OFFICE USE ONLY

Birth Certificate_____ Proof of Address_____ Immunizations_____
Report Card_____ Other Documents_____ Guardian ID: _____ __
Curriculum:_____ Grade: _____ Homeroom: _____ ID #: _____ __
Start Date:___/___/___ Registration Date:___/___/___

SMYRNA School District

Student Registration Form

Student Information - Personal

Last: _____ First: _____ Middle: _____

Birthdate: __/__/____ Place of Birth: _____ Gender: _____ Current Grade:_____

Ethnicity / Race (**Federal Requirement – Both Questions Must Be Answered**)
Is this student Hispanic/Latino? (Defined as a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race)
Choose only one: Yes, Hispanic or Latino_____ No, NOT Hispanic or Latino_____

What is this student's race? (Choose one or more, regardless of ethnicity)
American Indian or Alaskan Native_____ Asian_____ Black or African American_____
White_____ Native Hawaiian or Pacific Islander_____

Student Information – Educational

Previous School
Name:_____

Street Number and Name:_____ City, State, Zip Code:_____

Telephone Number:_____ Fax:_____

Is the student transferring from an alternative or special needs school? Yes_____ No_____

Has the student been previously homeschooled? Yes_____ No_____
(if yes, a copy of the DOE homeschool letter and portfolio MUST be provided)

Is the student currently receiving services for the following? (If yes, a copy of documentation MUST be provided)
HHPD_____ IEP_____ OT_____ PT_____ 504_____ Speech/Language_____

Did the student attend Preschool (Kindergarten Registration only)?
Yes_____ Name of Preschool:_____ No_____

Does the student participate in any special programs (Band, Chorus, Gifted, etc.)?
If yes, please list:_____

Student Information – Contact

School Messenger Phone Number 1:_____ Phone Number 2:_____

Physical 911 Address (NO PO Boxes):
Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____

Mailing Address / PO Box:
Street Number and Name:_____ Apt #:_____ PO Box:_____

City, State, Zip Code:_____

Parent / Guardian Information

Are there current custody/other legal documents on file? Yes_____ No_____ (if yes, a copy MUST be provided)

Guardian 1 Information (student MUST reside with this parent/guardian)
Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Guardian 2 Information Does the student reside with this parent/guardian? Yes_____ No_____
Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____ Email address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Emergency Contact Information

Emergency 1 Information
Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Other Contact Information (if alternative transportation is required, it must be entered here)

Other Contact 1 Information / Alternate Transportation Pick Up / Drop Off (Daycare, Babysitter, Boys and Girls Club, etc.)
Name:_____ Relationship:_____

Street Number and Name:_____ Apt #:_____

City, State, Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Additional Information

Has your family changed homes in the last three years? Yes_____ No_____

Has a parent or guardian worked on a farm, in the fields or in a factory with fruits, vegetables or animals? (For example, has a parent or guardian ever worked with watermelons, potatoes, mushrooms, corn, apples, chicken or shellfish?) Yes_____ No_____

OFFICE USE ONLY

Birth Certificate_____ Proof of Address_____ Immunizations_____
Report Card_____ Other Documents_____ Guardian ID: _____ __
Curriculum:_____ Grade: _____ Homeroom: _____ ID #: _____ __
Start Date:___/___/___ Registration Date:___/___/___

Are there other children in the family? Yes_____ No_____
Name:_____ Age:_____ Resides at Home? Yes_____ No_____
Name:_____ Age:_____ Resides at Home? Yes_____ No_____
Name:_____ Age:_____ Resides at Home? Yes_____ No_____

Delaware Department of Education

DEPARTMENT OF EDUCATION

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Dover, Delaware 19901-3639
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Secretary of Education
Voice: (302) 735-4000
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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 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 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, and a current (within 2 years) physical examination upon school entry and at ninth (9th) grade.

Talk with your health care provider about important issues[1] 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**
  - **Influenza (seasonal) vaccine** is recommended *each year* for *all* children (6 months and up).
  - **Human papillomavirus vaccine (HPV)** is recommended for all girls and boys (ages 11 or 12, minimum age 9) to prevent cancers, pre-cancers, and genital warts.
  - **Hepatitis A, Meningococcal, and Pneumococcal vaccines** are recommended for certain high risk groups.

Immunization Requirements for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]: **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 is required.
MMR[3]: 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 B[3]: 3 doses.
Varicella[4]: 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 is required.
MMR[3]: 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 B[3]: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
Varicella[4]: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

[1] Based on 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.

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 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	
3lood 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? ☐Glasses ☐Contacts ☐Other_____	Yes	No	
Dental concerns? ☐Braces ☐Bridge ☐Plate ☐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	

'nformation may be shared with appropriate personnel for health and educational purposes.

'arent/Guardian

Signature **Date**

CHILD'S NAME_____

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: / /

PART III – SCREENING & TESTING

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

Sc n

Height: _____ **Weight:** _____ **BMI:** _____ **BMI Percentile:** _____ **BP:** _____ **Pulse:** _____ **Other:** _____
(inches) (pounds)

Dental Screen

☐ **Problem Identified:** Referred for treatment
☐ **No Problem:** Referred for prevention
☐ **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**: ☐ At-Risk ☐ No Risk

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:** ☐ No ☐ Yes _____ Date

Vision: **Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date

Other: **Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓) NORMAL	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.

Please provide the parent with information on Special Needs Alert Program (SNAP) for EMS.

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:** _____