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Dover, DE 19904

Chief Executive Officer
Superintendent of Schools
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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: http://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.**

Capital School District
Student Registration Checklist

Student Name _____

Grade _____ Homeroom _____

	Items Required for Registration
	Registration Form
	Emergency Treatment Information
	Student Residency Form
	Delaware DOE Home Language Survey
	Birth Certificate
	Proof of residency with parent/guardian name – electric, gas, or water bill, mortgage statement or lease agreement w/landlord and parent/guardian's name *
	Immunization Records and current physical (within the last two years)
	Proof of parenthood/guardianship – may require custodial papers and primary placement papers
	Picture identification
	Capital School District Student History (2 Pages)
	Delaware Student Health Form & Student Health History Update Form
	Over the Counter Medications Permission Form
	Military Connected Youth Form
	Agricultural Work Survey
	Additional Items Required for Kindergarten / PreK
	Parent Information Form (2 pages)
	Speech Survey
	If Transferring from Another District
	Withdrawal papers from former school
	Transcript of grades or report cards from former school
	IEP/504 Documentation (if applicable)
	Standardized Assessment results

***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.**

Revised 02/04/2020

Capital School District Registration Form

School_____

School Year_____ Grade_____Date_____

Choice: Yes ___ No ___
District Of Residence_____
School of Residence _____
Homeroom _____
ID # _____
Office use only

Transferring from_____

Is this child currently attending or is there a contract signed with a charter school? Yes____ No____ Where_____

Has this child ever attended Capital School District before? Yes____ No____ When_____

Student Information

Legal Name of Child_____ Age_____

Nickname(s)_____ Has Child Been Retained? : ☐ Yes ☐ No Grade(s)_____

Birth Date:_____ Gender: ☐ Male ☐ Female Active Military: ☐ Yes ☐ No

Hispanic: ☐ Yes ☐ No Race: ☐ American Indian/AK ☐ Black/African American ☐ Caucasian ☐ Asian ☐ Native Hawaiian/Pacific Islander

Child's Home Language:_____

Child's Complete Mailing Address:
PO Box / Street_____
City/State/Zip_____
Development_____
Home Phone:_____

Child's Complete Physical Address (If Different):
Street_____
City/State/Zip_____
Development_____
Home Phone:_____

*Check if Applicable: ☐ Homeless ☐ Foster Care ☐ Speech ☐ Title I ☐ Gifted ☐ 504 Plan ☐ IEP ☐ Other

Special Programs Needed:_____

Parent / Guardian Information

☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian ☐ Other_____
Name:_____
Address:_____
Home Phone: _____
Work Phone:_____
Cell Phone:_____
Email:_____
Lives with: ☐ Yes ☐ No
Legal Custody: ☐ Joint ☐ Relative Caregiver ☐ Other _____
Emergency Contact:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____

☐ Parent ☐ Step-Parent ☐ Foster Parent ☐ Guardian ☐ Other_____
Name:_____
Address:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Email:_____
Lives with: ☐ Yes ☐ No
Legal Custody: ☐ Joint ☐ Relative Caregiver ☐ Other _____
Emergency Contact:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____

Siblings in Present Household Under Age 18:

Name_____ Age_____ Grade_____
Name_____ Age_____ Grade_____
Name_____ Age_____ Grade_____

This is to confirm to Capital School District Officials that I am the parent or legal guardian of the above child and that this is my legal address

_____ _____
Please Print Your Name Signature / Date

FOR OFFICE USE ONLY

Bus_____ **SPECIAL ED. CLASS**_____ **LUNCH**_____
ON COMPUTER_____ **RECORDS REQUESTED**_____ **TEACHER ASSIGNED**_____

Revised 02/03/2020

Capital School District Emergency Treatment and Contact Information

Student Name: _____ **School**: _____

Child Resides with: _____ Relationship: _____
_____ Relationship: _____
Address: _____ Homeroom: _____
_____ Grade: _____
Bus No. To School: _____ Birth Date: _____
Bus No. From School: _____ Gender (M/F): _____
Daycare/ Sitter Name: _____ Home Phone: _____
Daycare Phone: _____

Guardian 1 Information		**Guardian 2 Information**	
Name:		Name:	
Date of Birth:		Date of Birth:	
Home Address:		Home Address:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Business Phone:		Business Phone:	
Place of Employment:		Place of Employment:	
E-mail Address:		E-mail Address:	
Step-parent/Spouse Name:		Step-parent/Spouse Name:	
Place of Employment:		Place of Employment:	
Business Phone:		Business Phone:	
Cell Phone:		Cell Phone:	

IF PARENTS/GUARDIANS CANNOT BE REACHED, CALL:

Name	Relationship	Work Phone	Home Phone
1			
2			
3			

Student's Physician: _____ Phone _____
Student's Dentist: _____ Phone _____

Insurance Information:
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: _____

(Rev 8/2019)

Delaware Department of Education

DEPARTMENT OF EDUCATION

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Dover, Delaware 19901-3639
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Susan S. Bunting, Ed.D.
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(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.)

Rev. 12.8.17

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	☐ Feeding Problems	☐ Physical Problems
☐ Persistent High Fever	☐ Sleeping Problems	☐ Chronic Illness
☐ Head Injury	☐ Toileting Problems	

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.

_____

_____

Revised 02/04/2020

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 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**

Immunizations *Required* 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 dose 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 dose 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.

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.

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	
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? ☐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	

Information may be shared with appropriate personnel for health and educational purposes.
Parent/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:** / /

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

Screen	**Height:** _____ (inches) **Weight:** _____ (pounds) **BMI:** _____ **BMI Percentile:** _____ **BP:** _____ **Pulse:** _____ **Other:** _____
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**: ☐ Test Required ☐ Test Not Required **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.

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.

*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.

1. [ ] ADD/ADHD [ ] Bone/Spine [ ] Heart [ ] Speech
   [ ] Allergies [ ] Bowel/Bladder [ ] Infections [ ] Surgery
   [ ] Asthma [ ] Diabetes [ ] Kidney [ ] Vision
   [ ] Blood Disorder [ ] Emotional [ ] Physical Disability
   [ ] Body Piercing/Tattoo [ ] Hearing [ ] Seizures
   [ ] 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.***
12. Have you, your child or anyone in your household tested positive for COVID-19?

    NO [ ] *YES* [ ] ***If yes, please contact the school nurse.***

Revised 7/17/2020

2023 – 2024 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 possibly provide your student with additional supports and services if needed.

Please read the following statements and check the appropriate box below.

- If you are a parent or a step-parent, only check the box that specifically applies to you, your duty status and branch of the United States armed forces.
- If you are a parent or a step-parent meeting the definition of box one or two, and there is an immediate family member residing in the same household that meets the definition of box three, then both boxes should be checked.
- If your student is not a "military-connected youth", please check the fourth box, "Non-Applicable".

PARENTS OR STEP-PARENTS

☐ "**Active Duty"** - I am a parent or step-parent 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.

☐ "**Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action"** - A parent or step-parent ***residing in the same household***, who is on active duty, 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 pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

IMMEDIATE FAMILY MEMBER OR ANY OTHER PERSON RESIDING IN SAME HOUSEHOLD

☐ "**Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action"** - An immediate family member, including a sibling or any other person ***residing in the same household***, who is on active duty, 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 pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

☐ **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 18, 2023.

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

English/Spanish

Dear Parent/ Guardian, Date: _____

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

REV. 6/5/2020

CAPITAL
SCHOOL DISTRICT
198 Commerce Way
Dover, DE 19904

Permission for Use of Over-The-Counter Medications during the 2023-2024 School Year

Name of Student: _____ **Grade:** _____

Teacher's Name: _____

Does your child have allergies to any medication? **Yes**_____**No**_____

If yes, to what medicine? _____

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

_____ Advil / Ibuprofen / Motrin

_____ Anbesol/Orajel

_____ Anti-Fungal Cream

_____ Benadryl Liquid

_____ Benadryl Lotion (Anti-Itch)

_____ Burn Ointment/Spray

_____ Caladryl/Calamine Lotion

_____ Cough Drops

_____ Eye Wash Solution/Saline Rinse

_____ Hygiene Supplies

_____ Lip Ointment (Blistex/Chapstick)

_____ Skin Ointment (Bacitracin/ Hydrocortisone/ Neosporin)

_____ Sting Kill (Insect Sting Relief)

_____ Throat Spray (Chloraseptic Spray)

_____ Tums

_____ Tylenol / Acetaminophen

PARENT/GUARDIAN SIGNATURE:_____ Date:_____

Phone Number:_____