

School:			Student:		
Gender:	Grade:	HMRM:	Date Registered:	Registration Accepted By:	



Student Registration Card

For School Use Only:		Legal Guardianship/Caregiver	
ID #:		In student database:	
Birth Certificate:		Records requested:	
Immunization:		Grades received:	

STUDENT INFORMATION					
Grade:	Has this student ever been registered in a Delaware Public or Charter School? ☐ Yes ☐ No				
First Name:				Gender:	☐ Male ☐ Female
Middle Name:				Birth Date:	
Last Name:				Home Phone:	Unlisted?: ☐ Yes ☐ No
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V				
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 ☐ 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? ☐ Yes ☐ No		
Apt #:			Apt #:		
Address:			Address:		
Development:			Development:		
City, State, Zip:			City, State, Zip:		

PARENT/GUARDIAN CONTACT INFORMATION																										
First Name:											Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father														
Middle Name:												☐ Court Appointed Guardian ☐ Other (please list):														
Last Name:																										
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V										Living With:	☐ Yes ☐ No														
Apt #:											Cell Phone:															
Street Address:											Home Phone:											Unlisted? ☐ Yes ☐ No				
Development:											Work Phone:															
City:											Birth Date:															
State/Zip:											Employer:															
Please provide one email address; separating each character in the boxes provided:																										
First Name: Middle Name: Last Name: Generation: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V Apt #: Street Address: Development: City: State/Zip: Relationship: ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list): Living With: ☐ Yes ☐ No Cell Phone: Home Phone: Unlisted? ☐ Yes ☐ No Work Phone: Birth Date: Employer:																										
Please provide one email address; separating each character in the boxes provided:																										

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:	
	Relationship:		Relationship:	
	Address:		Address:	
	City, State, Zip:		City, State, Zip:	
	Cell Phone:		Cell Phone:	
	Home Phone:		Home Phone:	
	Work Phone:		Work Phone:	

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.

- | | | | | |
|------------------------------------|--|-------------------------------------|--|------------------------------------|
| ☐ ADD/ADHD | ☐ Bleeding/Blood Disorder | ☐ Concussion | ☐ Heart | ☐ Seizures* |
| ☐ Allergies | ☐ Body Piercing/Tattoo | ☐ Diabetes | ☐ Infections | ☐ Speech |
| ☐ Asthma* | ☐ Bone/Spine | ☐ Emotional | ☐ Kidney | ☐ Surgery |
| ☐ Behavior | ☐ Bowel/Bladder | ☐ Hearing | ☐ Physical Disability | ☐ Vision |

☐ 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:	
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Permission for Over the Counter Medication Administration
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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):

- | | |
|---|--|
| ☐ Acetaminophen (Tylenol®) | ☐ Cough Drops (>5 years) |
| ☐ Anbesol® | ☐ Ibuprofen (Advil®) |
| ☐ Bacitracin/Antibiotic ointment | ☐ Petroleum Jelly/Vaseline® (topical use) |
| ☐ Benadryl® | ☐ Sting Kill (insect sting relief) |
| ☐ Caladryl® | ☐ Tums® (>12 years) |

Parent/Guardian Signature:	Date:
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DELAWARE EMERGENCY/NURSING TREATMENT CARD
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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:
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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:	
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SPECIAL CUSTODY INFORMATION: If child lives with other than natural mother or father, please indicate:		ADDITIONAL INFORMATION	
Name:		Has the student been expelled?	☐ Yes ☐ No
Relationship:		Has student been involved in Gifted Program?	☐ Yes ☐ No
Do custodial papers exist for this student? ☐ Yes ☐ No		Does your child have (documentation required):	
If yes, please provide a copy of the papers to keep on file.		An IEP (Individualized Education Plan)?	☐ Yes ☐ No
		504 Accommodation Plan?	☐ Yes ☐ 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: ☐ Male ☐ Female		Age:	Grade:	Gender: ☐ Male ☐ Female	
School:				School:			
Name:				Name:			
Age:	Grade:	Gender: ☐ Male ☐ Female		Age:	Grade:	Gender: ☐ Male ☐ Female	
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.	
To School	My child will be riding the bus to school from home		
	My child will be riding the bus to school from daycare		
	My child will walk to school each day		
	My child will be driven to school each day		
From School	My child will be riding the bus from school to home		
	My child will be riding the bus to a daycare 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
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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.