name: ___________________________ Age: ______ Grade: ______
Name: ___________________________ Age: ______ Grade: ______
Name: ___________________________ Age: ______ Grade: ______
Migrant Survey

Have you moved across state or school district lines within the last 3 years?
☐ Yes  ☐ No

Have you ever or are you currently seeking employment in agriculture, food processing or in the fisheries?
☐ Yes  ☐ No

Was your move into the school district related to your employment?
☐ Yes  ☐ No

Student lives with*:  ☐ Father  ☐ Mother  ☐ Step-Father  ☐ Step-Mother  ☐ Guardian
*If there are custodial/guardianship restrictions, it will be necessary for you to provide the school with a copy of court records.

For New Kindergarten Enrollments ONLY

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

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

3. If yes, what was the name of the preschool or child care program/center?
   ____________________________________________________________

I verify all information presented on this form is factual. I understand that any misinformation regarding residency will result in the termination of this student’s enrollment in the Caesar Rodney School District.

It is the responsibility of the parent/guardian to inform the school of any changes in information on this form.

Signature: ____________________________ Date: ______________

Individual Enrolling Student

Relationship to Student: ____________________________

For Office Use Only

Enrolled By: ____________________________

Student ID: _______________ Records Requested: _______________ Room: ____  Bus: _______

Last State Test Score: PL Read: _______ PL Math: _______ Grade of Last Test: _______
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', you may stop here. You do not need to complete this form.

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. ____________________________ B. ____________________________ C. ____________________________ 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 8/2017)
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>
<th></th>
<th>Country of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td></td>
<td>Date of entry in US:</td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
<td>Date student first enrolled in a US school:</td>
</tr>
<tr>
<td>Birthdate:</td>
<td></td>
<td></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-English 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.
Rev. 12.8.17
Dear Parent/Guardian:

During the 2020-2021 school year, representatives of the media, including local, regional & national newspapers, radio and television may want to interview, photograph and/or videotape your child. The images used of your child may be with another individual or a group of individuals. Your child’s name could be used in a story along with any accompanying photographs or videotaped footage.

Also, the Caesar Rodney School District now has the capability of photographing events in and around your child’s schools and placing photographs on the Caesar Rodney School District website, “The CR Report” quarterly newsletter and the Caesar Rodney School District Facebook and Twitter pages where stories and photos of students and staff in our schools are highlighted daily.

Please complete the section below and return this form to the school office as soon as possible.

PLEASE CHECK ONE:

____ I do give permission for my child to be interviewed, photographed and/or videotaped by local, regional or national media representatives and employees of the Caesar Rodney School District for use in newsprint, television and radio as well as in district publications, yearbooks, websites, school presentations and social media, such as Facebook and Twitter.

____ I do not give permission for my child to be interviewed, photographed and/or videotaped by media representatives. However, I understand my child may be pictured in a yearbook, CR Report and/or on CRSD district websites and social media sites, such as Facebook and Twitter, and in school presentations.

Please print child’s name

Homeroom teacher

Parent/Guardian Signature

Date
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, and a current (within 2 years) physical examination upon school entry and at ninth (9th) grade.

Talk with your health care provider about important issues1 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
  - Influenza (seasonal) vaccine is recommended each year for all children (6 months and up).
  - Human papillomavirus vaccine (HPV) is recommended for all girls and boys (ages 11 or 12, minimum age 9) to prevent cancers, pre-cancers, and genital warts.
  - Hepatitis A, Meningococcal, and Pneumococcal vaccines are recommended for certain high risk groups.

Immunization Requirements for Newly Enrolled Students at Delaware Schools

KINDERGARTEN2: 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 is required.
MMR3: 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 doses.
Varicella4: 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 is required.
MMR: 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 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
Varicella: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

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

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

Parent/Guardian

Signature                      Date
**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.

<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>Hib</td>
</tr>
<tr>
<td>MMR</td>
<td>MMR</td>
<td>Hib</td>
<td>Hib</td>
<td>Hib</td>
</tr>
<tr>
<td>VAR</td>
<td>VAR</td>
<td>HepB/Hepl-2</td>
<td>HepB/Hepl-2</td>
<td>HepB/Hepl-2</td>
</tr>
<tr>
<td>MCV4</td>
<td>MCV4</td>
<td>HPV</td>
<td>HPV</td>
<td>HPV</td>
</tr>
<tr>
<td>Hep A</td>
<td>Hep A</td>
<td>Td/ Tdap</td>
<td>Td/ Tdap</td>
<td>Td/ Tdap</td>
</tr>
<tr>
<td>Influenza</td>
<td>Influenza</td>
<td>PPSV23</td>
<td>PPSV23</td>
<td>PPSV23</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**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></td>
<td>(inches)</td>
<td>(pounds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

**Tuberculosis Screen**

All new entrees must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry.

- Risk Assessment: Date ________ Results: ☐ At-Risk ☐ No Risk
- 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: ________

**Hearing**

- Type: ________ Date: ________ Results: ________ Referral: ☐ No ☐ Yes ________ Date

**Vision**

- Type: ________ Date: ________ Results: ________ Referral: ☐ No ☐ Yes ________ Date

**Other Screen**

- Type: ________ Date: ________ Results: ________ Referral: ☐ No ☐ Yes ________ Date
### 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>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose/Throat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genito-Urinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health status</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Print Name: __________________________ Signature: __________________________ Date: __________

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

Address: __________________________ Phone: __________________________
CAESAR RODNEY SCHOOL DISTRICT-MEDICAL CARD

Student Name: ____________________________  Birth Date: __________ Age: ______

Last  First  MI

Grade: _______  Teacher: _______________  Room: __________  Male  Female  

Resides with:  ❑Mother  ❑Father  ❑Other: ____________________________  Custody papers on file, if applicable

<table>
<thead>
<tr>
<th>Mother/Guardian Name</th>
<th>Date of Birth</th>
<th>Father/Guardian Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address or P.O. Box</td>
<td>Development</td>
<td>Street Address or P.O. Box</td>
<td>Development</td>
</tr>
<tr>
<td>City &amp; Zip Code</td>
<td>Home Phone ( )</td>
<td>City &amp; Zip Code</td>
<td>Home Phone ( )</td>
</tr>
<tr>
<td>Employer Name</td>
<td>Work Phone ( )</td>
<td>Employer Name</td>
<td>Work Phone ( )</td>
</tr>
<tr>
<td>Employer Department</td>
<td>Work Extension</td>
<td>Employer Department</td>
<td>Work Extension</td>
</tr>
<tr>
<td>Mother/Guardian-Email Address</td>
<td>Cell Phone ( )</td>
<td>Father/Guardian-Email Address</td>
<td>Cell Phone ( )</td>
</tr>
</tbody>
</table>

If parents/guardians cannot be reached, call: (Local contact preferred.)

1. Name ____________________________ Relationship to student __________
   Cell Phone ( )  Home Phone  Work Phone

2. Name ____________________________ Relationship to student __________
   Cell Phone ( )  Home Phone  Work Phone

Names of siblings living with student

<table>
<thead>
<tr>
<th>Name</th>
<th>Grade</th>
<th>Age</th>
</tr>
</thead>
</table>

Medical Insurance:  ❑Yes  ❑No  If yes:  ❑Private  ❑Medicaid – Delaware physician’s care  ❑Medicaid – United  Medicaid Number: ____________________________

I give permission for my child to have the age and weight appropriate dose of Tylenol (Acetaminophen), Advil (Ibuprofen) or an antacid as determined by and at the discretion of the nurse.

❑Yes  ❑No

I verify that all of the above information is correct. This information may be shared with school personnel on a “need to know” basis.

Parent/Guardian Signature ____________________________ Date __________

SCHOOL EMERGENCY PROCEDURES/ATTENDANCE REQUIREMENTS

Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. 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 contact the parents utilizing all numbers available listed on the emergency card.
2. The school will call the other telephone number(s) listed.
3. If none of the above answer, the school will call EMS (911) for transport to the nearest medical facility.
4. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
5. The school will continue to call the parents or guardians until one is reached.

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.

Mandatory Attendance Requirements- Sect. 2702, Chapter 27, Title 14, Del Code

I agree to make every reasonable effort to (1) have my child abide by the school code of conduct; (2) make certain that my child attends school regularly; and (3) to provide written documentation for the reason(s) for any absence.

Parent/Guardian Signature ____________________________ Date __________

PLEASE COMPLETE REVERSE SIDE
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 ended in June?
   NO [ ] YES [ ] Type of illness, with date(s) ____________________________

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

5. Has your child received any immunizations since school ended in June?
   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. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
   NO [ ] YES [ ] List _____________________________________________

10. What is the name of your child’s dentist?
    ______________________________________________________________

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

11. What is the name of your child’s primary healthcare provider?
    ______________________________________________________________

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

Thank you.

PLEASE COMPLETE REVERSE SIDE
Dear Parent or Guardian,

According to Delaware Code, Title 14, section 131; a child is not permitted to enter into school without acceptable evidence of immunization. If your child is a new enterer* to Delaware public schools he or she will not be permitted to enroll without an immunization record. Please see below for children of active duty members of the uniformed services.

Delaware law requires the following for entry to public school. If these items are not provided to the school within 14 CALENDAR DAYS from the date below your child will be denied entry into school.

1. IMMUNIZATIONS:
   - Four (4) or five (5) doses of DPT OR DTAP, or a combination thereof. A fifth dose is not required if the fourth dose is given after the fourth birthday.
   - Three (3) or four (4) doses of the polio (OPV or IPV) vaccine. A fourth dose is not required if the third dose is given after the fourth birthday.
   - Three (3) doses of Hepatitis B vaccine.
   - Two (2) doses of measles, mumps and rubella vaccine, MMR, (first dose after the age of 12 months, second dose after the fourth birthday).
   - Two (2) doses of Varicella (chicken pox), or a written disease history by a licensed healthcare provider. For new enterers, two doses are required for the following grade levels: (2012-2013 School Year: Grades K-9; 2013-2014 School Year: Grades K-10, etc.). One grade shall be added each year thereafter so that by the 2015-2016 School Year all children in grades kindergarten through 12 shall have received two doses.

2. PHYSICAL EXAM:
   - A physical examination by a physician, nurse practitioner, or physician’s assistant within the last two (2) years for all new enterers. A second health examination is required for all students entering 9th grade. Examinations completed no more than two years prior to entry into 9th grade will be accepted.

3. TUBERCULOSIS SCREENING:
   - Written results from either a TB risk assessment, a Tuberculosis skin test (Mantoux, PPD), or a Quantiferon TB Gold test, within the last twelve (12) months.

4. LEAD TEST:
   - All kindergarten and preschool students must show proof of a blood lead test, completed anytime after 1 year of age.

If you enroll your child over the summer, please be aware that if appropriate documentation is not provided for any of the above requirements within 14 days of the date below, the date of exclusion will start on the first day of school.

If your child is transferring to our school from another school in the state of Delaware we assume he or she currently complies with all the above requirements. However, if for any reason your child does not meet all of the above requirements, your student will also have 14 days from the date of this form to comply with regulations.

Military families: Children of active duty members of the uniformed services will have 30 days from the date of enrollment to comply with the above immunization requirements.

All documents should be turned in to the school as soon as possible. BY STATE LAW, FAILURE TO PROVIDE THESE DOCUMENTS WILL RESULT IN EXCLUSION FROM SCHOOL.
   * A new enterer is defined as a child entering a Delaware public school for the first time, including but not limited to foreign exchange students, immigrants, students from other states and territories and children entering from non-public schools.

Please sign below to acknowledge receipt of this information.

Parent/Guardian Signature

Date

Student’s Name

Grade

Copy distribution: White/School, Yellow/Parent

DCI FORM # SA-292