SMYRNA MIDDLE SCHOOL

REGISTRATION PACKET

Smyrna Middle School
700 Duck Creek Parkway • Smyrna, DE 19977
Phone (302)653-8584 Fax (302)653-3424

NEW STUDENT REGISTRATION CHECKLIST

Date: _____

Student Name (as listed on Birth Certificate): _____

Registration Year: _____ Grade: _____

Welcome to the Smyrna Middle School. Listed below are required documents needed to register your child(ren). All required documents must be provided before the student can be registered.

Documents to Be Provided (Copies will be made and originals will be returned to parent/guardian)

- ☐ Current Photo ID of the parent/guardian
- ☐ Original Birth Certificate
- ☐ Immunization Records
- ☐ Student Physical (see "Note from Nurse" for requirements)
- ☐ Most Recent Report Card
- ☐ Withdrawal Grades
- ☐ IEP / 504 Plan (Special Education Services)
- ☐ Legal Custody/Guardianship Documents
  - ☐ I am the parent (birth or adopted) of this child and this child lives with both parents.
  - ☐ I am the parent (birth or adopted) of this child and am not currently married to/living with the other parent, but I have been awarded custody/guardianship through the court (provide copy of court order)
  - ☐ I am NOT the parent (birth or adopted) of this child. I am a relative or friend. (Circle one)
    - ☐ I have been awarded legal guardianship of this child through the court (provide copy of court order)
    - ☐ I have NOT been awarded legal guardianship of this child through the court. Please contact: SSD Special Services Office - Pam Denney-Griffiths (302)653-3135
  - ☐ I am a foster parent
  - ☐ None of the above statements describe my relationship to this child. Please explain your relationship to this child on the back of this form

Residency Requirements - Parent/Guardian MUST live within the Smyrna School District (unless approved for Choice)

(Choose the appropriate box below)

☐ I am the **HOMEOWNER**

You MUST bring **ONE** of the following:
- ☐ Mortgage Statement, Deed, Sales Agreement or Current Property Tax Bill

AND

ONE of the following:
- ☐ Utility Bill (Electric, Gas, Water, Cable)
- ☐ Auto Registration
- ☐ Driver's License with Current Address

☐ I **RENT**

You MUST bring the following:
- ☐ Current signed lease/rental agreement

AND

ONE of the following:
- ☐ Utility Bill (Electric, Gas, Water, Cable)
- ☐ Auto Registration
- ☐ Driver's License with Current Address

☐ **I LIVE WITH ANOTHER SMYRNA SCHOOL DISTRICT RESIDENT**

You MUST complete a Multiple Occupancy form at:
Smyrna School District
Special Services Office
80 Monrovia Avenue
Smyrna DE 19977
(302) 653-3135

The Homeowner must provide the Proof of Residency
(Please refer to "Homeowner List" above)
AND
Parent/Guardian MUST provide TWO proofs of address

We can't accept cell phone bills, medical statements or bank statements as proof of residency

(Over)

NEW STUDENT REGISTRATION CHECKLIST (Page 2)

Forms to Be Completed & Returned

- ☐ Student Registration Form
- ☐ Home Access Center Request
- ☐ Emergency Card
- ☐ Parent & Student Contract
- ☐ McKinney-Vento Student Residency Questionnaire
- ☐ Transportation/Bus Request
- ☐ Records Release/Request
- ☐ DIAA Physical (Athletes)
- ☐ DE Student Health Form
- ☐ Agricultural Work Survey
- ☐ Home Language Survey
- ☐ Military-Connected Survey
- ☐ Wellness Packet (optional)

Questionnaire

1. Does this student have an **I**ndividualized **E**ducation **P**lan (IEP)? ☐Yes ☐No
2. Does this student have a 504 Plan? ☐Yes ☐No
3. Has this student ever been expelled from school? ☐Yes ☐No

I understand that at any point in time that I change addresses within the district or move out of the district, that I MUST IMMEDIATELY notify the School Office and present proof of residency for the new address.

I am aware that if I have enrolled my child/children based on false or inaccurate residency information, I will be held liable to the district for payment of all costs incurred and my child may be withdrawn from the school district.

Signature of Parent or Legal Guardian

Date

OFFICE USE ONLY

Birth Certificate ❑ Proof of Address ❑ Immunizations ❑ Report Card ❑ MKV ❑ 504 ❑

ESL ❑ IEP ❑ Guardian ID: ❑ ID #: _____ Pre-Reg KN Year: _____

Homeroom Teacher: _____ Grade: _____ CURR: _____

Start Date: _____ Registration Date: _____

Choice to: _____ Choice from: _____

Student Registration Form

Student Information – Personal

Last: _____ First Name: _____ Middle: _____

Birthdate: _____ Place of Birth: _____ Gender: _____

School Year: _____ Current Grade: _____

Student Ethnicity/Race *(Federal Requirement – Both Questions MUST be answered)*

Is the 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 the 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 Contact Information

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: _____

Student Information – Educational

Previous School

Name: _____

Street Name and Number: _____

City, State, Zip Code: _____

Telephone Number: _____ Fax Number: _____

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 of childcare program in Delaware this past year? Yes ❑ No ❑

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

If yes, what was the name of the program? _____

Student Information – Educational (continued)

Does the student participate in any special programs (Band, Chorus, Gifted, etc.)? Yes ❑ No ❑

If yes, please list: _____

Parent/Guardian Information

Are there current custody/other legal documents on file? Yes ❑ No ❑ *(if yes, a copy MUST by 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 the parent/guardian? Yes ❑ No ❑

Name: _____ Relationship: _____

Street Number and Name: _____ Apt. #: _____

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

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

Alert Now Contact Information *(Alert Now is the School District's automated calling system)*

Phone Number 1: _____ Phone Number 2: _____

Emergency Contact 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)*

****Additional Contact/Alternative Transportation Pick up or Drop off (Daycare, Babysitter, Boys & Girls Club, etc.)****

Name: _____ Relationship: _____

Street Number and Name: _____ Apt. #: _____

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

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

Siblings *(Please complete this section, if applicable, so students can be linked under one Home Access Center login)*

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

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

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

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:**	

Check 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

Individualized Education Program (IEP)
State of Delaware
Smyrna School District

Student Name:	
Student ID#:	DOB:
Address:	
City:	State:
Zip:	Current Grade:
District of residence:	
Attending Building:	**Smyrna Middle School**
Disability Classification:	

IEP Status

Meeting Date		Most Recent Evaluation Summary Report Date	
IEP Initiation Date		IEP Revision Date	
IEP End Date		IEP Revision Date	

Unless revised, this IEP is in effect for the school year including those students eligible for longer school years because of disability classification.

Parent 1:	☐ P ☐ S ☐ G
Address (if different):	
Phone (H):	(W):
Cell:	Email:
Parent 2:	☐ P ☐ S ☐ G
Address (if different):	
Phone (H):	(W):
Cell:	Email:

P S G – check if parent, surrogate, or guardian

Temporary Placement	
Agency Representative:	
Parent:	
Date:	
Within 60 days, an IEP meeting must be held.	

Meeting Participants

Role	Print Name	Signature
Parent 1		
Parent 2		
Student		
General Ed. Teacher		
Special Ed. Teacher		
Administrator / Designee		

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)

2021 – 2022 Military-Connected Youth Student Information Update Form

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

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

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

PARENTS OR STEP-PARENTS

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

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

IMMEDIATE FAMILY MEMBER OR ANY OTHER PERSON RESIDING IN SAME HOUSEHOLD

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

☐ **NON-APPLICABLE**

Student Name: _____ Grade: _____

School Name: _____

Homeroom Teacher Name: _____

Please return this form to your student's homeroom teacher on or before Monday, September 21, 2021.

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

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 check 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:

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: The 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

DELAWARE STUDENT HEALTH FORM – ADOLESCENT
Grades 7-12

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

To Parent or Guardian:

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

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

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

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

GRADES 7-12:

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

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

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

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

CHILD'S NAME_____

PART I – HEALTH HISTORY

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

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

Date:_____ **Examiner:**_____

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

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian
Signature **Date**

CHILD'S NAME_____

PART II IMMUNIZATIONS

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

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

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

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

PART III – SCREENING & TESTING

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

Screen	**Height: _____Weight: _____BMI: _____ BMI Percentile: _____BP: _____Pulse: _____Other: _____** (inches) (pounds)
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
Other Screen	**Hearing: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Vision: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Other: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

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

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

FOR CHRONIC & LIFE THREATENING CONDITIONS:

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 ☐ OTHER _____
   ☐ Bone/Spine ☐ Bowel/Bladder ☐ Diabetes ☐ Emotional ☐ Hearing
   ☐ Heart ☐ Infections ☐ Kidney ☐ Physical Disability ☐ Seizures
   ☐ Speech ☐ Surgery ☐ Vision

   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 illness 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 7/17/20

DELAWARE DEPARTMENT OF EDUCATION
Tuberculosis (TB) Risk Assessment Questionnaire for Students[1]

Prior to use of this form, the school nurse must review the student's health record and assure that the student is compliant with the requirements for a current health examination (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person, or by phone, and signed by the person who answered the questions.

Name: ____
Last First MI

Date of Birth: _______/______/______ Date Form Completed _______/______/______

1. Has your child had close contact[2] with anyone with an active infectious TB disease? ☐ YES ☐ NO
2. Was any household member, including your child, born in or has he/she traveled to area(s) where TB is common? (Refer to the Tuberculosis High Burden Countries list provided by the Delaware Division of Public Health.) ☐ YES ☐ NO
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB (i.e., those who are HIV infected, homeless[3], incarcerated[4], and/or illicit drug users)? ☐ YES ☐ NO
4. Does your child have a history of HIV infection, living in a shelter, incarceration, or illicit drug use? ☐ YES ☐ NO
5. Does your child have any health conditions or take medications that might affect his/her immune system? ☐YES ☐NO
6. Has your child ever had a positive test for tuberculosis? ☐ YES ☐ NO

Any "yes" response to questions 1 – 5 is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test for a TB blood test, such as The Quantiferon Gold TB Test, to the child.

A "yes" response to question 1 – 6 indicates probable previous exposure to TB, and requires medical follow-up to evaluate medical status.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

☐ **Does not** require a Tuberculosis Test ☐ **Does** require documentation related to current disease status

☐ **Does** require a Tuberculosis Test

TB testing and documentation must be completed and given to the school nurse by ____/____/____ (date) or your child will be excluded from school.

School Nurse Comments: ____

____

School Nurse (signature) ____

Parent/Guardian (signature) ____

- -

I give permission for the school nurse and my child's primary care physician __________________________ (name of physician) to share information relating to this form.

Name ____ Date ___________________________

____ Parent/Guardian (signature)

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[1]TB assessment is required by Regulation 805, http://regulations.delaware.gov/AdminCode/title14/800/805. The questionnaire was developed by Delaware Department of Education and the Division of Public Health. Revised 7/1/13, 5/2015, 4/2018.
[2]CDC describes "close contact" as prolonged, frequent, or intense contact with a person with TB, while he/she was in infectious.
[3]The term "homeless" means a situation where the person lived in a shelter or with others.
[4]Incarceration should be longer than one week.

SMYRNA MIDDLE SCHOOL
700 Duck Creek Parkway, Smyrna, DE 19977
(302) 653-8584 Fax: (302) 653-3424

Mrs. Stephanie Smeltzer	Mr. Erik Wilson	Mrs. Whitney Irwin	Dr. Christine Seitz
Principal	Associate Principal	Associate Principal	Associate Principal

A NOTE FROM THE NURSE:

Welcome to Smyrna Middle School! As you register to attend school here, you should know the following information. **If you are entering school for the first time or your previous school was:**

*not in Delaware *private school
*not in this country *home school

the Department of Education requires the following health information to be provided to the school nurse **BEFORE STARTING SCHOOL.**

1. **A Completed Physical Examination Form** – Your child must have a physical examination by a health care provider two years prior to entry into school. The form must have the date, the health care provider's signature, address and phone number. *(Department of Education Regulation 815)*

2. **A Complete Immunizations Record** – Your child must be up-to-date in immunizations or he/she may not enter school. *(Delaware Code, Title 14, Section 131)*

3. **A Mantoux (PPD) Tuberculosis Skin Test** – You must provide proof that a Mantoux skin test was administered, read, and results documented by a health care professional within the past twelve months prior to school entry.

OR

Your health care provider may complete a "**TB Risk Assessment Questionnaire**" and provide a copy of that document to the school. *(Department of Education Regulation 805)*

4. **Lead Blood Test – Children registering for pre-k and kindergarten must provide proof that they have had a blood test for lead.** *(Delaware Code, Title 16, Chapter 26)*

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO SEE THAT THE ABOVE LISTED ITEMS ARE TURNED IN TO THE SCHOOL. FAILURE TO DO SO WILL RESULT IN THE INTERRUPTION OF YOUR CHILD'S EDUCATION AND WILL VIOLATE SCHOOL ATTENDANCE AND IMMUNIZATION LAWS.

If your previous school was in Delaware, we will attempt to locate the student's health record. If we are unable to locate it within 14 calendar days, the students' parent/guardian will be required to provide the above information.

If you have any questions or problems providing the above information, please contact us at 653-8823.

Renee Startt, RN School Nurse
Kelley Willoughby, RN School Nurse

I understand the above immunization requirements for admission.

PARENT/GUARDIAN SIGNATURE DATE

SMYRNA SCHOOL DISTRICT

82 Monrovia Avenue, Smyrna, Delaware 19977
Telephone (302) 653-8585
Fax (302) 659-6290

Mrs. Deborah Judy
Assistant Superintendent

November 12, 2020

Dear Parent/Guardian,

The Delaware Department of Education and Delaware Department of Health and Social Services' Division of Public Health have requested that we provide you information regarding practices related to COVID-19.

We request that students and/or their families complete a health assessment consisting of a self-screening every morning before leaving for school.

Please answer the following questions:

- In the past 14 days, have you been near (within 6 feet for a total of 15 minutes or more) a person who has a lab-confirmed case of COVID-19, or have you had direct contact with their mucus or saliva?
- In the last 48 hours, have you had any of the following symptoms?
  - Fever of 100.4 F or above (or symptoms like alternating shivering and sweating)
  - New cough
  - New trouble breathing, shortness of breath or severe wheezing
  - New chills or shaking with chills
  - New muscle aches
  - Sore throat
  - Vomiting or diarrhea
  - New loss of smell or taste, or a change in taste
  - Nausea
  - Fatigue
  - Headache, congestion or runny nose (with no known other cause such as allergies)

If you answered **YES** to any of the questions above, do NOT send your child to school today. Instead, contact your child's primary healthcare provider and school nurse.

(This screening tool was adapted from the Mayo Clinic's online COVID-19 Self-Assessment. To use the Mayo Clinic's tool online, visit https://mayoclinic.org/covid-19-self-assessment-tool)

Additional considerations:

- Students must stay home if they are exhibiting any symptoms of COVID-19 or have been confirmed to have COVID-19 or if required by DPH to isolate or quarantine.
- Keep children who are sick at home; do not send them to school. Do not send children to school with a fever of 100.4º or greater.
- Teach your children to wash their hands frequently with soap and running water for 20 seconds.

SMYRNA SCHOOL DISTRICT

82 Monrovia Avenue, Smyrna, Delaware 19977
Telephone (302) 653-8585
Fax (302) 659-6290

Mrs. Deborah Judy
Assistant Superintendent

- Students in kindergarten through grade 12 must wear face coverings in the school building, except when doing so would inhibit the individual's health.
- Teach your children to cover coughs and sneezes with tissues or by coughing into the inside of the elbow.
- Teach your children to practice physical and social distancing by staying at least six feet away from people other than your family.

If you have questions, please contact your school nurse or child's primary healthcare provider. You can also call your school.

For information or general questions on COVID-19 and prevention, visit the Delaware Health and Social Services', Division of Public Health's website at https://coronavirus.delaware.gov/ or you can call 2-1-1 or text your ZIP code to 898-211 for deaf and hard of hearing.

Sincerely,

Deborah Judy

Deborah Judy

SMYRNA SCHOOL DISTRICT

82 Monrovia Avenue, Smyrna, DE 19977
Telephone: (302) 653-8585 • Fax: (302) 653-3149
State Mail Coode: N460

Transfer of Student Records – Request/Release Form

To: _____ Date: _____

School: _____

Fax: _____ From: **Smyrna Middle School**
700 Duck Creek Parkway, Smyrna DE 19977
State Mail Code: N460
Phone: (302) 653-8308 Fax: (302) 659-6293

Dear Registrar:

We are in the process of or have the following student registered at Smyrna Middle School.

Student Name: _____

Date of Birth: _____

Grade: _____

Please send us the information listed below. Please note that we may also be requesting some items be faxed in order to expedite the registration process.

Fax	Mail	Description	Fax	Mail	Description
❑	❑	Report Card – Recent	❑	❑	Attendance History Report
❑	❑	Transcript (with grade scale)	❑	❑	Birth Certificate
❑	❑	Discipline History Report	❑	❑	Immunization/Physical Records
❑	❑	Standardized Test Scores	❑	❑	Custody/Guardianship Court Documents
❑	❑	Withdrawal Form (with current grades)	❑	❑	Special Education Information (IEP/504)
	❑	Official Transcript (Signed & Sealed)			
	❑	Cumulative Folder (Including originals of all items above & Health/Medical Records)			

Additional Information:

_____

_____ _____ _____ _____
Dianna Turner, Administrative Assistant Date Parent/Guardian Signature Date

DISCLOSURE OF PUPIL'S RECORDS

FEDERAL LAW 99.31
"NO PARENT SIGNATURE REQUIRED FOR EDUCATIONAL RECORDS SENT TO ANOTHER EDUCATIONAL AGENCY"

SCHOOL USE ONLY
DATE:

REQUEST FOR BUS TRANSPORTATION

(Minimum of 24 hours notice)

Fax: (302) 653-1815

PROVIDE THE COMPLETED FORM TO YOUR CHILDS SCHOOL

TRANSPORTATION USE ONLY
DATE:

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

STUDENT'S NAME: _____

DEVELOPMENT: _____

STUDENT'S 911 ADDRESS: _____

_____

PARENT/GUARDIAN'S NAME: _____

HOME PHONE #: _____

BEST PHONE # 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:
LOCATION:	LOCATION:
PARENT _____ CONTRACTOR_____	PARENT _____ CONTRACTOR_____
TRANSPORTATION NOTES:	

B & G CLUB SIGNATURE _____DATE: _____

B & G PARENT SIGNATURE _____ DATE: _____