



198 Commerce Way  
Dover, DE 19904

## **Kindergarten - 12th Grade Registration Packet**

### **Welcome to the Capital School District! Home of the Senators!**

There are many opportunities within Capital School District, and we are excited to begin your child's registration process. Please visit our website: <https://www.capital.k12.de.us> and don't forget to "like" our Facebook page: <https://www.facebook.com/capitalschooldistrict>. We look forward to connecting with you on the latest and greatest happenings within Capital.

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

1. Birth Certificate
2. Proof of residency with parent/guardian name –electric, gas, or water bill, mortgage statement or lease agreement w/landlord and parent/guardian's name\*
3. Immunization records and current physical (within the last two years)
4. Picture identification
5. Proof of parenthood/guardianship – may require custodial papers and primary placement papers
6. IEP documentation (if appropriate)
7. 504 documentation (If appropriate)

If you are transferring to Capital School District from another school district, please include the following:

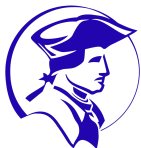
1. Withdrawal papers from the former school
2. Transcript of grades or report cards from former school
3. Standardized testing results (if available)

\*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.



Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

\*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.



# Capital School District Registration Form

School: \_\_\_\_\_

School Year: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

Choice: Yes \_\_\_ No \_\_\_

Homeroom \_\_\_\_\_

ID# \_\_\_\_\_

**Office Use Only**

School Transferring from: \_\_\_\_\_ State: \_\_\_\_\_

Is this registration for school choice/charter enrollment? ☐ Yes ☐ No - my child will attend Capital

If yes, what school district/charter: \_\_\_\_\_

Has this student attended Capital School District before? ☐ Yes ☐ No If yes, when: \_\_\_\_\_

## Student Information

Legal First Name: \_\_\_\_\_ Legal Last Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Nickname(s): \_\_\_\_\_ Have they been retained? ☐ Yes ☐ No Grade(s): \_\_\_\_\_

### Race/Ethnicity & Language Information:

Hispanic/Latino: ☐ Yes ☐ No

Race: ☐ American Indian/AK ☐ Black/African American ☐ Caucasian

☐ Asian ☐ Native Hawaiian / Pacific Islander

Primary Home Language: \_\_\_\_\_ Interested in Language Immersion? ☐ Yes ☐ No

Only available at specific schools. Please contact the front-office for questions regarding this program.

### Additional Information - check if applicable:

☐ Homeless ☐ Foster Care ☐ Speech ☐ Title 1 ☐ Gifted ☐ 504 Plan ☐ IEP ☐ Other

Special Programs Needed: \_\_\_\_\_

### Guardian 1 Information

☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian

☐ Other: \_\_\_\_\_

Legal First Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: ☐ Male ☐ Female

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

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

Email: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

Lives with student: ☐ Yes ☐ No

Legal Custody: ☐ Joint ☐ Relative Caregiver

Active Military: ☐ Yes ☐ No

### Guardian 2 Information

☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian

☐ Other: \_\_\_\_\_

Legal First Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: ☐ Male ☐ Female

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

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

Email: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

Lives with student: ☐ Yes ☐ No

Legal Custody: ☐ Joint ☐ Relative Caregiver

Active Military: ☐ Yes ☐ No

## Student Address Information

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

Mailing Address (if different): \_\_\_\_\_

**This is to confirm to Capital School District Officials that I am the parent/ legal guardian of the above child and that this is my legal address and the information I have provided is accurate.**

\_\_\_\_\_  
Please Print Your Name

\_\_\_\_\_  
Signature / Date



# Capital School District Registration Emergency /Treatment Form

Student Legal Full Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Daycare/Sitter Name: \_\_\_\_\_ Daycare Phone: \_\_\_\_\_

## Guardian 1 Information

Legal First Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: ☐ Male ☐ Female

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

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

Place of Employment: \_\_\_\_\_

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

Relation to Student: \_\_\_\_\_

Step-Parent/Spouse Name: \_\_\_\_\_

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

Lives with Student: ☐ Yes ☐ No

## Guardian 2 Information

Legal First Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: ☐ Male ☐ Female

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

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

Place of Employment: \_\_\_\_\_

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

Relation to Student: \_\_\_\_\_

Step-Parent/Spouse Name: \_\_\_\_\_

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

Lives with Student: ☐ Yes ☐ No

## Emergency Contacts Information

**At least ONE emergency contact is required. They will be called if the parent cannot be reached**

**Full Name**

**Date of Birth**

**Relation to Student**

**Phone Number**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance 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  
<http://education.delaware.gov>

## 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 |  | PLEASE FILL OUT ALL FIELDS!                 |  |
|---------------------|--|---------------------------------------------|--|
| 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.)



# Capital 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?

☐ Seizures

☐ Persistent High Fever

☐ Head Injury

☐ Feeding Problems

☐ Sleeping Problems

☐ Toileting Problems

☐ Physical Problems

☐ Chronic Illness

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.

\_\_\_\_\_  
\_\_\_\_\_

Dear Parent or Guardian,

According to Delaware Code, Title 14, section 131; a child is not permitted to enter into school without acceptable evidence of immunization. **If your child is a new enterer\* to Delaware public schools he or she will not be permitted to enroll without an immunization record.** Please see below for children of active duty members of the uniformed services.

Delaware law requires the following for entry to public school. **If these items are not provided to the school within 14 CALENDAR DAYS from the date below your child will be denied entry into school.**

**1. IMMUNIZATIONS:**

- Four (4) or five (5) doses of DPT OR DTAP, or a combination thereof. A fifth dose is not required if the fourth dose is given after the fourth birthday.
- Three (3) or four (4) doses of the polio (OPV or IPV) vaccine. A fourth dose is not required if the third dose is given after the fourth birthday.
- Three (3) doses of Hepatitis B vaccine.
- Two (2) doses of measles, mumps and rubella vaccine, MMR, (first dose after the age of 12 months, second dose after the fourth birthday).
- Two (2) doses of Varicella (chicken pox), or a written disease history by a licensed healthcare provider.
- Entering 9<sup>th</sup> Graders must additionally have 1 dose Tdap (adult booster) and 1 dose meningococcal<sup>2</sup> (In 8/2017 - Grades 9 & 10; in 8/2018 - Grades 9 - 11; 8/2019 - Grades 9 – 12)

**2. PHYSICAL EXAM:**

- A physical examination by a physician, nurse practitioner, or physician's assistant within the last two (2) years for all new enterers. A second health examination is required for all students entering 9th grade. Examinations completed no more than two years prior to entry into 9th grade will be accepted.

**3. TUBERCULOSIS SCREENING:**

- Written results from either a TB risk assessment, a Tuberculosis skin test (Mantoux, PPD), or a Quantiferon TB Gold test, within the last twelve (12) months.

**4. LEAD TEST:**

- All kindergarten and preschool students must show proof of a blood lead test, completed any time after 1 year of age.

**If you enroll your child over the summer, please be aware that if appropriate documentation is not provided for any of the above requirements within 14 days of the date below, the date of exclusion will start on the first day of school.**

**If your child is transferring to our school from another school in the state of Delaware** we assume he or she currently complies with all the above requirements. However, if for any reason your child does not meet all of the above requirements, your student will also have 14 days from the date of this form to comply with regulations.

**Military families:** Children of active duty members of the uniformed services will have **30 days from the date of enrollment** to comply with the above immunization requirements.

**All documents** should be turned in to the school as soon as possible. **BY STATE LAW, FAILURE TO PROVIDE THESE DOCUMENTS WILL RESULT IN EXCLUSION FROM SCHOOL.**

- \* *A new enterer is defined as a child entering a Delaware public school for the first time, including but not limited to foreign exchange students, immigrants, students from other states and territories and children entering from non-public schools.*

Transferring from: School \_\_\_\_\_, State \_\_\_\_\_, Country \_\_\_\_\_

Please sign below to acknowledge receipt of this information.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Grade

# DELAWARE STUDENT HEALTH FORM

## CHILDREN Pre-K - 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 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

<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.

# 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 (9<sup>th</sup>) grade.

Talk with your health care provider about important issues<sup>1</sup> 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; STI's; 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 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>2</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>2</sup>:** 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- ☐ **Varicella<sup>3</sup>:** 1-2 doses. The 1<sup>st</sup> dose must be given on or after the 1st birthday. Two doses are required for all new school enterers<sup>4</sup> in: K-9<sup>th</sup> grade in 2012-2013, K-10<sup>th</sup> grade in 2013-2014, K-11<sup>th</sup> grade in 2014-15 and K-12<sup>th</sup> 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

<sup>1</sup> Clinicians refer to: BrightFutures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3<sup>rd</sup> ed.) AAP, 2008  
Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

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

<sup>4</sup> A new school enterer is a child entering a Delaware school district for the first time.

CHILD'S NAME \_\_\_\_\_

**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 |
|--------------------------------------------------------------------------------------------------------------------------------|--------|----|-----------------------------|
| Developmental delay (speech, ambulation, other)?                                                                               | Yes    | No |                             |
| Serious injury of 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**

**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<br>/ /    | DTaP/ DT<br>/ /    | DTaP/ DT<br>/ /     | DTaP/ DT<br>/ /     | DTaP/ DT<br>/ /    |
|--------------------|--------------------|---------------------|---------------------|--------------------|
| OPV/ IPV<br>/ /    | OPV/ IPV<br>/ /    | OPV/ IPV<br>/ /     | OPV/ IPV<br>/ /     | OPV/ IPV<br>/ /    |
| PCV7/ PCV13<br>/ / | PCV7/ PCV13<br>/ / | PCV7/ PCV13<br>/ /  | PCV7/ PCV13<br>/ /  | PCV7/ PCV13<br>/ / |
| Hib<br>/ /         | Hib<br>/ /         | Hib<br>/ /          | Hib<br>/ /          |                    |
| MMR<br>/ /         | MMR<br>/ /         | HepB /HepB-2<br>/ / | HepB /HepB-2<br>/ / | HepB<br>/ /        |
| VAR<br>/ /         | VAR<br>/ /         | RV-2/ RV-3<br>/ /   | RV-2/ RV-3<br>/ /   | RV-3<br>/ /        |
| MCV4<br>/ /        | MCV4<br>/ /        | HPV<br>/ /          | HPV<br>/ /          | HPV<br>/ /         |
| Hep A<br>/ /       | Hep A<br>/ /       | Td/ Tdap<br>/ /     | Td/ Tdap<br>/ /     | Td<br>/ /          |
| Influenza<br>/ /   | Influenza<br>/ /   | PPSV23<br>/ /       | PPSV23<br>/ /       |                    |
| Other:<br>/ /      | Other:<br>/ /      | Other:<br>/ /       | Other:<br>/ /       | Other:<br>/ /      |

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

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Screen</b>              | Height: _____ Weight: _____ BMI: _____ BMI Percentile: _____ BP: _____ Pulse: _____ Other: _____<br>(inches) (pounds)                                                                                                                                                                                                                                                                                                   |
| <b>Dental Screen</b>       | <input type="checkbox"/> Problem Identified: Referred for treatment<br><input type="checkbox"/> No Problem: Referred for prevention<br><input type="checkbox"/> No Referral: Already receiving dental care                                                                                                                                                                                                              |
| <b>Tuberculosis Screen</b> | <p>All new enterers must have TB test <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior to</u> school entry.</p> <p>Risk Assessment: _____ Date: _____ Results: <input type="checkbox"/> Test Required <input type="checkbox"/> Test Not Required</p> <p>Mantoux Skin Test: _____ Date: _____ Results: _____ MM</p> <p>Other: (type) _____ Date: _____ Results: _____ MM</p>                   |
| <b>Lead Test</b>           | <p>Blood lead test required for children age 6 months through 6 years</p> <p>Date: _____ Results: _____</p>                                                                                                                                                                                                                                                                                                             |
| <b>Other Screen</b>        | <p>Hearing: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____<br/>Date</p> <p>Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____<br/>Date</p> <p>Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____<br/>Date</p> |

CHILD'S NAME \_\_\_\_\_

**PART IV COMPREHENSIVE EXAM**

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

| PHYSICAL EXAMINATION | NORMAL | Check (✓)<br>ABNORMAL | REFERRAL | HEALTHCARE PROVIDER COMMENT |
|----------------------|--------|-----------------------|----------|-----------------------------|
| 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: \_\_\_\_\_

### 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.

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

- |                                               |                                        |                                              |                                  |
|-----------------------------------------------|----------------------------------------|----------------------------------------------|----------------------------------|
| 1. <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Bone/Spine    | <input type="checkbox"/> Heart               | <input type="checkbox"/> Speech  |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Infections          | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney              | <input type="checkbox"/> Vision  |
| <input type="checkbox"/> Blood Disorder       | <input type="checkbox"/> Emotional     | <input type="checkbox"/> Physical Disability |                                  |
| <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Hearing       | <input type="checkbox"/> Seizures            |                                  |
| <input type="checkbox"/> 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.



198 Commerce Way  
Dover, DE 19904

**Permission for Use of Over-The- Counter Medications during the 2026-2027 School Year**

**Name of Student:** \_\_\_\_\_

**Teacher's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Does your child have allergies to any medications?** Yes \_\_\_\_\_ No \_\_\_\_\_

**If so, what medications?** \_\_\_\_\_

As parent/guardian, I give my permission for the above named student to have the following medications administered by the school nurse during the school year. I understand that he/she will be checked by the school nurse and the medications will be administered if indicated by the nurse's assessment. Please check only those medications you wish to be given to your child when needed.

\_\_\_\_\_ Advil/ Ibuprofen/ Motrin

\_\_\_\_\_ Eyewash Solution/Saline Rinse

\_\_\_\_\_ Anbesol/ Orajel

\_\_\_\_\_ Hygiene Supplies

\_\_\_\_\_ Anti- Fungal Cream

\_\_\_\_\_ Lip Ointment (Blistex/ Chapstick/ Vaseline/ Carmex)

\_\_\_\_\_ Benadryl lotion (Anti-itch)

\_\_\_\_\_ Skin Ointment (Bacitracin/ Hydrocortisone Cream/ Neosporin)

\_\_\_\_\_ Antihistamines (Benadryl/ Zyrtec)

\_\_\_\_\_ Sting Kill (Insect Sting Relief)

\_\_\_\_\_ Burn Ointment/Spray

\_\_\_\_\_ Throat Spray (Chloraseptic Spray)

\_\_\_\_\_ Caladryl/ Calamine Lotion

\_\_\_\_\_ Tums/Kids Pepto/Calcium Carbonate

\_\_\_\_\_ Cough Drops

\_\_\_\_\_ Tylenol/Acetaminophen

\_\_\_\_\_ Contact Solution/ Eye Drops

\_\_\_\_\_ Mouthwash

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

**Phone Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The Capital School District is an equal opportunity employer and does not discriminate on the basis of race, color, creed, religion, gender (including pregnancy, childbirth and related medical conditions), national origin, citizenship or ancestry, age, disability, marital status, veteran status, genetic information, sexual orientation, or gender identity, against victims of domestic violence, sexual offenses, or stalking, or upon any other categories protected by federal, state, or local law. Inquiries regarding nondiscrimination policies should be directed to the Title IX, District 504 and ADA Coordinators: Capital School District, 198 Commerce Way, Dover DE 19904. Phone (302) 672-1500



## 2026 – 2027 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 an 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 21, 2026.



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

English/Spanish

Dear Parent/ Guardian,

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

To better serve your child, \_\_\_\_\_, our district: Capital School 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", 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 Cannery | Cranberry bogs           | Meat or food packing plant                                       | Food processing                                  |
| Chicken house | Fresh/frozen juices      | Mushrooms                                                        | Pet food processing                              |
|               | 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