



Student: \_\_\_\_\_

**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"/> Concussion | <input type="checkbox"/> Heart               | <input type="checkbox"/> Seizures* |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Body Piercing/Tattoo    | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Infections          | <input type="checkbox"/> Speech    |
| <input type="checkbox"/> Asthma*      | <input type="checkbox"/> Bone/Spine              | <input type="checkbox"/> Emotional  | <input type="checkbox"/> Kidney              | <input type="checkbox"/> Surgery   |
| <input type="checkbox"/> Behavior     | <input type="checkbox"/> Bowel/Bladder           | <input type="checkbox"/> Hearing    | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Vision    |
| <input type="checkbox"/> Other: _____ |  |                                     |  |                                    |

Comments: \_\_\_\_\_

**\*If your child has asthma or seizures, you must provide the school nurse, at the start of each school year, with an Emergency Action Plan completed by a licensed healthcare provider, along with ALL emergency medications.**

( ) 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?  
To What? \_\_\_\_\_ What Happens? \_\_\_\_\_  
Treatment: \_\_\_\_\_

**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.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student:** \_\_\_\_\_

**Permission for Over the Counter Medication Administration**

I give permission for my child to have the following; as determined by the nurse. Generic medication may be substituted for name brand (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Acetaminophen (Tylenol®)       | <input type="checkbox"/> Cough Drops                             |
| <input type="checkbox"/> Anbesol®                       | <input type="checkbox"/> Ibuprofen (Advil®)                      |
| <input type="checkbox"/> Bacitracin/Antibiotic ointment | <input type="checkbox"/> Petroleum Jelly/Vaseline® (topical use) |
| <input type="checkbox"/> Benadryl®                      | <input type="checkbox"/> Sting Kill (insect sting relief)        |
| <input type="checkbox"/> Caladryl®                      | <input type="checkbox"/> Tums® (>12 yrs.)                        |

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**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:** \_\_\_\_\_

**FOOD INSECURITY: Colonial 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

**Student:** \_\_\_\_\_

<b>SPECIAL CUSTODY INFORMATION: If child lives with other than natural mother or father, please indicate:</b>		<b>ADDITIONAL INFORMATION</b>	
Name:		Has the student been expelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship:		Has student been involved in Gifted Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do custodial papers exist for this student? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Does your child have (documentation required):</b>	
If yes, please provide a copy of the papers to keep on file.		An IEP (Individualized Education Plan)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		504 Accommodation Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EDUCATIONAL BACKGROUND: Please list your child's most recent school experience (including preschool if applicable).**

Name of person or program: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home/Babysitter       Home Daycare       Early Childhood

Did your child receive any of the following services at the previous school?  Special Education     Title I     ESL     Other: \_\_\_\_\_

**SCHOOL AGE SIBLING INFORMATION**

Name:		Name:	
Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
School:		School:	
Name:		Name:	
Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
School:		School:	

**DAYCARE ARRANGEMENTS**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**TRANSPORTATION INFORMATION:**

**Please place a checkmark in the boxes that apply to your child.**      If bus stop is different from home address, please list the address in this column.

<b>To School</b>	My child will be riding the bus to school from <b>home</b>		
	My child will be riding the bus to school from <b>daycare</b>		
	My child will walk to school each day		
	My child will be driven to school each day		
<b>From School</b>	My child will be riding the bus from school to <b>home</b>		
	My child will be riding the bus to a <b>daycare</b> after school		
	My child will walk home after school each day		
	My child will be picked up from school each day		

I certify that I am a current resident of the State of Delaware and that all the statements on this application made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith. I understand and acknowledge that any misstatements or omission of material facts in the application form may result in the rejection of the application form, disqualification from the lottery process if applicable, withdrawal or invitation offer, and/or termination of school choice by the receiving local education agency to which I applied.

\_\_\_\_\_  
Parent/Guardian/Relative Caregiver Signature

\_\_\_\_\_  
Date

**Information Regarding How the Colonial School District Shares Student Information**

The Colonial School District recognizes the need to protect student information and privacy while promoting educational and extra-curricular activities in district and outside media. Federal law (FERPA) permits the district to release directory information under limited circumstances. Directory information is information about a student that is generally not considered an invasion of privacy, such as name, address, photograph, activities, and sports. If you wish to opt-out of the district releasing this information or including your child in articles and photos, please obtain an opt-out form from your child's school office.