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

2025-2026 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 2025.

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 2025 – 2026 School Year

Applications Accepted from **Monday, November 4, 2024** **to** **Wednesday, January 8, 2025**

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

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**:

Last name	First	Middle	Birth Date:

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
☐ Home Phone:	☐ Work Phone:	☐ Cell Phone:
Email address		

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

6. **Resident District and Resident School for 2025-2026 School Year:** (Please Enter the Name of the Delaware Public School District and School Attendance Area You Live In)

Resident District:	Resident School:

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

Current School (2023-2024 School Year):	Current Grade (2023-2024 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 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 4 , 2024 and on or before Wednesday, January 8, 2025, to the receiving local education agency or the DDOE and to the child's district of residence for enrollment during the 2025-2026 school year. Charter schools, vocational-technical school districts, and magnet schools may continue to accept applications after the January 8, 2025, deadline to fill remaining availability; however, only applications received by the January 8, 2025 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 2025-2026 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 8, 2025, 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 8, 2025, 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:

RD Use Only

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 Withdrawn: _____ Date Student Notified: _____ Date Invitation Accepted/Refused: _____

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

THOMAS EDISON CHARTER SCHOOL
www.thomasedison.charter.k12.de.us

For Office Use Only
Student ID: _____

2200 North Locust Street
Wilmington, Delaware 19802
(302) 778-1101 • fax (302) 778-2232
email: info@tecs.k12.de.us
Salome Thomas-EL, Principal/Head of School

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)

   ☐ Speech and Language ☐ Occupational Therapy ☐ Self-Contained Classroom
   ☐ Physical Therapy ☐ Counseling ☐ Inclusion Services
   ☐ Visually Impaired ☐ Resource Room ☐ Orientation and Mobility
   ☐ Deaf and Hard of Hearing ☐ Medical Services ☐ 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.)

English/Spanish

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

Dear Parent/ Guardian, Date: _____

To better serve your child, _____, our district: _____ and our school: _____ assist the Delaware Department of Education identify students who may qualify for additional education and support services. Your responses will remain confidential and used only for planning. Please complete 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 or 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 **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.

Revised: November 21, 2024

DEPARTAMENTO DE EDUCACIÓN DE DELAWARE
TITULO I, PARTE C
Encuesta de Trabajo Agrícola

English/Spanish

Fecha:_____

Estimado Padre/Madre o Adulto responsable del estudiante,

Para ayudar mejor a su hijo/a, _____, nuestro DISTRITO: _____ y nuestra ESCUELA: _____ asisten a El Departmento de Educacion de Delaware a identificar los estudiantes que califican para ayuda academica y apoyo adicional. Su respuesta permanecera confidencial y sera usada solo para planear servicios. Favor de llenar este formulario y devolverlo a la escuela de su hijo/a.

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/ Carniceria	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, pizcar 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: The ORIGINAL document 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 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 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: _____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**: ☐ 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:** _____