

# Thomas A. Edison Charter School

2200 North Locust Street Wilmington, DE 19802  
Office: 302-778-1101 Fax: 302-778-2232

For Office Use Only:

Date / Time received \_\_\_\_\_

For Office Use Only:

- Birth Certificate
- Immunizations
- Proof of Residency
- Child Find (KN only)
- Current Report Card
- Custody Papers
- Discipline Report
- Parent ID

## 2024-2025 K-8 STUDENT Supplemental Application

1. Complete one application for **each** child enrolling. 2. All information must be **complete** and **accurate**

*The Thomas A. Edison Charter School is a tuition-free public school, serving students in grades K - 8. Parents, students, and teachers will be expected to attend trimester conferences in which they promise to work together for student success.*

### Student Information (please print)

1. Name (From Birth Certificate) \_\_\_\_\_
2. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Child's Date of Birth: \_\_\_\_\_ 4. My child will be in grade \_\_\_\_\_ in August 2024.
5. Home Phone Number: \_\_\_\_\_ 6. Parent Cell Phone Number: \_\_\_\_\_
7. Parent eMail Address: \_\_\_\_\_

*The information requested in items 4-6 will NOT be used for selection purposes. It will be used to assist the school in evaluating the effectiveness of its recruitment.*

8. What is the language spoken at home? \_\_\_\_\_ What language/s does your child speak? \_\_\_\_\_
9. Has your child participated in either of these programs?  English as a Second Language  Bilingual Ed
10. Why are you choosing TECS for your child? \_\_\_\_\_

### Supplemental Checklist

*We must have copies of the following information in order to process an application.*

- 1. **LEGAL BIRTH CERTIFICATE** (A Birth Record with footprints is not acceptable)
- 2. **STUDENT SERVICES INTAKE INFORMATION FORM (Attached)**
- 3. **CHILDCARE TRANSPORTATION FORM (if applicable)**
- 4. **PROOF OF RESIDENCY**  
Recent (*within 3 months*) Utility bill with your name and address: Delmarva, Water, Lease Agreement or Mortgage Statement will only be accepted  
*a. If you reside at someone else's address, we need a copy of one of their bills and a notarized letter stating that you and your child live at that address.*
- 5. **IMMUNIZATION RECORD** (see attached letter)
- 6. **MOST RECENT PROGRESS REPORT/REPORT CARD** at time of registration (*if applicable*)  
*(If your child is accepted, we will require the final report card for the current school year to verify promotion and grade placement)*
- 7. **MOST RECENT BEHAVIOR/DISCIPLINE FILE** at time of registration (*if applicable*)
- 8. **I.E.P. (INDIVIDUALIZED EDUCATIONAL PROGRAM)**  
We must have a copy of the most recent I.E.P. or 504 Plan for all Special Education students.
- 9. **LEGAL DOCUMENTATION**  
If you are not the parent of the child you are registering, you will need to provide legal documentation from Family Court or the Division of Social Services indicating that you are the legal guardian.
- 10. **CHILD FIND SCREENING** (Kindergarten Students ONLY)  
If available, or complete the attached Child Find Screening Form
- 11. **PARENT/GUARDIAN'S DRIVER'S LICENSE OR STATE ISSUED PICTURE ID**

# Delaware Standard Application for Educational Options

“Receiving Local Education Agency” (RLEA) includes: DE Public School Districts (Choice),  
Charter Schools, Magnet Schools and Vocational-Technical Education Schools  
Enrollment for the 2024 – 2025 School Year

**Applications Accepted from Monday, November 6, 2023 to Wednesday, January 10, 2024**

**A parent residing within the State of Delaware may seek to enroll that parent’s child in a public school in any school district, charter school, magnet school or vocational-technical school through this application. Any student not currently registered in a public school in the State of Delaware must be registered in their School of Residence before submitting a Delaware Standard Application for Educational Options.**

State Student ID#: _____ RLEA Use Only
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Please Print

1. Are you applying for Kindergarten?  No  Yes
2. School(s) you are applying to in priority order:

1 <sup>st</sup> Choice	
2 <sup>nd</sup> Choice	
3 <sup>rd</sup> Choice	

3. Program Desired (if applicable):

4. Student’s Name:

Last name	First	Middle	Birth Date:
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Sex: Female  Male  Ethnicity: (optional) Hispanic or Latino Yes  No

Indicate this student’s race below (optional). Please select at least one race, regardless of ethnicity designation above. More than one response may be checked.

1 American Indian/AK  2 African American  5 Caucasian  6 Asian  7 Native Hawaiian or Other Pacific Islander

5. Parent/Guardian/Relative Caregiver Name: (Please Check Which Telephone Number is Your Preferred Method of Contact)

Last name	First	MI
Street address		
City	State	Zip
<input type="checkbox"/> Home Phone:	<input type="checkbox"/> Work Phone:	<input type="checkbox"/> Cell Phone:
Email address		

Check if above address is different from that on file at school.

6. Resident District and Resident School for 2024-2025 School Year: (Please Enter the Name of the Delaware Public School District and School Attendance Area You Live In)

Resident District:	Resident School:
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7. Present School Information:  Public  Non-Public

Current School (2023-2024 School Year):	Current Grade (2023-2024 School Year):
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8. Is Your Request for an Educational Option Related to Child Care Needs?  No  Yes (see below)

**If YES, you MUST complete the following for your Child Care Provider:**

Last name		First	MI
Street address			
City	State	ZIP	Telephone

9. Please list any brothers or sisters CURRENTLY ATTENDING and EXPECTED TO CONTINUE TO ATTEND the REQUESTED EDUCATIONAL OPTION in Question #2 for the 2024-2025 and 2025-2026 School Years:

Last name		First	MI
Birth Date:	School:	Grade:	

Last name		First	MI
Birth Date:	School:	Grade:	

10. Please check your preferred language for all written correspondence: English  Spanish

11. Is there a custody and/or court order in place for the child for whom this application is being submitted?

No  Yes (see below)

If yes, are you the parent or legal guardian named in the custody and/or court order that can make educational decisions for the child for whom this application is being submitted?

Yes (a copy may be requested by the receiving local education agency)  No

This application provided by the Delaware Department of Education (DDOE) MUST be submitted by the parent of a school age child on or after Monday, November 6, 2023 and on or before Wednesday, January 10, 2024, to the receiving local education agency or the DDOE and to the child's district of residence for enrollment during the 2024-2025 school year. Charter schools, vocational-technical school districts, and magnet schools may continue to accept applications after the January 10, 2024 deadline to fill remaining availability; however, only applications received by the January 10, 2024 deadline will be included in any lottery held by those institutions. This application provided by the Delaware Department of Education (DDOE) may be submitted by a parent enrolling their child in kindergarten to the receiving district up until the first day of the school year for enrollment in kindergarten during the 2024-2025 school year.

This application provided by the Delaware Department of Education (DDOE) may be submitted by the parent of a school age child after the January 10, 2024, deadline if "good cause" as defined in 14 Del.C., §402(2) exists. The receiving local education agency and district of residence shall accept and consider the application in the same manner as those applications submitted by the deadline. The board of the receiving local education agency shall take action to approve or disapprove the application filed in accordance with the provisions of 14 Del.C., §403(b) no later than 45 days after receipt thereof, unless the application is received prior to a lottery conducted as outlined in a local education agency's enrollment policy in the case of over-enrollment. Charter schools, vocational-technical school districts, and magnet schools may continue to accept applications after the January 10, 2024 deadline to fill remaining availability.

This application provided by the Delaware Department of Education (DDOE) may be withdrawn by the parent of a school age child any time prior to action taken by the receiving local education agency board. The parent shall give written notice to the board(s) of the receiving local education agency and the child's district of residence.

**NOTE: Once this application is received, additional information may be requested.**

I **certify** that I am a current resident of the State of Delaware and that all of the statements on this application made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith. I **understand** and **acknowledge** that any misstatements or omission of material facts in the application form may result in the rejection of the application form, disqualification from the lottery process if applicable, withdrawal of invitation offer, and/or termination of school choice by the receiving local education agency to which I applied.

Parent/Guardian/Relative Caregiver Signature:	Date:
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<b>RD Use Only</b>			
Date App. Rec'd: _____	Date App. Withdrawn: _____	Date Student Notified: _____	Date Invitation Accepted/Refused: _____
School: _____	Grade: _____	Good Cause App.: _____	



For Office Use Only  
 Student ID: \_\_\_\_\_

## STUDENT SERVICES INTAKE INFORMATION

*Thomas Edison Charter School is fully committed to providing a quality education to all of our students—including those with special circumstances. We need your help to assist us with providing the best possible education for your child. Please complete this form with care. If you have questions about the form, please contact us.*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Has your child been involved with early intervention services (birth to age 3)?  Yes  No
2. Has your child been screened for special education services?  Yes  No
3. Does your child have a current Individual Education Plan (IEP)?  Yes  No  
*If yes, we should receive a copy of the IEP prior to the start of school*
4. Has your child ever received special education services?  Yes  No
5. Does your child receive services under Section 504 of the Rehabilitation Act?  Yes  No

6. Please check the services your child has and/or still receives (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Speech and Language      | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Self-Contained Classroom   |
| <input type="checkbox"/> Physical Therapy         | <input type="checkbox"/> Counseling           | <input type="checkbox"/> Inclusion Services         |
| <input type="checkbox"/> Visually Impaired        | <input type="checkbox"/> Resource Room        | <input type="checkbox"/> Orientation and Mobility   |
| <input type="checkbox"/> Deaf and Hard of Hearing | <input type="checkbox"/> Medical Services     | <input type="checkbox"/> Adapted Physical Education |

7. Does your child take medication? (for ADHD, diabetes, etc)  Yes  No

If yes, what medication does your child take? \_\_\_\_\_

8. Does your child wear glasses?  Yes  No

9. Does your child wear a hearing aid?  Yes  No

10. Does your child receive special transportation?  Yes  No

11. Are you concerned that your child may have a special need that has not been evaluated yet?  Yes  No

If yes, please explain? \_\_\_\_\_

*The school is legally obligated to provide your child with all services on their IEP and it is extremely important that you inform us whether your child has an IEP. If you have any questions, please do not hesitate to reach out. Your signature on this form indicates that you understand these questions and that the information you provide, to your knowledge, is as accurate as possible.*

\_\_\_\_\_  
 Parent/Guardian Name

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

\_\_\_\_\_  
 Date



# DEPARTMENT OF EDUCATION

Townsend Building  
401 Federal Street Suite 2  
Dover, Delaware 19901-3639  
<http://education.delaware.gov>

Mark A. Holodick, Ed.D.  
Secretary of Education  
(302) 735-4000  
(302) 739-4654 - fax

## 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.)



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## Departamento de Educación de Delaware - Encuesta sobre el idioma que se habla en el hogar

Fecha: \_\_\_\_\_

Escuela: \_\_\_\_\_

Spanish

*El Departamento de Educación de Delaware exige a las escuelas que determinen el/los idioma(s) que los estudiantes hablan en el hogar. La información proporcionada solo será utilizada para decidir si el estudiante reúne los requisitos para comenzar el proceso de adquisición del inglés como segunda lengua y no será utilizada para temas relacionados con la inmigración ni se informará a las autoridades migratorias.*

Información sobre el estudiante			
Nombre:		País de origen:	
Apellido:		Fecha de ingreso en EE. UU.:	
Fecha de nacimiento:		Fecha en la que el estudiante se inscribió por primera vez en una escuela de EE. UU.:	

Haga un círculo en los grados a los que su hijo asistió en escuelas de EE. UU.

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

¿Durante cuántos meses el estudiante ha estado inscrito en una escuela de EE. UU.? \_\_\_\_\_

1. ¿Cuál fue el primer idioma que aprendió su hijo?

Idioma: \_\_\_\_\_ | Dialecto: \_\_\_\_\_

2. ¿Cuál es el idioma que su hijo usa con mayor frecuencia en el hogar?

Idioma: \_\_\_\_\_ | Dialecto: \_\_\_\_\_

3. ¿Cuál es el idioma que usted utiliza con más frecuencia para hablar con su hijo?

Idioma: \_\_\_\_\_ | Dialecto: \_\_\_\_\_

4. ¿Qué idioma (s) aparte del inglés se hablan en su casa?

Idioma: \_\_\_\_\_ | Dialecto: \_\_\_\_\_

5. ¿Con qué idioma preferiría recibir información de la escuela?

Idioma: \_\_\_\_\_ | Dialecto: \_\_\_\_\_

Nombre del padre

Firma del padre

Fecha

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 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: \_\_\_\_\_

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.



Fecha: \_\_\_\_\_

Estimado Padre/Madre o Adulto responsable del estudiante,

Con el fin de servir mejor a su niño, \_\_\_\_\_, el distrito escolar \_\_\_\_\_  
(Insert District/Charter School Name)

está asistiendo al estado de Delaware a identificar estudiantes elegibles para recibir beneficios y apoyos. La información proporcionada es confidencial y será utilizada por el Departamento de Educación para fines de planeación únicamente. Por favor, conteste las siguientes preguntas y devuelva este formulario a la escuela de su hijo.

1. ¿En los últimos 3 años, su familia se ha cambiado de: a) un *distrito escolar* a otro; b) un estado a otro; c) otro país a Estados Unidos?

\_\_\_\_\_ Sí \_\_\_\_\_ NO

**Si es "NO", no complete el resto de esta encuesta. Si es "SI", por favor continúe.**

2. ¿El motivo de este cambio ha sido por **buscar o aceptar** un empleo en una actividad agrícola o de pesca, o en alguna de las actividades enlistadas abajo? Conteste aunque tenga otro tipo de trabajo actualmente.

\_\_\_\_\_ Sí \_\_\_\_\_ NO

Si es "SI", por favor marque todo lo que corresponda si usted, su esposo/a u otro miembro del hogar ha trabajado en/con:

Granja	Rastro/ Carnicería	Cultivar Césped	Invernadero
Lechería	Procesar carne/pescado	Empacar carne/alimentos	Plantar y cultivar árboles
Rancho	Cultivo de Arandanos	Granja de Hongos	Procesar alimentos
Enlatadora	Jugo Fresco/Congelado	Plantar, pizar o empacar	Procesar limento para mascota
Gallineros	Pescado y Marisco	frutas, vegetales, semillas, o	Desyerbar o preparar el terreno
Planta de Pollo/Pollera	Frutas secas/especias	nueces	para plantar

Favor de anotar otro trabajo/actividad agrícola o de pesca que usted, su esposo/a u otro miembro del hogar haya realizado:

Anote todos los niños y jóvenes entre **3-21 años de edad** en el hogar, incluyendo los que no asisten a la escuela:

Nombre y Apellido	Fecha de Nacimiento	Edad	Grado	Escuela

Padre/Madre o Adulto responsable del estudiante: \_\_\_\_\_

Dirección: \_\_\_\_\_ Ciudad \_\_\_\_\_ Zip \_\_\_\_\_

Teléfono 1: \_\_\_\_\_ Teléfono 2 \_\_\_\_\_ Hora: \_\_\_\_\_ AM/PM

**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.

# 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<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.

**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
	Yes	No	
Developmental delay (speech, ambulation, other)?			
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?	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 / /	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

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

**PART IV – COMPREHENSIVE EXAM**

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

PHYSICAL EXAMINATION	Check (✓)			HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	REFERRAL	
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:** \_\_\_\_\_