

**Board of Education**  
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**7 Front Street  
Wyoming, DE 19934**

**Superintendent of Schools**  
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Voice: (302) 698-4800  
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#### **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  
Mellvaine 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 \_\_\_\_\_

	<b>Items Required for Registration</b>
	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)
	<b>Additional Items Required for Kindergarten / PreK</b>
	Parent Information Form (2 pages)
	<b>If Transferring from Another District</b>
	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 Physical Address (If Different):  
 Child's Complete Mailing Address: Street \_\_\_\_\_  
 PO Box / Street \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ Development \_\_\_\_\_  
 Development \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 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 \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

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: \_\_\_\_\_

### 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.



# 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 issues<sup>1</sup> regarding your child, such as:

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

### Immunizations Required for Newly Enrolled Students at Delaware Schools

#### **KINDERGARTEN<sup>2</sup>:**

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

#### **GRADES 1-6:**

- DTaP/DTP:** 4 or more doses. If the 4<sup>th</sup> dose was prior to the 4<sup>th</sup> birthday, a 5<sup>th</sup> 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 3<sup>rd</sup> dose was prior to the 4<sup>th</sup> birthday, a 4<sup>th</sup> dose is required.
- MMR<sup>3</sup>:** 2 doses. The 1<sup>st</sup> dose should be given on or after the 1<sup>st</sup> birthday. The 2<sup>nd</sup> dose should be given after the 4<sup>th</sup> birthday.
- Hep B<sup>3</sup>:** 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- Varicella<sup>4</sup>:** 2 doses. The 1<sup>st</sup> dose must be given on or after the 1<sup>st</sup> birthday and the 2<sup>nd</sup> dose after the 4<sup>th</sup> 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

<sup>1</sup> Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3<sup>rd</sup> ed.) AAP, 2008

<sup>2</sup> Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.

<sup>3</sup> Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

<sup>4</sup> 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?	Yes	No	
<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts			
<input type="checkbox"/> Other _____			
Dental concerns?	Yes	No	
<input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other?			
Date of exam _____			
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