



OFFICE USE ONLY

Birth Certificate _____ Proof of Address _____ Immunizations _____
Report Card _____ Other Documents _____ Guardian ID: _____
Curriculum: _____ Grade: _____ Homeroom: _____ ID #: _____
Start Date: _____ Registration Date: _____

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) Yes, Hispanic or Latino No, NOT Hispanic or Latino

What is this student's race? (Choose one or more, regardless of ethnicity)

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

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 your child attend a preschool or childcare program in Delaware this past year? Yes No
If yes, in which county did your child attend the program? New Castle County Kent County Sussex County
If yes, what was the name of the program? _____
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 - *NOT A PARENT / GUARDIAN LISTED ABOVE

Name: _____ Relationship: _____

Street Number and Name: _____ Apt #: _____

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

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: _____ Email address: _____

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 worked with watermelons, potatoes, mushrooms, corn, apples, chicken or shellfish?) Yes No

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 STUDENT HEALTH FORM – CHILDREN

PreK-Grade 6

To be completed by licensed healthcare provider:
 Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician's Assistant (PA)

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) and your health care provider (Parts I, II, and III). All students in Delaware public schools must provide documentation of current immunizations. Additionally, a current (within 2 years) health examination is required upon school entry.

Talk with your health care provider about important issues¹ regarding your child, such as:

- School (readiness or adaptation, after school, parent-teacher communication, maturity, performance, special services)
- Mental and Physical Activity (healthy weight, well-balanced diet, physical activity, limited screen time)
- Emotional Well-Being (family time, social interactions, self-esteem, resolving conflicts, friends)
- Physical Growth & Development (dental care, healthy eating, puberty)
- Injury & Illness Prevention & Safety (seat belt or booster seat, bicycle safety, swimming, abuse protection, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- Immunizations

Immunizations Required for Newly Enrolled Students at Delaware Schools

KINDERGARTEN²:

- DTap/DTP: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
- Polio: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- MMR₃: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- Hep B₃: 3 doses.
- Varicella⁴: 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6:

- DTap/DTP: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required. Students who start the series at age 7 or older only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTap, DTP, or DT dose was administered—which ever is later.
- Polio: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- MMR₃: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- Hep B₃: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- Varicella⁴: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

Immunizations Strongly Recommended by the Delaware Division of Public Health

- Influenza (seasonal) vaccine: *each year for all children (6 months and up).*
- Tetanus-Diphtheria-Pertussis (Tdap): booster at age 11 or five years after the last dose
- Meningococcal (MCV4): all children at 11 or 12 years, and a booster does at age 16
- Human papillomavirus vaccine (HPV): all girls and boys (ages 11 or 12)
- Pneumococcal vaccine (PCV13): children with specific risk factors
- Pneumococcal vaccine (PPSV): certain high risk groups
- Hepatitis A: unvaccinated children who are or will be at increased risk

¹ Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd ed.) AAP, 2008
² Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.
³ Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
⁴ Varicella disease history must be verified by a health care provider to be exempted from vaccination.

PARENT		HEALTHCARE PROVIDER COMMENT	
Developmental delay (speech, ambulation, other)?		Yes	No
Serious injury or illness?			
Medication?			
Hospitalizations?			
When? What for?			
Surgery? (List all) 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		Date	

*To be completed by parent/guardian prior to exam
The healthcare provider should review and provide comments in the last column.*

PART I - HEALTH HISTORY

Name: _____ Date: _____
 Gender: _____ Examiner: _____
 DOB: _____

CHILD'S NAME _____

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

PART III - SCREENING & TESTING

Child is fully immunized per DPH/CDC recommendations (refer to cover page) Yes No

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	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	PSPV23	PSPV23	Other:
Other:	Other:	Other:	Other:	Other:

Immunizations - Shaded Vaccines Required. Regulations is located at Title 14 Section 804 Immunizations.

Entire section below to be completed by MD/DO/APN/NP/PA
 Printed VAR form may be attached in lieu of completion.

PART II - IMMUNIZATIONS

CHILD'S NAME _____

Address: _____
 Phone: _____

Print Name: _____ Signature: _____ Date: _____

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

DIAGNOSIS			EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO	YES	NO

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: _____

PHYSICAL EXAMINATION	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				

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

PART IV - COMPREHENSIVE EXAM

CHILD'S NAME _____

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.

Date _____
Parent/Guardian's _____

Signature _____

Student _____
DOB: _____ Grade _____ Teacher _____

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

- | | | | |
|---|--|--|----------------------------------|
| <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 | |
| OTHER | | | |

Comments: _____

2. Does your child have allergies to medicine, food, latex or insect bites? YES NO
To What _____ What happens? _____
Treatment _____

3. Has your child had any illnesses since school last ended? YES NO
Type of illness, with date(s) _____

4. Has your child had surgery since school last ended? YES NO
Type of surgery, with date(s) _____

5. Has your child received any immunizations since school last ended? YES NO
List immunizations, with dates _____

6. Is your child being treated or evaluated for any health conditions? YES NO
List condition _____

7. Is your child on any medication or treatment? YES NO
Name of medication and/or treatment _____

Revised 7/17/2020

- Does your child need medicine during school hours? YES NO
8. Has your child ever been examined by an eye doctor? YES NO
- Date of last exam _____
- Glasses Prescribed YES NO
- 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.
12. Have you, your child or anyone in your household tested positive for COVID-19? YES NO
- If yes, please contact the school nurse.



DEPARTMENT OF EDUCATION

Susan S. Bunting, Ed.D.
 Secretary of Education
 Voice: (302) 735-4000
 FAX: (302) 739-4654

Townsend Building
 401 Federal Street Suite 2
 Dover, Delaware 19901-3639
 DOE WEBSITE: <http://www.doe.k12.de.us>

Delaware Department of Education Home Language Survey

Date: _____

School: _____

The Delaware Department of Education requires schools to determine the language(s) spoken at home by each student. The information provided will only be used to determine whether your student is eligible to begin the English as a Second Language process and will not be used for immigration matters or reported to immigration authorities.

Student Information	
First Name:	
Country of birth:	
Last Name:	
Date of entry in the US:	
Birthdate:	
Date student first enrolled in a US school:	

Circle grades your child attended in US schools

- PK
- K
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12

How many total months has the student been enrolled in a US school? _____

1. What language did your child first learn? _____

Language: _____	Dialect: _____
-----------------	----------------

2. What language does your child most often use at home? _____

Language: _____	Dialect: _____
-----------------	----------------

3. What languages do you most often speak to your child? _____

Language: _____	Dialect: _____
-----------------	----------------

4. What language(s) other than English are spoken in your home? _____

Language: _____	Dialect: _____
-----------------	----------------

5. What language would you prefer to receive information from your school? _____

Language: _____	Dialect: _____
-----------------	----------------

Parent Name _____
 Parent Signature _____
 Date _____

LEA: Please have all families complete this home language survey at the student's initial enrollment in school. This form must be signed and dated by the parent or guardian and kept in the student's file. (If a language other than English or Non-US English is listed on questions 1-3, the LEA must continue with a records review, step 2 of the English learner identification process.)

Dear Parent/ Guardian,

Date: _____

In order to serve your child, _____, the _____, _____
(Insert District/Charter School Name)
District/Charter School is

helping the State of Delaware identify students who may qualify to receive additional education and support services.

The information provided below will be kept confidential with in the Department of Education and will be used for planning purposes only. Please answer the following questions 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; c) another country to the U.S.?

_____ YES _____ NO

If "NO," do not complete the remainder of this survey. If "YES," please continue.

2. Was the reason for this change to look for or to accept a job in an agricultural or fishing activity such as those listed below? Answer this question even if you have a different type of job now.

_____ YES _____ NO

If "YES," please circle all that apply if you or your husband/wife, or someone in your household has worked with, on, or in a:

Farm	Chicken processing plant	Dried or dehydrated fruits/spices	Plant nursery/greenhouse
Dairy	Processing meat/fish	Sod farms	Tree growing or harvesting
Ranch	Cranberry bogs	Meat or food packing plant	Food processing
Cannery	Fresh/frozen juices	Mushrooms	Pet food processing
Chicken house	Fishery	Planting, picking, or packing fruits, vegetables, seeds, or nuts	Cleaning, weeding or preparing land for planting

Please 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: All ORIGINAL copies of the survey with "YES" responses for BOTH questions 1 and 2 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 NS10 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.

The Smyrna School District does not discriminate in employment, educational programs, services or activities based on race, color, marital status, creed, religion, national origin, gender, age, genetic information, sexual orientation, gender identity, disability or any other protected category or status in accordance with state and federal laws. Inquiries should be directed to the District Superintendent.

B & G CLUB SIGNATURE _____ DATE: _____
 B & G PARENT SIGNATURE _____ DATE: _____

IF STUDENTS ATTEND BOYS & GIRLS CLUB WE NEED A SIGNATURE

FOR TRANSPORTATION ONLY		FOR TRANSPORTATION ONLY	
BUS: _____	CONTRACTOR: _____	BUS: _____	CONTRACTOR: _____
START DATE: _____	START DATE: _____	STOP: _____	STOP: _____
TRANSPORTATION NOTES:		TRANSPORTATION NOTES:	

PICK UP ADDRESS	DROP OFF ADDRESS
NAME: _____	NAME: _____
DEVELOPMENT: _____	DEVELOPMENT: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____	CITY: _____
STATE: _____	STATE: _____
ZIP: _____	ZIP: _____
BEST PHONE#: _____	BEST PHONE#: _____

CHECK HERE IF SAME AS PICKUP

DATE OF REQUEST: _____ SCHOOL/GRADE: _____

STUDENT'S NAME: _____

DEVELOPMENT: _____

STUDENT'S 911 ADDRESS: _____

PARENT/GUARDIAN'S NAME: _____

HOME PH#: _____

BEST PH# TO USE: _____

DATE: _____
TRANSPORTATION USE ONLY

REQUEST FOR BUS TRANSPORTATION
 (Minimum of 24 hours notice)
 Fax: (302) 653-1815

DATE: _____
SCHOOL USE ONLY

U.S. Mail Address:
 Clayton Elementary School
 510 West Main Street
 Clayton, DE 19938

Delaware State Mail Address:
 Clayton Elementary School
 Smyrna School District
 State Mail N460

You may mail the above applicable student information to:

NOTE: When records are requested by school personnel for a student who has enrolled or intends to enroll in a school system, parental permission is no longer required (Family Educational Rights and Privacy Act; Final Rule on Education Records; Buckley Amendment; Section 99.31; Paragraph b; Federal Register; June 17, 1976; Volume 41, Number 118, Page 24673).

Name: _____
 Parent/Legal Representative _____
 Date _____

Witnessed by:

<input type="checkbox"/>	Cumulative Record
<input type="checkbox"/>	Withdrawing Grades
<input type="checkbox"/>	Standardized Test Scores
<input type="checkbox"/>	Health Records
<input type="checkbox"/>	Special Education Records
<input type="checkbox"/>	Court/Custody Records
<input type="checkbox"/>	Other:

The following information may be disclosed/released:

I hereby authorize _____ to disclose the information described below concerning the above named student to be released to the Smyrna School District for the purpose of educational programming/planning of the above named student.

Student Name:		Birth date:	
Address:			
Home Phone :		Other:	
Parent/Guardian:			
Relationship to Student:			

AUTHORIZATION FOR RELEASE OF INFORMATION

SMYRNA SCHOOL DISTRICT
 CLAYTON ELEMENTARY SCHOOL
 510 WEST MAIN STREET
 CLAYTON, DE 19938
 302-653-8587
 302-653-3421 (FAX)



Date records requested _____
 Date records received _____