

Board of Education

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7 Front Street
Wyoming, DE 19934

Caesar Rodney Schools

Caesar Rodney High School
Air Base Middle School
Fred Fifer III Middle School
Magnolia Middle School
Postlethwait Middle School
W. Reily Brown Elementary School
Allen Frear Elementary School
David E. Robinson Elementary School
W. B. Simpson Elementary School
Star Hill Elementary School
Nellie Hughes Stokes Elementary School
Major George S. Welch Elementary School
McIlvaine Early Childhood Center
Caesar Rodney Countywide Programs
Caesar Rodney Intervention Programs

Welcome to the Caesar Rodney School District!

Home of the Riders

There are many opportunities within Caesar Rodney School District for your student to excel and we are excited to begin your child's registration process. Please visit our website: <http://www.crk12.org>.

***To ensure a successful registration, the following information is required:**

1. Student's Birth Certificate
2. Proof of residency with parent/guardian name – mortgage statement or lease agreement w/landlord and parent/guardian's name*. If a mortgage statement or lease agreement is not available, the school will need a copy of the electric, gas, or water bill.
3. Immunization records and current physical (within the last two years)
4. Photo identification of the parent and/ or guardian
5. Custody documentation (if applicable)
6. IEP documentation (if appropriate)
7. 504 documentation (If appropriate)

If you are transferring to Caesar Rodney School District from another school district, please provide the following:

1. Withdrawal papers from the former school
2. Transcript of grades or report cards from former school
3. Standardized testing results (if available)

Kindergarten: In Delaware, students must be five years old by August 31th of the current school year to attend kindergarten.

***The lack of information will not serve as a barrier to registration and placement for those students who are eligible for services under the McKinney Vento Homeless Education Act.**

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 Coordinators. The following have been appointed to serve as the District's Compliance Coordinators. These coordinators can be contacted at the Paul L. Dunbar Administration Building at 7 Front Street, Wyoming, DE 19934 or at (302) 698-4800.



Caesar Rodney School District Student Registration Checklist

Student Name _____

Grade _____ **Homeroom** _____

	Items Required for Registration
	Registration Form
	Emergency Treatment Information
	Student Residency Form
	Delaware DOE Home Language Survey
	Agriculture Work Survey
	Birth Certificate
	Proof of Residency with parent/guardian name – mortgage statement or lease agreement w/landlord and parent/guardian’s name *. If a mortgage statement or lease agreement is not available, the school will need a copy of the electric, gas, or water bill.
	Immunization Records and current physical (within the last two years)
	Proof of parenthood/guardianship – may require custodial papers and primary placement papers
	Picture identification
	Caesar Rodney School District Student History (2 Pages)
	Delaware Student Health Form (one of the below)
	Children – PreK to Grade 6 (4 pages)
	Adolescent – Grades 7-12 (4 pages)
	Additional Items Required for Kindergarten / PreK
	Parent Information Form (2 pages)
	If Transferring from Another District
	Withdrawal papers from former school
	Transcript of grades or report cards from former school
	IEP/504 Documentation (if applicable)
	Standardized Assessment results

*The lack of information will not serve as a barrier to registration and placement for those students who are eligible for services under the McKinney Vento Homeless Education Act.

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Caesar Rodney School District Registration Form

School _____
School Year _____ Grade _____ Date _____

Choice: Yes ___ No ___
District Of Residence _____
School of Residence _____
Homeroom _____
ID # _____
Office use only

Transferring from _____

Is this child currently attending or is there a contract signed with a charter school? Yes ___ No ___ Where _____

Has this child ever attended Caesar Rodney School District before? Yes ___ No ___ When _____

Student Information

Legal Name of Child _____ Age _____

Nickname(s) _____ Has Child Been Retained? : [] Yes [] No Grade(s) _____

Birth Date: _____ Gender: [] Male [] Female Active Military: [] Yes [] No
Hispanic: [] Yes [] No Race: [] American Indian/AK [] Black/African American [] Caucasian [] Asian
[] Native Hawaiian/Pacific Islander

Child's Home Language: _____
Child's Complete Mailing Address: PO Box / Street _____ City/State/Zip _____ Development _____ Home Phone: _____
Child's Complete Physical Address (If Different): Street _____ City/State/Zip _____ Development _____ Home Phone: _____

*Check if Applicable: [] Homeless [] Foster Care [] Speech [] Title I [] Gifted [] 504 Plan [] IEP [] Other

Special Programs Needed: _____

Parent / Guardian Information

[] Parent [] Step-Parent [] Foster Parent [] Guardian [] Other _____

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Lives with: [] Yes [] No
Legal Custody: [] Joint [] Relative Caregiver [] Other _____

[] Parent [] Step-Parent [] Foster Parent [] Guardian [] Other _____

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Lives with: [] Yes [] No
Legal Custody: [] Joint [] Relative Caregiver [] Other _____

Emergency Contact:

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

Emergency Contact:

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

Siblings in Present Household Under Age 18:

Name _____ Age _____ Grade _____
Name _____ Age _____ Grade _____
Name _____ Age _____ Grade _____

This is to confirm to Caesar Rodney School District Officials that I am the parent or legal guardian of the above child and that this is my legal address

Please Print Your Name

Signature / Date

FOR OFFICE USE ONLY
BUS _____ SPECIAL ED. CLASS _____ LUNCH _____
CHROMEBOOK _____ RECORDS REQUESTED _____ TEACHER ASSIGNED _____



Caesar Rodney School District Emergency Treatment and Contact Information

Student Name: _____

School: _____

Child Resides with: _____

Relationship: _____

Address: _____

Relationship: _____

Bus No. To School: _____

Homeroom: _____

Bus No. From School: _____

Grade: _____

Daycare/ Sitter Name: _____

Birth Date: _____

Daycare Phone: _____

Gender (M/F): _____

Home Phone: _____

Guardian 1 Information

Name: _____
 Date of Birth: _____
 Home Address: _____

 Home Phone: _____
 Cell Phone: _____
 Business Phone: _____
 Place of Employment: _____
 E-mail Address: _____
 Step-parent/Spouse Name: _____
 Place of Employment: _____
 Business Phone: _____
 Cell Phone: _____

Guardian 2 Information

Name: _____
 Date of Birth: _____
 Home Address: _____

 Home Phone: _____
 Cell Phone: _____
 Business Phone: _____
 Place of Employment: _____
 E-mail Address: _____
 Step-parent/Spouse Name: _____
 Place of Employment: _____
 Business Phone: _____
 Cell Phone: _____

IF PARENTS/GUARDIANS CANNOT BE REACHED, CALL:

Name	Relationship	Work Phone	Home Phone
1			
2			
3			

Student's Physician: _____ Phone _____

Student's Dentist: _____ Phone _____

Insurance Information:

Provider: _____ Group #: _____ Policy #: _____ Medicaid # _____

Indicate student's medical problems: _____

Medication student takes regularly: _____

ALLERGIES (food, medication, environmental) _____

SCHOOL EMERGENCY PROCEDURES

In case of illness or injury, the school will attempt to contact both parents at all numbers available. If the parent is unable to be reached the emergency contacts will be called in the order they are listed. If no emergency contact is reached, appropriate medical care will be provided, including contacting the student's physician and transfer by ambulance (if necessary) to a medical facility for further care and evaluation. The school will continue to call the parents, guardians or physician until one is reached.

I have read and understand the School Emergency Procedure and I agree to its implementation. If I cannot be reached, I agree to assume responsibility for the cost of emergency care including transportation by ambulance if necessary. I consent to emergency care, treatment, surgery, diagnostic procedure, or the administration of anesthesia which may be carried out based on the medical judgement of the attending physician to ensure my child's health, safety and welfare.

Parent/Guardian Signature _____ Date _____

This information may be shared with school personnel on a "need to know" basis



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', please skip questions 1 – 4 and complete the bottom section.

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: _____



DEPARTMENT OF EDUCATION

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

Mark Holodick, 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.)



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

English/Spanish

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 within 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: The ORIGINAL document 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.



DEPARTAMENTO DE EDUCACIÓN DE
DELAWARE
TITULO I, PARTE C
Encuesta de Trabajo Agrícola

English/Spanish

Fecha: _____

Estimado Padre/Madre o Adulto responsable del estudiante,

Con el fin de servir mejor a su niño, _____, el distrito escolar _____,
(Insert District/Charter School Name)

está asistiendo al estado de Delaware a identificar estudiantes elegibles para recibir beneficios y apoyos. La información proporcionada es confidencial y será utilizada por el Departamento de Educación para fines de planeación únicamente. Por favor, conteste las siguientes preguntas y devuelva este formulario a la escuela de su hijo.

1. ¿En los últimos 3 años, su familia se ha cambiado de: a) un *distrito escolar* a otro; b) un estado a otro; c) otro país a Estados Unidos?

_____ Sí _____ NO

Si es "NO", no complete el resto de esta encuesta. Si es "SI", por favor continúe.

2. ¿El motivo de este cambio ha sido por **buscar o aceptar** un empleo en una actividad agrícola o de pesca, o en alguna de las actividades enlistadas abajo? Conteste aunque tenga otro tipo de trabajo actualmente.

_____ Sí _____ NO

Si es "SI", por favor marque todo lo que corresponda si usted, su esposo/a u otro miembro del hogar ha trabajado en/con:

- | | | | |
|-------------------------|------------------------|--------------------------------|---------------------------------|
| Granja | Rastro/ Carnicería | Cultivar Césped | Invernadero |
| Lechería | Procesar carne/pescado | Empacar carne/alimentos | Plantar y cultivar árboles |
| Rancho | Cultivo de Arandanos | Granja de Hongos | Procesar alimentos |
| Enlatadora | Jugo Fresco/Congelado | Plantar, pizar o empacar | Procesar limento para mascota |
| Gallineros | Pescado y Marisco | frutas, vegetales, semillas, o | Desyerbar o preparar el terreno |
| Planta de Pollo/Pollera | Frutas secas/especias | nueces | para plantar |

Favor de anotar otro trabajo/actividad agrícola o de pesca que usted, su esposo/a u otro miembro del hogar haya realizado:

Anote todos los niños y jóvenes entre **3-21 años de edad** en el hogar, incluyendo los que no asisten a la escuela:

Nombre y Apellido	Fecha de Nacimiento	Edad	Grado	Escuela

Padre/Madre o Adulto responsable del estudiante: _____

Dirección: _____ Ciudad _____ Zip _____

Teléfono 1: _____ Teléfono 2 _____ Hora: _____ AM/PM

DISTRICTS: The ORIGINAL document 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.



DELAWARE DEPARTMENT OF EDUCATION

English/Haitian-

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 with 5 columns: First / Last name, Date of Birth, Age, Grade, School

Parent/Guardian: _____ Date: _____

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 Migrant Education Program Office within 10 days of the student's enrollment by State



Depatman Edikasyon Delaware
Pwogram Edikasyon pou Migran

English/Haitian-Creole

Chè Paran(yo),

Dat: _____

Nan lide pou pi byen sèvi pitit ou a, _____ la _____ Distri Lekòl
(Insert District/Charter School Name)

yo ap ede Eta Delaware idantifye elèv ki kapab kalifye pou resevwa plis edikasyon ak sèvis sipò.

Enfòmasyon ke w bay pi ba ap rete konfidansyèl. Tanpri reponn kesyon sa yo epi retounen fòm sa a nan lekòl pitit ou .

1) Nan twa (3) dènye ane yo, eske fanmi ou te chanje soti nan: a) yon distri lekòl pou al nan yon lòt ; b) yon eta pou ale nan yon lot eta ; c) yon lòt peyi pou vin nan US

_____ Wi _____ Non

Si w repon « Non » ou pa bezwen kontinye rès sondaj la. Si w repon « Wi » tanpri kontinye.

2) Eske rezon kifè chanjman sa yo sete pou w chache si w jwen oswa aksepte yon djob nan jaden oswa nan yon nan aktivite sa yo ki nan lis anba a. Reponn kesyon sa a mem si w gen yon lòt kalite travay ki diferan kounye a.

_____ Wi _____ Non

Si "wi", tanpri ansèkle tout sa ki aplike pou oumenm oswa mari ou / madanm, oswa yon moun lakay ou ki te travay nan youn nan sa yo:

- fèm Usine ki prepare poul Fwi a kepis sech epi santibon Pepinyè / lakòz efè tèmik
letye Usine kote yo prepare vyann / pwason Kote yo van sèl pwason Kote yo plante pye bwa oswa rekòlte
elvaj Kote ki gen Cseriz Usine Kote yo anbale vyann ak manje Faktory kote yo met manje nan mamit
konsèrveri Ji fresh / jele dyondyon Preparasyon manje pou bet
Kay Poul Lapèch Plante ,ranmase, anbale fwi, legim, Netwayaj, saklay te plantasyon
vyan, nwa

Tanpri ajoute nenpòt lòt travay ki gen rapò ak aktivite agrikòl oswa lapèch ke w ka fè : _____

Tanpri fè lis tout ti moun lakay ou ki gen laj 3-21 ane. Mete sak pako ale lekòl tou

Table with 5 columns: Non/sinyati, Dat timoun nan fèt, Laj li, Clas li, Lekòl li

Paran/ moun responsab : _____ Dat: _____

Apt. No _____ Katye _____ Kòd _____

Phone _____ Pi bon lè pou rele w _____ AM/PM Lòt telefòn/ selilè Nimero telefòn li _____

DISTRICTS: The ORIGINAL document 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.



Caesar Rodney School District Student History

Date _____ School _____

Child's Name _____
(Last) (First) (Middle)

Birth Date _____ Race _____ Sex M F

PLEASE READ EACH QUESTION CAREFULLY AND FILL IN THE BLANKS COMPLETELY AND ACCURATELY.

1. Birth weight of child? _____ Born early? Yes No If yes, how many weeks early? _____

2. Were there any **unusual** difficulties for the mother or baby during pregnancy or birth of this child? Yes No
If yes, please explain: _____

Did your child need oxygen at time of birth? Yes No

3. Does your child have asthma? Yes No If yes, Mild Moderate Severe
Medication at school? _____

4. Does your child have: Sickle Cell Anemia? Yes No

5. Does your child have: Diabetes? Yes No

6. Does your child have allergies (medicine, food, environment, insect bites, latex, etc)? Yes No
If yes, list them and describe in detail what happens to the child. _____

7. Does your child take medicine for allergies? Yes No Medication _____
Would it be necessary to have this medicine on hand at school in case of a sudden allergic reaction? Yes No

8. Has this child ever been **admitted** overnight to a hospital? Yes No Why? _____

9. Has this child ever been on any long-term medication? Yes No
If yes, what kind? _____

10. Has this child experienced any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Persistent High Fever | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Chronic Illness |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Toileting Problems | |

If yes to any of the above, please explain:

11. Speech Problems? Yes No Evaluation? Yes No Therapy? Yes No

If yes, where? _____

12. Hearing problems? Yes No

Doctor's Name _____ Date of Last Visit _____

13. Vision Problems? Yes No Glasses Contacts

Doctor's Name _____ Date of last visit _____

14. Has this child ever had chickenpox? Yes Date _____ No

15. At about what age did the child begin the following?

Sit alone _____ Crawl _____ Walk _____ Say simple words _____

16. Have you had concerns that your child might experience difficulty adjusting or achieving in school? Yes No

Explain: _____

17. Has the child had any previous school or nursery experiences? Yes No

If yes, where? _____ When? _____

18. Do you believe your child has a special need: Please check **all** your concerns from the following list.

Behavior: Has Tantrums Is not able to accept limits
 Resists rules or refuses to comply with requests Is destructive with toys

Socialization: Does not play with other children Does not separate from me easily

Speech/Language: Has unclear or garbled speech Has difficulty expressing wants
 Uses incomplete sentences Needs instructions repeated often

Attention: Is easily distracted Has a short attention span
 Darts from one task to another Persists when asked to stop

Developmental Abilities: Does not appear to be learning at an average rate
 Acts much younger than his or her age
 Has had delays in developmental milestones
 Seeks much younger friends

Motor: Is clumsy
 Has difficulty using pencils, crayons or scissors
 Has difficulty buttoning or zipping

19. Is English the primary language in the home? Yes No Primary Language _____

20. Please write here any concerns you have regarding your child's physical, mental, and/or emotional health.

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 issues¹ regarding your child, such as:

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

Immunizations Required for Newly Enrolled Students at Delaware Schools

KINDERGARTEN²:

- DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
- Polio:** 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- MMR³:** 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- Hep B³:** 3 doses.
- Varicella⁴:** 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6:

- DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required. Students who start the series at age 7 or older only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTaP, DTP, or DT dose was administered –whichever is later.
- Polio:** 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- MMR³:** 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- Hep B³:** 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- Varicella⁴:** 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.

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
	Yes	No	
Developmental delay (speech, ambulation, other)?			
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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	Yes	No	
Dental concerns? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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

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: _____ Weight: _____ BMI: _____ BMI Percentile: _____ BP: _____ Pulse: _____ Other: _____ (inches) (pounds)
Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior</u> to school entry. Risk Assessment: _____ Date _____ Results: <input type="checkbox"/> Test Required <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date

PART IV – COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓)			HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	REFERRAL	
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:** _____



Caesar Rodney School District Parent Information Form (PreK/K Only)

Child's Name: _____

Date of Birth: _____

Male Female School: _____

Pre-Kindergarten Experience (Required)

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

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

3. If yes, what was the name of the program?

4. During the day, my child:

- | | | | |
|--|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Attends preschool: | <input type="checkbox"/> full day | <input type="checkbox"/> half day | <input type="checkbox"/> occasionally |
| <input type="checkbox"/> Attends a daycare center: | <input type="checkbox"/> full day | <input type="checkbox"/> half day | <input type="checkbox"/> occasionally |
| <input type="checkbox"/> Is home with a sitter: | <input type="checkbox"/> full day | <input type="checkbox"/> half day | <input type="checkbox"/> occasionally |
| <input type="checkbox"/> Is home with a parent: | <input type="checkbox"/> full day | <input type="checkbox"/> half day | <input type="checkbox"/> occasionally |

Other: _____

5. My child uses:

- | | | | |
|---------------------------------------|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Crayons | <input type="checkbox"/> Scissors | <input type="checkbox"/> Telephone | <input type="checkbox"/> DVD Player |
| <input type="checkbox"/> Pen/pencil | <input type="checkbox"/> Blocks | <input type="checkbox"/> Videogames | <input type="checkbox"/> iPad/iPod |
| <input type="checkbox"/> Refrigerator | <input type="checkbox"/> Computer | <input type="checkbox"/> Paper | <input type="checkbox"/> Computer/ laptop |
| <input type="checkbox"/> Glue/paste | <input type="checkbox"/> Fingerpaint | <input type="checkbox"/> TV | |

6. The things my child does that please me most are: _____

7. The things my child does (or does not do) that worry me most are: _____

8. My child prefers the following toys and activities: _____

9. The activities my child and I do together are: _____

10. When my child disobeys me, I _____

11. My child speaks in: single words phrases sentences

12. He or she began to talk at _____ months.

13. My child was: full term premature (by _____ weeks)

14. My child has the following medical problem(s): _____

15. When I leave my child for a short time or with a sitter, he or she will: _____

16. When my child and I look at a book, he or she will: _____

17. My child: sleeps through the night frequently wakes up

18. My child is: independent dependent for his/her age

Parental Concerns

1. Behavior. My child:

- Has tantrums
- Is not able to accept limits
- Resists rules or refuses to comply with request
- Is destructive with toys
- Clings to an adult
- Appears sluggish or lacks energy
- Is fearful or worries a lot
- Rarely smiles, giggles or laughs

2. Socialization. My child:

- Does not play with other children
- Does not separate from me easily
- Will not work in a group
- Is left out of activities with other children

3. Speech/Language. My child:

- Has unclear or garbled speech
- Has difficulty expressing wants
- Uses incomplete sentences
- Needs instructions repeated often
- Repeats what he or she says
- Doesn't remember simple information from day to day
- Gives inappropriate answers to questions

4. Self-Help. My Child:

- Has toileting difficulties
- Has difficulty feeding or dressing him/her self
- Has difficulty following routines

5. Attention. My Child:

- Is easily distracted
- Has a short attention span
- Darts from one task to another
- Persists when asked to stop

6. Developmental Abilities. My child:

- Does not appear to be learning at an average rate
- Has had delays in developmental milestones
- Does not seem to understand well
- Acts much younger than his/her age
- Seeks much younger friends

7. Motor. My child:

- Is clumsy
- Has difficulty using pencils, crayons, or scissors
- Has difficulty buttoning or zipping
- Has hand/eye coordination problems
- Has poor control of body movements

8. Hearing. My child:

- Has trouble hearing
- Asks people to repeat or talk louder
- Favors one ear over the other
- Is startled at sudden noises
- Has earaches
- Speaks loudly
- Watches a person's face when that person talks

9. Vision Problems. My child:

- Has eyes that turn in or out
- Squints
- Tilts his or her head
- Wants to sit too close to the TV
- Holds books very close to his/ her face
- Blinks a lot
- Rubs his/her eye

10. Medical/Health Related.

My child:

- Has been to the hospital _____ times
- Has had serious illnesses
- Has had accidents

If you have a concern that is not listed, please write it here: _____

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. Additionally, a current (within 2 years) health examination is required upon school entry and prior to ninth (9th) grade.

Talk with your health care provider about important issues¹ 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:** 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.
- MMR²:** 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 B²:** 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- Varicella³:** 1-2 doses. The 1st dose must be given on or after the 1st birthday. Two doses are required for all new school enterers⁴ in: K-9th grade in 2012-2013, K-10th grade in 2013-2014, K-11th grade in 2014-15 and K-12th grade in 2015-2016.

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 dose 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 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.

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
	Yes	No	
Developmental delay (speech, ambulation, other)?			
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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	Yes	No	
Dental concerns? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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**

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	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior</u> to school entry. Risk Assessment: _____ Date _____ Results: <input type="checkbox"/> Test Required <input type="checkbox"/> Test Not Required Mantoux Skin Test: _____ Date _____ Results: _____ MM Other: (type) _____ Date _____ Results: _____ MM
Other Screen	Hearing: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date

PART IV – COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓)		HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	
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.

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

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 [] 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 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.