Registration hours are 8:00 a.m. – 3:00 p.m. daily, M-F.
Please bring all required documents at that time. Thank you!

Welcome to

Nellie H. Stokes Elementary

REGISTRATION REQUIREMENTS

Proof of Residency in the Caesar Rodney School District. You must provide one of the following:
- Mortgage, lease or rental agreement with parent/guardian’s name and address, and current driver’s license
  - Secondary proof of residency (may be requested) a current utility bill, (electric, gas, oil, water, or sewer bill) with parent/guardian’s name and address along with their current driver’s license.
- Copy of CR School Choice acceptance letter, if not a CR resident
- Is the student and family living with another person/family in the district? If yes, please see below:
  - If living with a friend/relative who leases/rents their home in the CR School District it is required that the parent/guardian’s name be listed as occupants on the lease/rental agreement; in addition, the CR School District Residency Affidavit needs to be signed (by both parties, parent/guardian & rental/lease holder) in front of school administration or registrar with the following information provided:
  
  ✔ Driver’s License updated to reflect new address (for parent/guardian), current address for rental/lease holder
  ✔ A current bill or piece of mail with parent/guardian name and new address

  ~ OR ~

  - If living with a friend/relative who owns their home in the CR School District, it is required that the new enrollee’s parent/guardian and homeowner complete and sign the CR School District Residency Affidavit in the presence of school administration or registrar. In addition, the following information is required:
    ✔ Homeowner provides mortgage documents with name address listed, current address on license
    ✔ Parent/guardian of new enrollee must provide an updated driver’s license to reflect new address, a
    ✔ A current bill or piece of mail with parent/guardian name and new address

Verification of Student Age.
- Birth certificate
- Passport
- Military ID
- Official School Records

Parent/Legal guardian must accompany student to register.
- Custody arrangements? Parent/guardians must have current picture ID and must provide “Delaware Legal Guardianship” through the Family Court system paperwork that is signed by a judge.

Information from previous school.
- Withdrawal form and most recent grades
- Immunization Record
- 9th grade students must have a physical dated after Aug. 2015
  * Unofficial transcript (10th – 12th grades)
  * Report Card showing promotion (8th to 9th)
  * Copy of most recent IEP, 504 Plan, Psychological Evaluation, Health Plan (if required)

Please note: If partial documentation is received, and our office has to contact the previous school for pertinent information, the enrollment process cannot proceed until ALL information is obtained. We appreciate your patience.
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: □ 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 #: ___________________________

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: _______

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM**
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.

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: ________

Where Educational Excellence Is A Tradition

Revised 3/23/15
Date: ____________________________

REQUEST FOR SCHOOL RECORDS

School: ____________________________________________
Address: __________________________________________

Phone: ____________________________________________

The following student(s) has/have registered at Nellie H. Stokes Elementary School. Please forward all cumulative school records including health, psychological reports, standardized test results and any other applicable educational information for the student listed below at your earliest convenience.

Student Name: ___________________ Grade: _____ Date of Birth: ______
Student Name: ___________________ Grade: _____ Date of Birth: ______
Student Name: ___________________ Grade: _____ Date of Birth: ______

According to the Family Rights and Privacy Act (Buckley Amendment), it is no longer necessary to obtain written consent to release records between school.

Thank you for your cooperation,

Sincerely,

Michelle Christman
Secretary

WHERE EDUCATIONAL EXCELLENCE IS A TRADITION
National Blue Ribbon School 2011

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 Officers: Paul L. Dunbar Administrative Building, 7 Front Street, Wyoming DE, 19934, Phone (302) 698-4800
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>
</tr>
</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.)

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
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 ___________________________

Grade: _______ Age: _______

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
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 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 issues** 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**

**KINDERGARTEN**: 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.
- 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.
- Varicella: 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 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>Condition</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>No</td>
<td></td>
</tr>
<tr>
<td>Medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery? (List all)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear/Hearing problems?</td>
<td></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>No</td>
<td></td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Allergies (food, insect, other)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Family history of sudden death before age 50?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Child wakes during the night coughing?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Diagnosis of asthma?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood disorders (hemophilia, sickle cell, other)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Excessive weight gain or loss?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Diabetes?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Loss of function of one or paired organs (eye, ear, kidney, testicle)?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Seizures?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Head injuries/Concussion/Passed out?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Muscle, Bone, or Joint problem/Injury/Scoliosis?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ADHD/ADD?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Behavior concerns?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Eye/Vision concerns?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dental concerns?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Braces</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bridge</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Plate</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Date of exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other diagnoses?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does your child have health insurance?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does your child have dental insurance</td>
<td>No</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.

| Immunizations – Shaded Vaccines Required. Regulations is located at Title 14 Section 804 Immunizations |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| DTaP/DT                                        | DTaP/DT                                        | DTaP/DT                                        | DTaP/DT                                        | DTaP/DT                                        |
| OPV/IPV                                        | OPV/IPV                                        | OPV/IPV                                        | OPV/IPV                                        | OPV/IPV                                        |
| PCV7/PCV13                                     | PCV7/PCV13                                     | PCV7/PCV13                                     | PCV7/PCV13                                     | PCV7/PCV13                                     |
| Hib                                            | Hib                                            | Hib                                            | Hib                                            | Hib                                            |
| MMR                                            | MMR                                            | HepB/HeB-2                                     | HepB/HeB-2                                     | HepB                                           |
| VAR                                            | VAR                                            | RV-2/RV-3                                      | RV-2/RV-3                                      | RV-3                                           |
| MCV4                                           | MCV4                                           | HPV                                            | HPV                                            | HPV                                            |
| Hep A                                          | Hep A                                          | Td/ Tdap                                       | Td/ Tdap                                       | Td                                             |
| Influenza                                      | Influenza                                      | PPSV23                                         | PPSV23                                         |                                                |
| Other:                                         | Other:                                         | Other:                                         | Other:                                         | Other:                                         |

### PART III – SCREENING & TESTING

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

<table>
<thead>
<tr>
<th>Screen</th>
<th>Height: (inches)</th>
<th>Weight: (pounds)</th>
<th>BMI:</th>
<th>BMI Percentile:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Other:</th>
</tr>
</thead>
</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.
- **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:** ___________

**Other Screen**

- **Hearing:** Type: ___________ Date: ___________ Results: ___________ **Referral:** □ No □ Yes Date ___________
- **Vision:** Type: ___________ Date: ___________ Results: ___________ **Referral:** □ No □ Yes Date ___________
- **Other:** Type: ___________ Date: ___________ Results: ___________ **Referral:** □ No □ Yes Date ___________
## 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>
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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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<tr>
<td>Thyroid</td>
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<tr>
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<tr>
<td>Genito-Urinary</td>
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<tr>
<td>Neurological</td>
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<tr>
<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.

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

**Recommendations or Referrals:**

---

### DIAGNOSIS

<table>
<thead>
<tr>
<th>EMERGENCY PLAN ATTACHED</th>
<th>CARE PLAN OR PRESCRIPTION PLAN ATTACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>NO</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: ___________________________
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. ___________________________________ 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 8/2017)
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 a:

- Farm
- Dairy
- Ranch
- Cannery
- Chicken house
- Chicken processing plant
- Processing meat/fish
- Cranberry bogs
- Fresh/frozen juices
- Fishery
- Dried or dehydrated fruits/spices
- Sod farms
- Meat or food packing plant
- Mushrooms
- Planting, picking, or packing fruits, vegetables, seeds, or nuts
- Plant nursery/greenhouse
- Tree growing or harvesting
- Food processing
- Pet food processing
- 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>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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 Title I, Part C Office within 10 days of the student’s enrollment by State Mail Code D3708 or by U.S. Postal Service to 401 Federal Street, Suite 2, Dover, DE 19901. 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 May 31, 2017
**Temporary** IEP**

State of Delaware

**Student Identification Information**

<table>
<thead>
<tr>
<th>Student Name</th>
<th>School</th>
<th>Nellie H. Stokes Elementary</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B.</td>
<td></td>
<td>Grade</td>
</tr>
<tr>
<td>Student ID #</td>
<td></td>
<td>3874 Upper King Rd</td>
</tr>
</tbody>
</table>

**School Address**

Dover, DE  19904

**School Telephone**

302-697-3205

**Parent/Guardian/Surrogate**

**Student Address**

**Telephone**

**Disability**

**IEP Status**

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Most Recent Evaluation</th>
<th>Initiation Date</th>
<th>Summary Report Date</th>
</tr>
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<tbody>
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</table>

<table>
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<tr>
<th>End Date</th>
<th>Revision Date</th>
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</thead>
<tbody>
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</tbody>
</table>

**TEMPORARY PLACEMENT DATE:** **

Admin/Designee: 

Parent/Guardian: 

**Within 60 calendar days, a meeting must be held.**

**Participants Attending IEP Team Meeting Of (Date)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Signature</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Parent/Guardian/Surrogate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General Education Teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Special Education Teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administrator/Designee</td>
</tr>
</tbody>
</table>

This form is for use only by staff of the Caesar Rodney School District (Temporary Placement Form)  

Revised July 2014
2019-2020 School Year

Dear Parent/Guardian:

The Caesar Rodney Child Nutrition Program welcomes your children to the 2019-2020 school year. Families are encouraged to place money in their children’s cafeteria account to use for payment for breakfast and/or lunch. Having money on account prevents forgotten or lost money, speeds up the meal lines, and allows your children more time to enjoy their meal.

We continue to offer PayPams on-line payment service. You may log onto PayPams.com to electronically add money to your children’s cafeteria accounts, monitor their balances, and receive email notifications for low balances. If you do not wish to pay electronically, you may still register for emailed low balance notifications. In addition to balance notifications you can log on to the website to see what your child is purchasing. If your children do not bring home a PayPams flyer, it is available on the Caesar Rodney School District website – https://www.crk12.org.

If you are not interested in applying for free or reduced priced meals you are not required to complete and return the Meal Benefit Form.

If you are interested in applying for meal benefits – please read the instructions carefully. Complete ONE FORM PER FAMILY, listing all household members (all children and all adults (friends and relatives) living at your address) with all income listed OR students’ names with the SNAP or DE-TANF case number listed. You may receive more than one form if you have more than one child, but only one form should be returned per household. Please return the completed Meal Benefit Form as soon as possible to your child’s school cafeteria or to the Child Nutrition Office located in the Caesar Rodney District Office at 7 Front Street, Wyoming, DE 19934.

Please read the Instructions for Applying and the Meal Benefit Form thoroughly. It is very important that you complete the form correctly, as we are unable to process incomplete or incorrect forms. Please provide a current phone number on the form so we can reach you if we have questions.

Forms will be processed in the order they are received / within 10 days of receipt in the Child Nutrition Office. Meal benefits (free or reduced meals) do not begin until the form has been processed and the child’s eligibility has been determined. Please send money or pack your children’s meals until you are notified that your eligibility has been changed. You are responsible to pay any debts your children incur before they are eligible to receive free or reduced meals.

Should you have any questions, please call the Child Nutrition Office at 302-697-4978. We wish your children a very successful school year.

Sincerely,

Paul R. Rodgers, MS, SNS
Child Nutrition Supervisor

Privacy Act Statement: This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires the information on this meal benefit form. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations for number or other identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We may share your information with education, health, and nutrition programs to help them evaluate, fund or determine benefits for these programs, auditors for program reviews, and law enforcement officials to help them find violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating against you on the basis of race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication (e.g., Braille, large print, audiocassette, American Sign Language, etc.) should contact the responsible Agency or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at https://www.usda.gov/oascr/complaint-form and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.

WHERE EDUCATIONAL EXCELLENCE IS A TRADITION

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 Officers: Paul L. Dunbar Administrative Building, 7 Front Street, Wyoming DE, 19934. Phone (302) 697-4800
The Caesar Rodney School District offers a choice of healthy meals each school day. Children may buy meals at the following rates:

<table>
<thead>
<tr>
<th>GRADE</th>
<th>FULL PRICE</th>
<th>REDUCED PRICE</th>
<th>FREE BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breakfast</td>
<td>Lunch</td>
<td>Breakfast</td>
</tr>
<tr>
<td>PK-5</td>
<td>No Cost</td>
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</tr>
<tr>
<td>6-8</td>
<td>70 cents</td>
<td>$1.10</td>
<td>40 cents</td>
</tr>
<tr>
<td>9-12</td>
<td>70 cents</td>
<td>$1.25</td>
<td>40 cents</td>
</tr>
</tbody>
</table>

1. **DO I NEED TO FILL OUT A MEAL BENEFIT FORM (MBF) FOR EACH CHILD?** No. Complete the MBF to apply for free or reduced price meals. Use one Free and Reduced Price School Meal Benefit Form for all students in your household. We cannot approve a MBF that is not complete, so please be sure to fill out all required information. Return the completed Meal Benefit Form to the school's cafeteria manager or the Child Nutrition Office.

2. **WHO CAN GET FREE MEALS?** All children in households receiving DE-SNAP* or DE-TANF can get free meals regardless of your income. Also, your children can get free meals if your household’s income is within the free limits on the Federal Income Eligibility Guidelines.

3. **CAN FOSTER CHILDREN GET FREE MEALS?** Yes, foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

4. **CAN HOMELESS, RUNAWAY AND MIGRANT CHILDREN GET FREE MEALS?** Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven’t been informed your children will get free meals, please call Nicole Clayton or Chad Holloway (homeless information) or Dr. Darren Guido (migrant information) at 302-698-4800 to see if they qualify.

5. **WHO CAN GET REDUCED PRICE MEALS?** Your children can get reduced price meals if your household income is within the reduced price limits on the Federal Eligibility Income Chart, shown on this MBF.

6. **SHOULD I FILL OUT A MBF IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS?** Please read the letter you received carefully and follow the instructions. Call the Child Nutrition Office at 302-697-4978 if you have questions.

7. **MY CHILD’S MBF WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE?** Yes. Your child’s MBF is only good for that school year and for the first few days of this school year. You must send in a new MBF unless you have already received notification from the Child Nutrition Office that your child is eligible for the new school year.

8. **I RECEIVE WIC. CAN MY CHILDREN GET FREE MEALS?** Children in households receiving WIC may be eligible for free or reduced price meals. Please fill out a MBF.

9. **WILL THE INFORMATION I GIVE BE CHECKED?** Yes and we may ask you to send written proof.

10. **IF I DON’T QUALIFY NOW, MAY I APPLY LATER?** Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free or reduced price meals if the household income drops below the income limit.

11. **WHAT IF I DISAGREE WITH THE SCHOOL’S DECISION ABOUT MY MBF?** You should talk to Paul R. Rodgers at 302-697-4978. You may also ask for a hearing by calling or writing to: Dr. Kevin R. Fitzgerald, Superintendent, 7 Front Street, P.O. Box 188, Wyoming, DE 19934, or telephone 302-698-4800.

12. **MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?** Yes. You and/or your children do not have to be a U.S. citizen to qualify for free or reduced price meals.

13. **WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends). Also include yourself and all children living with you.

14. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only got $500, put down that you earn $1000 per month. If you normally receive overtime, include it, but not if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

15. **ARE WE IN THE MILITARY; DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME?** If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. All other allowances must be included in your gross income.

16. **MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS COMBAT PAY COUNTED AS INCOME?** If the combat pay is received in addition to basic pay because of their deployment and it wasn’t received before they were deployed, combat pay is not counted as income. Contact the Child Nutrition Office at 302-697-4978 for more information.

17. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** To find out how to apply for DE-SNAP or other assistance benefits, contact your local assistance office or call the DE-SNAP hotline at 1-800-464-4357.

### INCOME TO REPORT

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Yearly</th>
<th>Monthly</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,107</td>
<td>$1,926</td>
<td>$445</td>
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<tr>
<td>2</td>
<td>$31,284</td>
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<td>3</td>
<td>$39,461</td>
<td>$3,289</td>
<td>$759</td>
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<tr>
<td>4</td>
<td>$47,638</td>
<td>$3,970</td>
<td>$917</td>
</tr>
<tr>
<td>5</td>
<td>$55,815</td>
<td>$4,652</td>
<td>$1,074</td>
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<tr>
<td>6</td>
<td>$63,992</td>
<td>$5,333</td>
<td>$1,231</td>
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<tr>
<td>7</td>
<td>$72,169</td>
<td>$6,015</td>
<td>$1,388</td>
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<tr>
<td>8</td>
<td>$80,346</td>
<td>$6,696</td>
<td>$1,546</td>
</tr>
</tbody>
</table>

For each additional household member add: +$8,177 +$682 +$158

Remember, you must report the total income amount before taxes, social security, health benefits, union dues, or other deductions are made.

### Earnings from Work
- Wages/Salaries/Tips
- Strike Benefits
- Unemployment Compensation
- Worker’s Compensation
- Net Income from Self-Owned business or day care business or farm
- Alimony/Child Support Payments

### Pensions/Retirement/Social Security Pensions
- Supplemental Security Income
- Retirement Income
- Veteran’s Payments
- Social Security

### Other Monthly Income/Self-Employment
- Disability Benefits
- Cash Withdrawal from Savings
- Interest/Dividends
- Income from Estates/Trusts/Investments
- Regular Contributions from Persons Not Living in the Household
- Net Royalties/Annuities
- Net Rental Income
- Military Allowance for Off-Base Housing
- Any Other Income

*DE-SNAP: Delaware Supplemental Nutrition Assistance Program (formerly the Food Stamp Program)*

If you have other questions or need help, call 302-697-4978. Si necesita ayuda, por favor llame al teléfono: 302-697-4978. Si vous voudriez d’aide, contactez nous au numéro: 302-697-4978.
INSTRUCTIONS FOR APPLYING:

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM DE-SNAP OR DE-TANF, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.
Part 2: List the case number for any household member (including adults) receiving DE-SNAP or DE-TANF benefits. The case number is NOT the number on your EBT card. If you do not know your case number, please call your case worker.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Check “No” if you do not want information from the Free & Reduced Meal Benefit Form shared with Medicaid or the State Children’s Health Insurance Program (CHIP).
Part 6: Complete this section and sign the form. The last four digits of a Social Security Number are not necessary.
Part 7: Answer this section if you choose to.

IF NO ONE IN YOUR HOUSEHOLD GETS DE-SNAP or DE-TANF BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.
Part 2: Skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Nicole Clayton or Chad Holloway (homeless liaison) or Dr. Darren Guido (migrant coordinator) at 302-698-4800.
Part 4: Complete only if a child in your household isn’t eligible under Part 3. See instructions for All Other Households.
Part 5: Check “No” if you do not want information from the Free & Reduced Meal Benefit Form shared with Medicaid or the State Children’s Health Insurance Program (CHIP).
Part 6: Complete this section and sign the form. The last four digits of a Social Security Number are not necessary.
Part 7: Answer this section if you choose to.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If all children in the household are foster children:

Part 1: List all foster children and the school name for each child. Check the box indicating the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Check “No” if you do not want information from the Free & Reduced Meal Benefit Form shared with Medicaid or the State Children’s Health Insurance Program (CHIP).
Part 6: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 7: Answer this section if you choose to.

If some of the children in the household are foster children:

Part 1: List all household members and the name of school for each child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Nicole Clayton or Chad Holloway (homeless liaison) or Dr. Darren Guido (migrant coordinator) at 302-698-4800. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.
   * Box “A”, Name: List all household members with income.
   * Box “B”, Gross Income and How Often It Was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits), and disability benefits. Under All Other Income, list Worker’s Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, WIC, Federal education benefits and foster payments received by the family from the boarding agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
   * Box “C”, Child Income: Report all income earned or received by children. Report the combined gross income for ALL children listed in Part 1 in your household in the box marked “Child Income”. What is Child Income? Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.
Part 5: Check “No” if you do not want information from the Free & Reduced Meal Benefit Form shared with Medicaid or the State Children’s Health Insurance Program (CHIP).
Part 6: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn’t have one).
Part 7: Answer this question, if you choose.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Nicole Clayton or Chad Holloway (homeless liaison) or Dr. Darren Guido (migrant coordinator) at 302-698-4800. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.
   * Box “A”, Name: List all household members with income.
   * Box “B”, Gross Income and How Often It Was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits), and disability benefits. Under All Other Income, list Worker’s Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, WIC, Federal education benefits and foster payments received by the family from the boarding agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
   * Box “C”, Child Income: Report all income earned or received by children. Report the combined gross income for ALL children listed in Part 1 in your household in the box marked “Child Income”. What is Child Income? Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.
Part 5: Check “No” if you do not want information from the Free & Reduced Meal Benefit Form shared with Medicaid or the State Children’s Health Insurance Program (CHIP).
Part 6: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn’t have one).
Part 7: Answer this question, if you choose.

*DE-SNAP – Delaware Supplemental Nutrition Assistance Program (formerly the Food Stamp Program)
**CAESAR RODNEY SCHOOL DISTRICT CHILD NUTRITION**
**MEAL BENEFIT FORM FOR 2019-2020 SCHOOL YEAR**

Please read the instructions, complete, sign, and return form to the school. If you need help, please call 302-697-4978.

**PART 1. ALL HOUSEHOLD MEMBERS**

<table>
<thead>
<tr>
<th>Names of all household members (First Name, Middle Initial, Last Name)</th>
<th>Name of school for each child or indicate &quot;N/A&quot; if the child is not in school</th>
<th>Grade</th>
<th>Check if a foster child (legal responsibility of welfare agency or court). * If all children listed below are foster, skip to Part 6 to sign this form.</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**PART 2. BENEFITS:** If any member of your household receives DE-SNAP, DE-TANF or FDPIR Cash Assistance, provide the name and case number (we cannot process forms with EBT #s) for the person who receives benefits and skip to Part 5. If no one receives these benefits, skip to Part 3.

Name: [ ]

Case Number (NOT Your EBT #): [ ]

**PART 3.** If any child you are applying for is HOMELESS, MIGRANT, or a RUNAWAY, please check the appropriate box and call Nicole Clayton or Chad Holloway (homeless liaison) or Dr. Darren Guido (migrant coordinator) at 302-698-4800.

<table>
<thead>
<tr>
<th>Homeless</th>
<th>Runaway</th>
<th>Migrant</th>
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<tbody>
<tr>
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</table>

**PART 4. Total Household Gross Income:** You must tell us the gross income (before taxes and deductions) of each person in the household and how often it is received (HOW MUCH AND HOW OFTEN). For household members receiving no income, please write "0" or leave fields blank to report no income.

<table>
<thead>
<tr>
<th>A. NAME</th>
<th>B. GROSS INCOME (before deductions) and HOW OFTEN IT IS RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>(List the income of everyone living in the house, yourself, all children, relatives, and/or friends)</td>
<td>Example: Jane Doe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Earnings from work before deductions</th>
<th>Public Assistance, child support, alimony</th>
<th>Pensions, retirement</th>
<th>Social Security</th>
<th>All Other Income</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**C. CHILD INCOME**

Sometimes children in the household earn income. Please include the TOTAL income earned by all children listed in Part 1 here. If none of the children earn income, indicate by putting N/A in the box.

<table>
<thead>
<tr>
<th>Child Income</th>
<th>Weekly</th>
<th>Bi-Weekly</th>
<th>Bi-Monthly</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**PART 5. Children's Health Insurance Program (CHIP)**

☐ NO! I DO NOT want information from my Free and Reduced Price Meal Benefit Form shared with Medicaid or the State Children's Health Insurance Program (CHIP). For more information about DECHIP, call: 1-800-996-9969.

IF YOU DO NOT CHECK THIS BOX, YOUR INFORMATION WILL BE SHARED WITH MEDICAID AND/OR DECHIP.

**PART 6. Signature and Social Security Number (ADULT MUST SIGN BELOW).**

An adult household member must sign the MBF. If Part 4 is completed, the adult signing the form must also list the last four digits of their Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this form is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Signature: [ ]

Print name: [ ]

Address: [ ]

City: [ ]

State: [ ]

Zip Code: [ ]

Work Phone: [ ]

Cell Phone: [ ]

Social Security Number: X X X X - X X [ ]

I do not have a Social Security Number [ ] Date: [ ]

**PART 7. Children's racial and ethnic identities (optional)**

Choose one or more (regardless of ethnicity):

- Asian
- White
- Black or African American
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

Choose one ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Don't fill out this part. This is for school use only.

Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice A Month X 24, Monthly X 12

Total Annual Income: [ ]

Household Size: [ ]

Categorical Eligibility: [ ]

Determining Official's Signature: [ ]

Date Withdrawn: [ ]

Eligibility: [ ] Free [ ] Reduced [ ] Denied [ ]

Date: [ ]

Reason: [ ]

Verifying Official's Signature: [ ]

Date: [ ]

* SNAP: Supplemental Nutrition Assistance Program (formerly the Food Stamp Program)
August, 2019

Dear Parent/Guardian:

**PLEASE READ**

Due to the volume of permission slips we receive at the beginning of each school year, all accounts are now given full access unless we receive notice from a parent to restrict the account.

Please understand we only have the ability to give full access or restrict the money on their accounts. If you allow your child to purchase extras with their account money – they will have full access. We cannot restrict their account on certain days, number of times per week, only ice cream on Fridays, etc. Please express to your child how you expect them to use the money.

You can track your child’s spending through the PayPams website – PayPams.com. By registering for an account, you can track purchases, receive low balance emailed notifications, etc. You can access these features without using PayPams to deposit money into your child’s account.

If you DO NOT want your child to be permitted to spend the money in their account as they choose, please fill out the form below. By returning this form, your child will only be able to purchase a reimbursable breakfast and/or lunch daily. They will not be able to purchase any extra items with the money on their account.

Parents may continue to restrict or “unrestrict” accounts anytime during the school year.

<table>
<thead>
<tr>
<th>If you <strong>DO NOT</strong> want your child to use the money on their account for extra purchases, you can have his/her account restricted by filling in the following information and returning this paper to your child’s cafeteria.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please restrict my child’s account.</td>
</tr>
<tr>
<td>Student’s Name</td>
</tr>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>Parent Signature</td>
</tr>
<tr>
<td>Phone</td>
</tr>
</tbody>
</table>

WHERE EDUCATIONAL EXCELLENCE IS A TRADITION

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 Officers: Paul L. Dunbar Administrative Building, 7 Front Street, Wyoming DE, 19934. Phone (302)98-4800
Dear Parent/Guardian:

During the 2019-2020 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
Student / Family / School Compact
2019 – 2020 Academic Year

Student: __________________________________________

Nellie H. Stokes Elementary School’s faculty and the parents of the students participating in activities, services, and programs funded by Title I, Part A of the Elementary and Secondary Education Act, agree that this compact outlines how the parents, the entire school staff, and the students will share responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children achieve the state’s high standards.

I understand that learning is important and I must do my part to succeed. I will:
• Come to school each day prepared to learn.
• Complete all of my class work and homework on time.
• Follow the rules and be responsible for my behavior.
• Ask for help when I need it.
• Have a positive attitude about school.

Student Signature __________________________________________

I realize the importance of working with the school to improve my child’s academic performance. I can assist this process by:
• Providing an environment that encourages reading.
• Monitoring assignments and assisting with homework.
• Reinforcing consistent school attendance.
• Responding promptly to all school communications.
• Contacting the school if I have any questions or concerns.
• Participating in conferences and school functions.
• Serving on school and district based committees as needed.

Parent/Guardian Signature __________________________________________

The teachers and staff of Nellie H. Stokes Elementary School realize the importance of providing every child with a high quality curriculum and developmentally appropriate instruction. The teachers and staff will:
• Provide high quality curriculum and instruction in a supportive and effective learning environment. This will enable the participating children to meet the state’s student academic achievement standards through teacher professional development in researched based strategies and state standards.
• Provide the opportunity for parent-teacher conferences during which the compact will be discussed as it relates to the individual after the first, second and third marking period (or as needed).
• Provide parents with frequent reports of the children’s progress through interims, report cards, assessments and or notes returned in the Wednesday envelope.
• Provide parents with reasonable access to staff through appointments made through the main office, e-mails and phone calls.
• Provide parents opportunities to volunteer and participate in their child’s class, and to observe classroom activities by advertising these opportunities though written and verbal communication as well as encouraging parents to contact the main office to discuss opportunities with administrators and teachers.

Teacher Signature __________________________________________

Principal Signature __________________________________________
**DELAWARE EMERGENCY TREATMENT CARD**

**Student Name:**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
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<table>
<thead>
<tr>
<th>Birth Date:</th>
<th>Age:</th>
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</table>

**Grade:**

Teacher: Room:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

Resides with: ☐ Mother ☐ Father ☐ Other: 

Custody papers on file, if applicable: Yes or No

Please provide a primary phone number to receive District Message notifications

<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>
</table>

<table>
<thead>
<tr>
<th>Street Address or P.O. Box</th>
<th>Development</th>
<th>Street Address or P.O. Box</th>
<th>Development</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City &amp; Zip Code</th>
<th>Home Phone</th>
<th>City &amp; Zip Code</th>
<th>Home Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Work Phone</th>
<th>Employer Name</th>
<th>Work Phone</th>
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<thead>
<tr>
<th>Employer Department</th>
<th>Work Extension</th>
<th>Employer Department</th>
<th>Work Extension</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother/Guardian Email address</th>
<th>Cell Phone</th>
<th>Father/Guardian Email address</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

If parents/guardians cannot be reached, call:

1. Name | Relationship to student | Cell Phone | Home Phone | Work Phone

2. Name | Relationship to student | Cell Phone | Home Phone | Work Phone

Parent/Guardian Signature [Sign & date]

Date

PLEASE COMPLETE REVERSE SIDE

**DELAWARE EMERGENCY TREATMENT CARD**

**Student Name:**

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<th>Last</th>
<th>First</th>
<th>MI</th>
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</table>

<table>
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<tr>
<th>Birth Date:</th>
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**Grade:**

Teacher: Room:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
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</table>

Resides with: ☐ Mother ☐ Father ☐ Other: 

Custody papers on file, if applicable: Yes or No

Please provide a primary phone number to receive District Message notifications

<table>
<thead>
<tr>
<th>Mother/Guardian Name</th>
<th>Date of Birth</th>
<th>Father/Guardian Name</th>
<th>Date of Birth</th>
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<th>Development</th>
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</table>

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<tr>
<th>City &amp; Zip Code</th>
<th>Home Phone</th>
<th>City &amp; Zip Code</th>
<th>Home Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Work Phone</th>
<th>Employer Name</th>
<th>Work Phone</th>
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<th>Employer Department</th>
<th>Work Extension</th>
<th>Employer Department</th>
<th>Work Extension</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother/Guardian Email address</th>
<th>Cell Phone</th>
<th>Father/Guardian Email address</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

If parents/guardians cannot be reached, call:

1. Name | Relationship to student | Cell Phone | Home Phone | Work Phone

2. Name | Relationship to student | Cell Phone | Home Phone | Work Phone

Please sign & date

Parent/Guardian Signature [Sign & date]

Date

PLEASE COMPLETE REVERSE SIDE
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.

A. 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.

B. 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