

For Office Use Only:

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

## Thomas A. Edison Charter School

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

For Office Use Only:

- |  |   |
|--|---|
| <input type="checkbox"/> Birth Certificate   | <input type="checkbox"/> Immunizations        |
| <input type="checkbox"/> Proof of Residency  | <input type="checkbox"/> Child Find (KN only) |
| <input type="checkbox"/> Current Report Card | <input type="checkbox"/> Custody Papers       |
| <input type="checkbox"/> Discipline Report   | <input type="checkbox"/> Parent ID            |

### 2019-2020 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 2019.
5. Home Phone Number: \_\_\_\_\_
6. Parent Cell Phone Number: \_\_\_\_\_

*We start in mid-August and go through mid-June.*

*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.*

7. What is the language spoken at home? \_\_\_\_\_ What language/s does your child speak? \_\_\_\_\_
8. Has your child participated in either of these programs?  English as a Second Language  Bilingual Ed
9. 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 2019 – 2020 School Year**

**Applications Accepted from Monday, November 5, 2018 to Wednesday, January 9, 2019**

**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

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

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

- Program Desired (if applicable):

- 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

- 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.

- Resident District and Resident School for 2019-2020 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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- Present School Information:  Public  Non-Public

Current School (2018-2019 School Year):	Current Grade (2018-2019 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 2018 – 2019 and 2019-2020 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 5, 2018 and on or before Wednesday, January 9, 2019, to the receiving local education agency or the DDOE and to the child’s district of residence for enrollment during the 2019 - 2020 school year. Charter schools, vocational-technical school districts, and magnet schools may continue to accept applications after the January 9, 2019 deadline to fill remaining availability; however, only applications received by the January 9, 2019 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 2019-2020 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 9, 2019, 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 9, 2019 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:  
Student ID \_\_\_\_\_

# THOMAS EDISON CHARTER SCHOOL

## Student Services Intake Information

Thomas Edison Charter School, is fully committed to providing quality education to all of our students—including those with special needs. We need your help, so please complete this page with care.

1. Has your child been involved with early intervention services (birth to 3)?

Yes                       No

2. Has your child been screened for special education by the public schools?

Yes                       No

3. Does your child have a current Individual Educational Plan (IEP)?

Yes                       No

\*\* If your child does have an Individual Educational Plan (IEP), we should receive a copy of the IEP prior to your child entering 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 of 1973?

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"/> physical therapy	<input type="checkbox"/> counseling
<input type="checkbox"/> inclusion services	<input type="checkbox"/> resource room
<input type="checkbox"/> self-contained classroom	<input type="checkbox"/> visually impaired
<input type="checkbox"/> orientation and mobility	<input type="checkbox"/> medical services
<input type="checkbox"/> deaf & hard of hearing	<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: \_\_\_\_\_

Because the school is legally obligated to provide your child with all services on his or her IEP, it is extremely important that you inform us whether your child has an IEP. Please call or drop in to ask any questions you may have.

Your signature on this form indicates that you understand these questions and that the information you provide is accurate.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Student Name: \_\_\_\_\_ DOB : \_\_\_\_\_



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## Home Language Survey

*Delaware Department of Education requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students. Please complete the portion below and return this survey to your child's school.*

**Parent/Guardian Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

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

***The next 6 questions are to be completed by a parent or legal guardian:***

1. What language did your child first learn to speak?
2. What language did your child first learn to read/write?
3. What language do you use most often when speaking to your child?
4. What language does your child use most often when speaking to others in your home?
5. Has your child ever participated in an English as a Second Language (ESL) program?
6. Has your child ever participated in a Bilingual program?

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

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

Dear Parent/ Guardian,

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

In order to serve your child, \_\_\_\_\_, the Thomas Edison Charter School 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: The ORIGINAL document must be submitted to the Delaware Department of Education Title I, Part C Office within 10 days of the student’s enrollment by State Mail Code D370B or by U.S. Postal Service to 401 Federal Street, Suite 2, Dover, DE 19901. 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.**



**Depatman Edikasyon Delaware  
Pwogram Edikasyon pou Migran  
Sondaj Travay Agrikòl**

English/Spanish

Estimado Padre/Madre o Adulto responsable del estudiante,

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

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: \_\_\_\_\_ Hora disponible: \_\_\_\_\_ AM / PM Otro núm. de teléfono \_\_\_\_\_

**DISTRICTS: The ORIGINAL document must be submitted to the Delaware Department of Education Title I, Part C Office within 10 days of the student's enrollment by State Mail Code D370B or by U.S. Postal Service to 401 Federal Street, Suite 2, Dover, DE 19901. 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, and a current (within 2 years) physical examination upon school entry and at ninth (9<sup>th</sup>) grade.

### 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**
  - **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<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> 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> 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.

<sup>1</sup> Based on 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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	Yes	No	
Dental concerns? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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**

**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

<b>Screen</b>	<b>Height:</b> _____ <b>Weight:</b> _____ <b>BMI:</b> _____ <b>BMI Percentile:</b> _____ <b>BP:</b> _____ <b>Pulse:</b> _____ <b>Other:</b> _____ (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 <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior</u> to school entry. <b>Risk Assessment:</b> _____ <b>Date</b> _____ <b>Results:</b> <input type="checkbox"/> At-Risk <input type="checkbox"/> No Risk <b>Mantoux Skin Test:</b> _____ <b>Date</b> _____ <b>Results:</b> _____ MM <b>Other: (type)</b> _____ <b>Date</b> _____ <b>Results:</b> _____ MM
<b>Lead Test</b>	Blood lead test required for children age 6 months through 6 years <b>Date:</b> _____ <b>Results:</b> _____
<b>Other Screen</b>	<b>Hearing: Type:</b> _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date <b>Vision: Type:</b> _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date <b>Other: Type:</b> _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <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.

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:** \_\_\_\_\_