Milford School District

Application for Bus Transportation or Address Change

Home Address: _____ City: _____ Zip: _____

If you have moved, please note previous address:

_____

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

Student Name: _____ School: _____

Pick-Up Address: _____ City: _____

Drop-Off Address: _____ City: _____

Student Name: _____ School: _____

Pick-Up Address: _____ City: _____

Drop-Off Address: _____ City: _____

Student Name: _____ School: _____

Pick-Up Address: _____ City: _____

Drop-Off Address: _____ City: _____

Student Name: _____ School: _____

Pick-Up Address: _____ City: _____

Drop-Off Address: _____ City: _____

****If either the "Pick-up" or "Drop-off" address is not at the home address, please give the Caregiver's Information below.****

Name: _____ Phone #: _____

_____

Parent / Guardian Signature

_____ _____

Printed Parent / Guardian Name **Date**

For Office Use Only

Please Attach ID and Scan with ID Attached

Milford School District
Request for Student Records

Please fax the following items:
____ Birth Certificate
____ Immunization Records
____ Last Report Card
____ Withdrawal Grades
____ Demographic Sheet from School
____ IEP/504 Plan
____ Other (_____)

To:_____
Prior School Name

_____
Address

_____
School Phone Number Fax Number

I authorize and request that the records be sent to the Milford School District for:

_____ _____ _____
Student Grade Date of Birth

Please mail or fax records to:

_____

_____

_____

_____

_____

Please include:

- Cumulative Records
  - Complete Transcript including grades and credits up to withdrawal date (High School)
  - Previous Report Cards (Elementary and Middle School)
- Explanation of grading system
- Test results: Standardized, Aptitude/Interest & Psychological
- Health & Immunization Records
- Special Education Records or Accommodation Plans, including IEP and evaluations on reports (Special Education Audit File)
- Any other data that will help us provide satisfactory adjustments to our school

Records will be used for professional purposes only and will be kept confidential.

_____ _____
Parent or Guardian Signature Date

Milford School District

Last Name: _____

Student's Name: _____ Date of Birth: _____ Grade: _____ Age: _____

Address: _____ Gender: _____ Race: _____

City: _____ State: _____ Zip: _____ Ethnicity: Hispanic Origin? _____

Student Resides with: _____ Relationship: _____ Custody Papers on File: ___

Bus # to: _____ Bus # from: _____ Transportation: Other: _____ Day Care: Name/Phone #: _____

Parent/Guardian #1	Parent/Guardian #2
Name: _____ DOB: _____	Name: _____ DOB: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Home Address: _____	Home Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Email Address: _____	Email Address: _____
Place of Employment: _____	Place of Employment: _____
Work Phone: _____ Ext: _____	Work Phone: _____ Ext: _____

Parent/Guardian will be contacted first. If unavailable, the following emergency contacts will be contacted.

Name	Relationship	Home Phone	Cell Phone	Work Phone

Medical Insurance Information

Insurance Company: ID Number: Group: Medicaid #:

Other Insurance Information:

I give the School Nurse permission to talk to my child's medical Doctor/Dentist, as needed: Yes ___ No ___

Physician: Phone: Dentist: Phone:

SCHOOL EMERGENCY PROCEDURES

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 call the home. If there is no answer,
2. The school will call the Mother's, Father's or Guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician 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.

I verify that all the above information is correct. This information may be shared with school personnel on a "need to know" basis. Please contact the school if any of the above information changes.

Parent/Guardian Signature: _____ Date: _____

Please complete and return: The State of Delaware requires that all students have an emergency card on file in the School Nurse's Office.

MILFORD SCHOOL DISTRICT
HEALTH QUESTIONNAIRE

Today's Date: _____

Student's Name: _____ Birthdate: _____

Sex: _____ Grade: ____

Please list all other persons living in your child's household:

Name	Birthdate	Relationship to Child

PLEASE ANSWER ALL QUESTIONS LISTED BELOW

Has your child had any of the following? Please check and explain.

Asthma		Bone or Muscle Problems	
Chicken Pox		Heart Disease	
Diabetes		Heart Murmur	
Seizures		Frequent Ear Infections	
Kidney Problems		Frequent Sore Throats	
Bleeding Problems		Headaches	
Stomach Problems		Fainting / Blackouts	

Please explain any problem(s) checked above: _____

_____

Allergies to Medicines, Food, Insect Bites, Bee Stings, etc.? Please list: _____

_____

What medicine does your child take for allergic reactions? _____

Hospitalizations? List dates and reason: _____

Surgery? List dates and type: _____

Serious Illnesses/Injuries? List dates and type: _____

Has your child had any immunizations since kindergarten? Yes ☐ No ☐

If yes, list type and date: _____

_____

Does your child visit the dentist regularly? Yes ☐ No ☐

If yes, list type and date: _____

_____

Milford School District

Does your child have a hearing problem? Yes ☐ No ☐
If yes, list problem: _____

Does your child have a vision problem, wear glasses or contacts? Yes ☐ No ☐
If yes, list problem and date of last eye exam: _____
If he/she wears glasses or contacts, when was the last new prescription? _____

Does your child take any **daily** medications? Yes ☐ No ☐
If yes, list medicine and illness/condition: _____
_____

Will medicine need to be given at school? Yes ☐ No ☐
If yes, please see school nurse to sign permission forms.

Is your child presently being treated for an illness? Yes ☐ No ☐
If yes, list illness and medicine: _____

Has your child's development been normal? Yes ☐ No ☐
(Walking, Talking, Toilet Training, Physical Growth and Development)
If no, list reasons: _____

Were there any problems with the pregnancy and delivery of this child? Yes ☐ No ☐
If yes, list problems: _____

Has your child had any emotional upsets or changes in his/her life? Yes ☐ No ☐
(Moves, Separation, Divorce of Parents, Death, etc.)
If yes, please explain: _____

Are you concerned about your child's behavior? Yes ☐ No ☐
If yes, please explain: _____

Does your child have any other health problems you are concerned
or that the school should be aware of? Yes ☐ No ☐
If yes, please explain: _____

Please list any serious health problems of this child's mother, father, grandparents, sisters or brothers:

_____
_____

Please list the date of your child's last physical exam and the name of the doctor:

_____
_____

Additional Comments/Concerns: _____
_____
_____
_____
_____
_____

Milford School District

Permission for Use of Over -The- Counter Medications during the Current School Year!

Name of Student: _____ Date:_____

Does your child have allergies to medicine, food, latex or insect bites: Yes ____ No ____
If yes: To What? _____ What Happens?_____
Treatment: _____

As parent/guardian, I give my permission for the above named student to have the following medications administered by the school nurse during the current school year. I understand that he/she will be checked by the school nurse and the medications will be administered if indicated following the nurse's assessment. Please check only those medications you wish to be given to your child when needed.

_____ Anbesol/Oragel (mouth Pain)
_____ Anti fungal Cream
_____ Benadryl Lotion (anti- itch)
_____ Blistex (lip ointment)
_____ Burn Ointment/ Spray
_____ Caladryl Lotion
_____ Calamine Lotion (anti-itch)
_____ Carmex (mouth lesions)
_____ Chapstick (lip balm/ Vaseline)
_____ Contact lens solution/saline/ rewetting
_____ Cough drops
_____ Eye Wash solution
_____ Hydrocortisone cream
_____Medicated Powder/Baby Powder
_____ Mineral Ice (muscle pain)
_____ Sting Kill (Insect Sting relief)
_____ Throat Spray(Chloreseptic Spray)
_____ Triple Antibiotic Ointment
_____ Vicks (vapor rub)

_____ Advil/ Ibuprofen
_____ Tylenol/Acetaminophen
_____ Tums (antacid)
_____ Benadryl

My child may use hand sanitizer: ____ YES ___ NO My child may need help with hand sanitizer ___YES ___NO

If your child requires prescription medication during the school day, please contact your child's school nurse
ex. Medication for: ADHD, ADD, Diabetes, Seizures, Asthma medications (inhalers, nebulizer medication), Epi-pens, Benadryl, etc.

Medical Diagnosis: _____
My child takes medication at home: (before school/after school)
Name of Medication/s:

- **Students may not carry medications during the school day without Parent/Doctor/School Nurse permission. Paperwork must be completed and on file in the nurses office.**

PARENT/GUARDIAN SIGNATURE_____ Date: _____

Dear Parent or Guardian,

According to Delaware Code, Title 14, section 131; a child is not permitted to enter into school with 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) does 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.
- Students entering 9th grade must have 1 dose of Tdap (adult booster) and 1 dose of meningococcal. (compliance grades 9-12)

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 text (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 one (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 immunizations 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

Milford School District

Temporary Special Education Placement for Transfer Students
(30 days maximum)

Student Name _____ School: _____ Date: _____

Parent/Guardian: _____Birthdate: _____

Address: _____Grade: _____

City_____ State_____ Zip_____ Phone #:_____

Documentation of Phone Conference:

School: _____Phone #: _____ _____

Date: _____ Person: _____Title: _____

Classification: _____

Time Per Day: Special Ed Time: _____ Regular Ed Time: _____

Setting: _____

Special Education		Related Services	
Subjects	Grade Level	Service	Time/Freq.

Date of Last Reevaluation: _____

Other Information: _____

Related Services: _____

Temporary Placement:

Classification: Same as Above
Time Per Day: _____
Setting: _____
Special Education & Related Services: _____

Signature of Parent/Guardian: _____