For Office Use Only:
Date / Time received _____
Entered in eSchool _____

Thomas A. Edison Charter School
2200 North Locust Street Wilmington, DE 19802
Office: 302-778-1101 Fax: 302-778-2232

For Office Use Only:	
☐ Birth Certificate	☐ Immunizations
☐ Proof of Residency	☐ Child Find (KN only)
☐ Current Report Card	☐ Custody Papers
☐ Discipline Report	☐ Parent ID

2015-2016 K-8 STUDENT Supplemental Application

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

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 2015.

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**

~ ~ Thomas Edison Charter School holds mandatory family interviews for all new students ~ ~

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 2015 – 2016 School Year

Applications Accepted from Monday, November 3, 2014 to Wednesday, January 14, 2015

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

Please Print

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

1st Choice	
2nd Choice	
3rd Choice	

3. **Program Desired (if applicable):**
4. **Student's Name – From Birth Certificate**:

Last name	First	Middle	Birth Date:

Sex:
Female ☐ Male ☐

Ethnicity:
Hispanic or Latino Yes ☐ No ☐

Race:
1 American Indian/Alaska Native ☐ 2 Black/African American ☐ 3 White/Caucasian ☐ 4 Asian American ☐
5 Native Hawaiian/Other Pacific Islander ☐ Multi-racial ☐

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
☐ Home:	☐ Work:	☐ Cell:
Email address		

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

6. **Resident District and Resident School for 2015-2016 School Year:** (Please Enter the Name of the Public School District and School Attendance Area You Live In)

Resident District:	Resident School:

7. **Present School Information:** ☐ Public ☐ Non-Public

Current School (2014 – 2015 School Year):	Current Grade (2014 – 2015 School Year):

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 2014 – 2015 and 2015 – 2016 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 ☐

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 3, 2014 and on or before Wednesday, January 14, 2015, to the receiving local education agency or the DDOE and to the child's district of residence for enrollment during the 2015 – 2016 school year. Charter schools, vocational-technical school districts, and magnet schools may continue to accept applications after the January 14, 2015 deadline to fill remaining availability; however, those holding a lottery, will include applications received by the January 14, 2015 deadline.

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 2015 – 2016 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 14, 2015, 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 14, 2015 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 RLEA and the child's district of residence.

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

Parent/Guardian/Relative Caregiver Signature:	Date:

RD Use Only

Date App. Rec'd: _____ Date App. Withdrawn: _____ Date Student Notified: _____ Date Invitation Accepted/Refused: _____

School: _____ Grade: _____ Good Cause App.: _____

DELAWARE STUDENT HEALTH FORM – CHILDREN
PreK- Grade 6

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

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) and your health care provider (Parts I, II, and III). All students in Delaware public schools must provide documentation of current immunizations, and a current (within 2 years) physical examination upon school entry and at ninth (9th) grade.

Talk with your health care provider about important issues[1] regarding your child, such as:

- ☐ **School** (readiness or adaptation, after school, parent-teacher communication, maturity, performance, special services)
- ☐ **Mental and Physical Activity** (healthy weight, well-balanced diet, physical activity, limited screen time)
- ☐ **Emotional Well-Being** (family time, social interactions, self-esteem, resolving conflicts, friends)
- ☐ **Physical Growth & Development** (dental care, healthy eating, puberty)
- ☐ **Injury & Illness Prevention & Safety** (seat belt or booster seat, bicycle safety, swimming, abuse protection, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- ☐ **Immunizations**
  - **Influenza (seasonal) vaccine** is recommended *each year* for *all* children (6 months and up).
  - **Human papillomavirus vaccine (HPV)** is recommended for all girls and boys (ages 11 or 12, minimum age 9) to prevent cancers, pre-cancers, and genital warts.
  - **Hepatitis A, Meningococcal, and Pneumococcal vaccines** are recommended for certain high risk groups.

Immunization Requirements for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]: **DTaP/DTP**: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
Polio: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th is required.
MMR[3]: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
Hep B[3]: 3 doses.
Varicella[4]: 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6: **DTaP/DTP**: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required. Students who start the series at age 7 or older only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTap, DTP, or DT dose was administered - whichever is later.
Polio: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th is required.
MMR[3]: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
Hep B[3]: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
Varicella[4]: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

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

CHILD'S NAME_____

PART I – HEALTH HISTORY

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

Name:_____ **Gender:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
Serious injury or illness?			
Medication?			
Hospitalizations? When? What for?			
Surgery? (List all) When? What for?			
Ear/Hearing problems?			
Heart problems/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Allergies (food, insect, other)?	Yes	No	
Family history of sudden death before age 50?	Yes	No	
Child wakes during the night coughing?	Yes	No	
Diagnosis of asthma?	Yes	No	
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:** / /

PART III – SCREENING & TESTING

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

Screen	**Height: _____Weight: _____BMI: _____ BMI Percentile: _____BP: _____Pulse: _____Other: _____** (inches) (pounds)
Dental Screen	☐ **Problem Identified:** Referred for treatment ☐ **No Problem:** Referred for prevention ☐ **No Referral:** Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry. **Risk Assessment:** **Date**_____ **Results**: ☐ At-Risk ☐ No Risk **Mantoux Skin Test:** **Date**_____ **Results**:_____MM **Other:** (type)_____ **Date**_____ **Results**:_____MM
Lead Test	Blood lead test required for children age 6 months through 6 years **Date**:_____ **Results**:_____
Other Screen	**Hearing: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Vision: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Other: Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

PART IV – COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	REFERRAL	HEALTHCARE PROVIDER COMMENT
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal examination				
Nutritional status				
Mental health status				

FOR CHRONIC & LIFE THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency care plan for school.

Please attach care plan, protocols, and/or emergency care plan.

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

Recommendations or Referrals:_____

_____

_____

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

Print Name: _____ **Signature:** _____ **Date:** _____

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

Address: _____ **Phone:** _____