OFFICE USE ONLY

Birth Certificate_____ Proof of Address_____ Immunizations_____
Report Card_____ Other Documents_____ Guardian ID: _____ __
Curriculum:_____ Grade: _____ Homeroom: _____ ID #: _____ __
Start Date:___/___/___ Registration Date:___/___/___

Student Registration Form

Student Information - Personal

Last: _____ First: _____ Middle: _____

Birthdate: _____ Place of Birth: _____ Gender: _____ Current Grade:_____

Ethnicity / Race (**Federal Requirement – Both Questions Must Be Answered**)
Is this student Hispanic/Latino? (Defined as a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race)
Choose only one: Yes, Hispanic or Latino☐ No, NOT Hispanic or Latino☐

What is this student's race? (Choose one or more, regardless of ethnicity)
American Indian or Alaskan Native☐ Asian☐ Black or African American☐
White☐ Native Hawaiian or Pacific Islander☐

Student Information – Educational

Previous School
Name:_____

Street Number and Name:_____ City, State, Zip Code:_____

Telephone Number:_____ Fax:_____

Is the student transferring from an alternative or special needs school? Yes☐ No☐

Has the student been previously homeschooled? Yes☐ No☐
(if yes, a copy of the DOE homeschool letter and portfolio MUST be provided)

Is the student currently receiving services for the following? (If yes, a copy of documentation MUST be provided)
HHPD☐ IEP☐ OT☐ PT☐ 504☐ Speech/Language☐

Did your child attend a preschool or childcare program in Delaware this past year? Yes☐ No☐
If yes, in which county did your child attend the program? ○New Castle County/ ○Kent County/ ○Sussex County
If yes, what was the name of the program? _____
Does the student participate in any special programs (Band, Chorus, Gifted, etc.)?
If yes, please list:_____

Student Information – Contact

School Messenger Phone Number 1:_____ Phone Number 2:_____

Physical 911 Address (NO PO Boxes):
Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____

Mailing Address / PO Box:
Street Number and Name:_____ Apt #:_____ PO Box:_____

City, State, Zip Code:_____

Parent / Guardian Information

Are there current custody/other legal documents on file? Yes☐ No☐ (if yes, a copy MUST be provided)

Guardian 1 Information (student MUST reside with this parent/guardian)

Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Guardian 2 Information Does the student reside with this parent/guardian? Yes☐ No☐

Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Emergency Contact Information

Emergency 1 Information - *NOT A PARENT / GUARDIAN LISTED ABOVE

Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Other Contact Information (if alternative transportation is required, it must be entered here)

Other Contact 1 Information / Alternate Transportation Pick Up / Drop Off (Daycare, Babysitter, Boys and Girls Club, etc.)

Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Additional Information

Has your family changed homes in the last three years? Yes☐ No☐

Has a parent or guardian worked on a farm, in the fields or in a factory with fruits, vegetables or animals? (For example, has a parent or guardian ever worked with watermelons, potatoes, mushrooms, corn, apples, chicken or shellfish?) Yes☐ No☐

Are there other children in the family? Yes☐ No☐

Name:_____ Age:_____ Resides at Home? Yes☐ No☐

Name:_____ Age:_____ Resides at Home? Yes☐ No☐

Name:_____ Age:_____ Resides at Home? Yes☐ No☐

DELAWARE STUDENT HEALTH FORM – CHILDREN
PreK- Grade 6

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

To Parent or Guardian:

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

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

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

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]:

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

GRADES 1-6:

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

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

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

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

CHILD'S NAME_____

PART I – HEALTH HISTORY

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

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

Date:_____ **Examiner:**_____

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

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

Parent/Guardian

Signature **Date**

CHILD'S NAME_____

PART II – IMMUNIZATIONS

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

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

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

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

PART III – SCREENING & TESTING

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

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

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

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

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

FOR CHRONIC & LIFE THREATENING CONDITIONS:

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

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

Recommendations or Referrals:_____

_____

_____

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

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

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

Address: _____ **Phone:** _____

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

OTHER

_____

Comments:

_____

_____

2. Does your child have allergies to medicine, food, latex or insect bites?

NO☐ YES☐ To What_____ What happens?

_____

Treatment

_____

3. Has your child had any illnesses since school last ended?

NO☐ YES☐ Type of illness, with date(s)

_____

4. Has your child had surgery since school last ended?

NO☐ YES☐ Type of surgery, with date(s)

_____

5. Has your child received any immunizations since school last ended?

NO☐ YES☐ List immunizations, with dates

_____

6. Is your child being treated or evaluated for any health conditions?

NO☐ YES☐ List condition

_____

7. Is your child on any medication or treatment?

NO☐ YES☐ Name of medication and/or treatment

_____

Does your child need medicine during school hours?

NO☐ YES☐ ***If yes, please contact the school nurse to make arrangements.***

8. Has your child ever been examined by an eye doctor?

   NO☐ YES☐ Date of last exam_____

   NO☐ YES☐ Glasses Prescribed

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

   _____

9. What is the name of your child's dentist? _____

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

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

    _____

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

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?

☐NO YES☐***If yes, please contact your School Nurse or School Counselor.***

12. Have you, your child or anyone in your household tested positive for COVID-19?

☐*NO YES*☐***If yes, please contact the school nurse.***

Revised 7/17/2020

Delaware Department of Education

DEPARTMENT OF EDUCATION

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

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

Delaware Department of Education Home Language Survey

Date: _____ **School:** _____

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

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

Circle grades your child attended in US schools

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

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

1. What language did your child first learn?

   Language: _____ | Dialect: _____

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

   Language: _____ | Dialect: _____

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

   Language: _____ | Dialect: _____

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

   Language: _____ | Dialect: _____

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

   Language: _____ | Dialect: _____

_____ Parent Name _____ Parent Signature _____ Date

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

Rev. 12.8.17

Delaware Department of Education

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

English

Dear Parent/ Guardian, Date: _____

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

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

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

_____ YES _____ NO

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

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

_____ YES _____ NO

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

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

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

_____

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

First / Last name	Date of Birth	Age	Grade	School

Parent/Guardian: _____

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

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

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

REV. 6/5/2020

SCHOOL USE ONLY
DATE:

REQUEST FOR BUS TRANSPORTATION

(Minimum of 24 hours notice)

Fax: (302) 653-1815

TRANSPORTATION USE ONLY
DATE:

DATE OF REQUEST: _____ **SCHOOL/GRADE:** _____

STUDENT'S NAME: _____

DEVELOPMENT: _____

STUDENT'S 911 ADDRESS: _____

_____

PARENT/GUARDIAN'S NAME: _____

HOME PH#: _____

BEST PH# TO USE: _____

PICK UP ADDRESS	***DROP OFF ADDRESS*** _____ ***CHECK HERE IF SAME AS PICKUP***
NAME:	NAME:
DEVELOPMENT:	DEVELOPMENT:
ADDRESS:	ADDRESS:
CITY:	CITY:
STATE: ZIP:	STATE: ZIP:
BEST PHONE#:	BEST PHONE#:

FOR TRANSPORTATION ONLY	***FOR TRANSPORTATION ONLY***
BUS: CONTRACTOR:	BUS: CONTRACTOR:
START DATE:	START DATE:
STOP:	STOP:
TRANSPORTATION NOTES:	

IF STUDENTS ATTEND BOYS & GIRLS CLUB WE NEED A SIGNATURE

B & G CLUB SIGNATURE _____ DATE: _____
B & G PARENT SIGNATURE _____ DATE: _____

SA/lm 3/4/21

Date records requested _____ Date records received _____

SMYRNA SCHOOL DISTRICT
CLAYTON ELEMENTARY SCHOOL
510 WEST MAIN STREET
CLAYTON, DE 19938
302-653-8587
302-653-3421 (FAX)

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name:		Birth date:	
Address:			
Home Phone :		Other:	
Parent/Guardian:			
Relationship to Student:			

I hereby authorize _____to disclose the information described below concerning the above named student to be released to the Smyrna School District for the purpose of educational programming/planning of the above named student.

The following information may be disclosed/released:

	Cumulative Record
	Withdrawing Grades
	Standardized Test Scores
	Health Records
	Special Education Records
	Court/Custody Records
	Other:

Witnessed by:

_____ _____ _____

Name: Parent/Legal Representative Date

NOTE: When records are requested by school personnel for a student who has enrolled or intends to enroll in a school system, parental permission is no longer required (Family Educational Rights and Privacy Act; Final Rule on Education Records; Buckley Amendment; Section 99.31; Paragraph b; Federal Register; June 17, 1976; Volume 41, Number 118, Page 24673).

You may mail the above applicable student information to:

U.S. Mail Address:
Clayton Elementary School
510 West Main Street
Clayton, DE 19938

Delaware State Mail Address:
Clayton Elementary School
Smyrna School District
State Mail N460