



Red Clay Enrollment Document Checklist

Please complete the forms included in this packet and return to your assigned school.

- Birth Certificate: A valid birth certificate. A copy of the birth certificate sent directly to the school by the previous school may be accepted. If the birth certificate does not contain the name of the parent who is registering the child, additional guardianship verification is required. A legal document (from the court system) may be accepted with the birth certificate if it states the parent's name, relationship to the child and the child's date of birth
- Record of physical examination (completed within the last 24 months)
- Current immunization record
- Tuberculosis Risk Assessment
 - Kindergarten students only: Lead Screening
- Most recent student report card (grades K-8), most recent transcript (grades 9-12)
- IEP (Individualized Education Plan) documentation (if applicable)
- Copy of parent/guardian photo ID

Two Proofs of Residence - Parent, legal guardian or relative caregiver of the child being registered is required to provide at least two documents from the list below. Addresses must be the same on both documents.

At least one item from group A and one item from group B must be provided.

Group A:

- Copy of the most recent month's mortgage statement (copy of home settlement statement may be accepted in lieu of mortgage statement if the home was recently purchased and a mortgage statement has not been received)
- Rental agreement (showing legal parent, legal guardian, or relative caregiver as an occupant)
- Sewer bill (current year)
- Real estate tax receipt (current year)
- A recent original gas or electric bill

Group B:

- Current automobile registration card or automobile insurance policy statement
- Rental insurance policy statement
- Most current year's tax documents
- Paycheck or pay stub (dated within the past 30 days)
- Two consecutive bank statements (dated within the past 90 days)
- Official US Postal Service change of address notification on returned mail (yellow label with new address should be attached to envelope next to the old address)
- Correspondence from a DE state agency such as Delaware Health and Social Services, Department of Services for Children, Youth and their Families, Department of Labor, or Delaware Division of Social Services

If living in the residence of another person, please complete the "Red Clay Consolidated School District Owner/Renter Affidavit of Multiple Occupancy" and the "Red Clay Consolidated School District Affidavit of Multiple Occupancy".

Please direct any questions to your assigned Red Clay school.



Red Clay Consolidated School District

STUDENT DATA CARD

School Year: 2026-2027

For Office Use Only:

School:			
ID:			
Grade:		Hmrm:	

STUDENT INFORMATION

First Name:				2026-2027 Grade:	
Middle Name:				Birth Date:	
Last Name:				Nickname/Preferred Name:	
Generation:	<input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Phone:	

RACE and ETHNICITY DESIGNATION

Is this student Hispanic or Latino? (Select one answer.) Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino Yes No

Indicate this student's race below. You must select at least one race, regardless of ethnicity designation. More than one response may be selected.

American Indian or Alaskan Native American
 Black or African American
 White
 Asian
 Native Hawaiian or Pacific Islander

ADDRESS Please indicate Physical (home) and Mailing address if they are different.

Physical Address		Mailing Address		Same as Physical?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Apt #:		Apt #:		
Address:		Address:		
Development:		Development:		
City, State, Zip:		City, State, Zip:		

SPECIAL CUSTODY INFORMATION If child lives with anyone other than mother or father listed on birth certificate please indicate:

Name:		
Relationship:		
Custodial Papers on file with school?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADDITIONAL INFORMATION

Has the student been expelled? Yes No

Does your child have (documentation required):

IEP (Individualized Education Plan)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Learning Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
504 Accommodation Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Difficulties:	<input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION BACKGROUND INFORMATION Name and address of previous school, pre-school, or child care

Name:			
Address:			
City, State, Zip:			
Phone:		Fax:	

SCHOOL AGE SIBLING INFORMATION

Name:			Name:		
School:	Grade:		School:	Grade:	
Name:			Name:		
School:	Grade:		School:	Grade:	

For Office Use Only:	Student:	ID:
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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.

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

- | | | | | |
|---------------------------------------|--|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infections | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone/Spine | <input type="checkbox"/> Emotional | <input type="checkbox"/> Kidney | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Hearing | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Other: _____ | | | | |

Comments: _____

() Yes () No **2. Does your child have allergies to medicine, latex or insect bites?**
 To What? _____ What Happens? _____
 Treatment: _____

() Yes () No **3. Does your child have a food allergy, intolerance or religious preference?**
 To What? _____ Type: Allergic Reaction Intolerance Religious Preference
 Treatment: _____ What Happens? _____
 To What? _____ Type: Allergic Reaction Intolerance Religious Preference
 Treatment: _____ What Happens? _____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy. Please provide an Emergency Action Plan and ALL emergency medications to the School Nurse.

() Yes () No **4. Will your child require an individualized, allergen-free menu designed by Nutrition Services?**
Note: Meals provided from home provide the safest food options at school for food-allergic students.
 No. I will take full responsibility for providing my child with allergen-free school meals.
 Yes. I will provide the School Nurse with a Food Allergy Plan completed by a licensed healthcare provider.

() Yes () No **5. Has your child had any illnesses since school last ended?**
 Type of illness, with date(s): _____

() Yes () No **6. Has your child had surgery since school last ended?**
 Type of surgery, with date(s): _____

() Yes () No **7. Has your child received any immunizations since school last ended?**
 List of immunization(s), with date(s): _____

() Yes () No **8. Is your child being treated or evaluated for any health conditions?**
 List condition(s): _____

() Yes () No **9. Is your child on any medication or treatment?**
 Name of medication and/or treatment: _____

() Yes () No Does your child need medicine during school hours? **If yes, please contact the School Nurse to make arrangements.*

() Yes () No **10. Has your child ever been examined by an eye doctor?**
 Date of last exam: _____ Glasses Prescribed: () Yes () No
 If your child wears glasses or contact lenses, when was the prescription last changed? _____

() Yes () No **11. What is the name of your child's dentist?** _____
 What is the date of his/her last dental exam? _____

12. What is the name of your child's primary healthcare provider? _____
 What is the date of his/her last physical exam? _____

() Yes () No **13. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year? *If yes, please contact your School Nurse or School Counselor.**

For Office Use Only:	Student:	ID:
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Permission for Over the Counter Medication Administration

I give permission for my child to have the following as determined by the nurse:

Acetaminophen (Tylenol®) Yes No Ibuprofen (Advil®) Yes No Tums® Yes No
 Cough Drops Yes No Eye Wash Solution/Saline Rinse Yes No

Parent/Guardian Signature: _____

Date: _____

FOOD INSECURITY: Red Clay has programs to support families who have limited access to food. Please answer the following questions regarding your access to food for your family.

Within the past 12 months, we worried whether our food would run out before we got money to buy more. ___ Often ___ Sometimes ___ Never
 Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. ___ Often ___ Sometimes ___ Never

DELAWARE EMERGENCY/NURSING TREATMENT CARD

Medical Information			
Physician:	_____	Phone:	_____
Family Dentist:	_____	Phone:	_____
Indicate student's serious medical diagnoses: _____			
Student is allergic to:	Medicine: _____	Food: _____	Other: _____
Medical Insurance:	Medicaid No.: _____		
Other:	Certificate No.: _____	Group No.: _____	Type: _____

The purpose of this form is to provide the school with information to be used for the care of a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures that will normally be followed in caring for your child when your child requires emergency assistance at school for either a medical or behavioral health concern. 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 parent/guardian 1's, or parent/guardian 2'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.
7. The information on this form may be shared with emergency medical staff.

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.

Parent/Guardian Signature: _____

Date: _____

For Office Use Only:	Student:	ID:
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PARENT/GUARDIAN CONTACT INFORMATION

First Name:	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father
Middle Name:	<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other (please list):
Last Name:	Birth Date:
Generation: <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Living With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:	Home Phone:
Apt #:	Cell Phone:
Development:	Work Phone:
City, State, Zip:	Education Level: High school diploma/GED or above: <input type="checkbox"/> Yes <input type="checkbox"/> No
E-Mail:	

First Name:	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father
Middle Name:	<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other (please list):
Last Name:	Birth Date:
Generation: <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Living With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:	Home Phone:
Apt #:	Cell Phone:
Development:	Work Phone:
City, State, Zip:	Education Level: High school diploma/GED or above: <input type="checkbox"/> Yes <input type="checkbox"/> No
E-Mail:	

First Name:	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father
Middle Name:	<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other (please list):
Last Name:	Birth Date:
Generation: <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Living With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:	Home Phone:
Apt #:	Cell Phone:
Development:	Work Phone:
City, State, Zip:	Education Level: High school diploma/GED or above: <input type="checkbox"/> Yes <input type="checkbox"/> No
E-Mail:	

EMERGENCY CONTACT INFORMATION: Must be 18 years of age or older.

Important: In the event of an emergency, individuals listed here will be contacted if parent/guardian cannot be reached.

First Name:	First Name:
Last Name:	Last Name:
DOB (if known):	DOB (if known):
Relationship:	Relationship:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:



DEPARTMENT OF EDUCATION

Townsend Building
 401 Federal Street Suite 2
 Dover, Delaware 19901-3639
<http://education.delaware.gov>

Mark A. Holodick, Ed.D.
 Secretary of Education
 (302) 735-4000
 (302) 739-4654 - fax

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: _____

To better serve your child, _____, our district: _____ and our school: _____ assist the Delaware Department of Education identify students who may qualify for additional education and support services. Your responses will remain confidential and used only for planning. Please complete 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 or 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.



2025 – 2026 MILITARY-CONNECTED YOUTH STUDENT INFORMATION UPDATE FORM

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

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

- This form should be completed by a parent or stepparent annually.
- If your student is not a “military-connected youth”, please check the third box, “Non-Applicable”.

CHECK ONE OF THE FOLLOWING:

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

STATE “Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action” pursuant to 14 **DE Admin. Code** 932, 14 **Del.C. Chapter 1, §122 (b)(28)**, 10 U.S.C. §101(d) (2014).

- I am a parent or stepparent who is an active-duty member of the National Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service.
- I am a parent or stepparent, or there is an immediate family member, including a sibling or any other person *residing in the same household*, who is serving in the reserve component, identified as a disabled veteran, killed in action, or recently retired (within 18 months prior to September 30 of the current school year) from a branch of the United States armed forces. Such branches consist of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service.
- There is an immediate family member, including a sibling or any other person *residing in the same household*, who is on active-duty member of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service.

NON-APPLICABLE

Student Name: _____ Grade: _____

School Name: _____

Homeroom Teacher Name: _____

Please return this form to your student’s homeroom teacher on or before Monday, September 22, 2025.



Kindergarten Registration Questionnaire

1. Did your child attend a preschool or child care program in Delaware this past year?

Circle: Yes or No

2. If yes, in which county did your child attend the program?

Circle: New Castle County / Kent County / Sussex County

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

RED CLAY CONSOLIDATED SCHOOL DISTRICT

DAYCARE TRANSPORTATION REQUEST

Student Name _____ Date _____
Last First M.I.
Student I.D. _____ School _____ Grade _____
Home Address _____ Kindergarten – AM PM
Development _____ City _____ Zip _____
Home Phone _____ Work Phone _____ Pager _____ Cell Phone _____
Emergency Contact _____ Telephone No. _____

Before-School Child Care: Home Other

Name of Provider _____
Street Address _____
Development _____
City _____ Zip _____ Telephone No. _____

After-School Child Care: Home Other Same as above

Name of Provider _____
Street Address _____
Development _____
City _____ Zip _____ Telephone No. _____

Parent/Guardian (*please print*) _____
Parent/Guardian Signature _____
Date _____

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 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 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 or TB Risk Assessment, which must be done within 12 months prior 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:** _____

DELAWARE STUDENT HEALTH FORM – ADOLESCENT Grades 7-12

To be completed by licensed healthcare provider:

Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician's Assistant (PA)

To Parent or Guardian:

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

Talk with your health care provider about important 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:** Completion of the primary series plus an adolescent booster dose of Tdap administered at age 11-12 or prior to entry into Grade 9.
- Polio:** 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- 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:** 2 doses. The 1st dose must be given on or after the 1st birthday.
- Meningococcal:** 1 dose is required for entry into Grade 9. A second dose is recommended by the Division of Public Health for all adolescents.

Immunizations Strongly Recommended by the Delaware Division of Public Health

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

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

²Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

³Varicella disease history must be verified by a health care provider to be exempted from vaccination.

⁴A new school entrant 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 or 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 _____ Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Date 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:

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

Recommendations or Referrals: _____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
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Print Name: _____ Signature: _____ Date: _____

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

Address: _____ Phone: _____

