School:			Student:	
Gender:	Grade:	HMRM:	Date Registered:	Registration Accepted By:

Colonial SCHOOL DISTRICT — The Power of WE

Student Registration Card

For School Use Only:		Legal Guardianship/Caregiver	
ID #:		In student database:	
Birth Certificate:		Records requested:	
Immunization:		Grades received:	

STUDENT INFORMATION

Grade:	Has this student ever been registered in a Delaware Public or Charter School? ☐ Yes ☐ No		
First Name:		Gender:	☐ Male ☐ Female
Middle Name:		Birth Date:	
Last Name:		Home Phone:	Unlisted?: ☐ Yes ☐
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V		

RACE and ETHNICITY DESIGNATION

Is this student Hispanic or Latino? (Select one answer.) Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino ☐ Yes ☐ No

Indicate this student's race below. You must select at least one race, regardless of ethnicity designation. More than one response may be selected.

☐ American Indian or Alaskan Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Pacific Islander

ADDRESS: Please indicate Physical (home) and Mailing address if they are different.

Physical Address		Mailing Address Same as Physical? ☐ Yes ☐ No	
Apt #:		Apt #:	
Address:		Address:	
Development:		Development:	
City, State, Zip:		City, State, Zip:	

PARENT/GUARDIAN CONTACT INFORMATION

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Apt #:		Cell Phone:	
Street Address:		Home Phone:	Unlisted? ☐ Yes ☐ No
Development:		Work Phone:	
City:		Birth Date:	
State/Zip:		Employer:	

Please provide one email address; separating each character in the boxes provided:

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Apt #:		Cell Phone:	
Street Address:		Home Phone:	Unlisted? ☐ Yes ☐ No
Development:		Work Phone:	
City:		Birth Date:	
State/Zip:		Employer:	

Please provide one email address; separating each character in the boxes provided:

EMERGENCY CONTACT INFORMATION: Must be 18 years of age or older.

Important
In the event of an emergency, individuals listed here will be contacted if parent/guardian **cannot** be reached.

First Name:		First Name:	
Last Name:		Last Name:	
Relationship:		Relationship:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	

Student:

Student Health History Update: **This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.**

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADD/ADHD	☐ Bleeding/Blood Disorder	☐ Concussion	☐ Heart	☐ Seizures
☐ Allergies	☐ Body Piercing/Tattoo	☐ Diabetes	☐ Infections	☐ Speech
☐ Asthma	☐ Bone/Spine	☐ Emotional	☐ Kidney	☐ Surgery
☐ Behavior	☐ Bowel/Bladder	☐ Hearing	☐ Physical Disability	☐ Vision

☐ Other: ______

Comments: ______

( ) Yes ( ) No **2. Does your child have allergies to medicine, latex or insect bites?**

To What? ______ What Happens? ______

Treatment ______

( ) Yes ( ) No **3. Does your child have a food allergy?**

To What? ______ What Happens? ______

Treatment: ______

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy.
Please provide an Emergency Action Plan and ALL emergency medications to the School Nurse.

( ) Yes ( ) No **4. Will your child require an individualized, allergen-free menu designed by Nutrition Services?**

Note: Meals provided from home provide the safest food options at school for food-allergic students.

☐ **No.** I will take full responsibility for providing my child with allergen-free school meals.

☐ **Yes.** I will provide the School Nurse with a Food Allergy Plan completed by a licensed healthcare provider.

( ) Yes ( ) No **5. Has your child had any illnesses since school last ended?**

Type of illness, with date(s): ______

( ) Yes ( ) No **6. Has your child had surgery since school last ended?**

Type of surgery, with date(s): ______

( ) Yes ( ) No **7. Has your child received any immunizations since school last ended?**

List of immunization(s), with date(s): ______

( ) Yes ( ) No **8. Is your child being treated or evaluated for any health conditions?**

List condition(s): ______

( ) Yes ( ) No **9. Is your child on any medication or treatment?**

Name of medication and/or treatment: ______

( ) Yes ( ) No Does your child need medicine during school hours? ****If yes, please contact the School Nurse to make arrangements.***

( ) Yes ( ) No **10. Has your child ever been examined by an eye doctor?**

Date of last exam: ______ Glasses Prescribed: **( ) Yes ( ) No**

If your child wears glasses or contact lenses, when was the prescription last changed? ______

( ) Yes ( ) No **11. What is the name of your child's dentist?** ______

What is the date of his/her last dental exam? ______

12. What is the name of your child's primary healthcare provider? ______

What is the date of his/her last physical exam? ______

( ) Yes ( ) No **13. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year? *If yes, please contact your School Nurse or School Counselor.**

( ) Yes ( ) No **14. Have you, your child or anyone in your household tested positive for COVID-19?** ****If yes, please contact the School Nurse.***

Parent/Guardian Signature: ______ **Date:** ______

Student:

Permission for Over the Counter Medication Administration

I give permission for my child to have the following; as determined by the nurse:

☐ Acetaminophen (Tylenol®)
☐ Ibuprofen (Advil®)
☐ Anbesol®
☐ Tums®
☐ Caladryl®
☐ Bacitracin/Antibiotic ointment
☐ Cough Drops

Parent/Guardian Signature: ____________ **Date:** ____________

DELAWARE EMERGENCY/NURSING TREATMENT CARD

Medical Information

Physician: ____________ Phone: ____________

Family Dentist: ____________ Phone: ____________

Indicate student's serious medical diagnoses: ____________

Student is allergic to: Medicine: ____________ Food: ____________ Other: ____________

Medical Insurance: Medicaid No.: ____________

Other: Certificate No.: ____________ Group No.: ____________ Type: ____________

The purpose of this form is to provide the school with information to be used for the care of a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures that will normally be followed in caring for your child when your child requires emergency assistance at school for either a medical or behavioral health concern. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.
7. The information on this form may be shared with emergency medical staff.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

Parent/Guardian Signature: ____________ **Date:** ____________

FOOD INSECURITY: **Colonial has programs to support families who have limited access to food. Please answer the following questions regarding your access to food for your family.**

Question		Often		Sometimes		Never
Within the past 12 months, we worried whether our food would run out before we got money to buy more.		Often		Sometimes		Never
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.		Often		Sometimes		Never

Student:	

SPECIAL CUSTODY INFORMATION: If child lives with other than natural mother or father, please indicate:		ADDITIONAL INFORMATION	
Name:		Has the student been expelled?	☐ Yes ☐ No
Relationship:		Has student been involved in Gifted Program?	☐ Yes ☐ No
Do custodial papers exist for this student? ☐ Yes ☐ No		**Does your child have (documentation required):**	
If yes, please provide a copy of the papers to keep on file.		An IEP (Individualized Education Plan)?	☐ Yes ☐ No
		504 Accommodation Plan?	☐ Yes ☐ No

EDUCATIONAL BACKGROUND: Please list your child's most recent school experience (including preschool if applicable).	
Name of person or program:	
Address:	
City, State, Zip:	
☐ Home/Babysitter ☐ Home Daycare ☐ Early Childhood	
Did your child receive any of the following services at the previous school? ☐ Special Education ☐ Title I ☐ ESL ☐ Other:	

SCHOOL AGE SIBLING INFORMATION											
Name:						Name:					
Age:		Grade:		Gender:	☐ Male ☐ Female	Age:		Grade:		Gender:	☐ Male ☐ Female
School:						School:					
Name:						Name:					
Age:		Grade:		Gender:	☐ Male ☐ Female	Age:		Grade:		Gender:	☐ Male ☐ Female
School:						School:					

DAYCARE ARRANGEMENTS	
Name:	
Address:	
City, State, Zip:	
Phone:	

TRANSPORTATION INFORMATION:			
	Please place a checkmark in the boxes that apply to your child.		If bus stop is different from home address, please list the address in this column.
To School	My child will be riding the bus to school from **home**		
	My child will be riding the bus to school from **daycare**		
	My child will walk to school each day		
	My child will be driven to school each day		
From School	My child will be riding the bus from school to **home**		
	My child will be riding the bus to a **daycare** after school		
	My child will walk home after school each day		
	My child will be picked up from school each day		

I certify that I am a current resident of the State of Delaware and that all 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 or invitation offer, and/or termination of school choice by the receiving local education agency to which I applied.

Parent/Guardian/Relative Caregiver Signature

Date

Information Regarding How the Colonial School District Shares Student Information

The Colonial School District recognizes the need to protect student information and privacy while promoting educational and extra-curricular activities in district and outside media. Federal law (FERPA) permits the district to release directory information under limited circumstances. Directory information is information about a student that is generally not considered an invasion of privacy, such as name, address, photograph, activities, and sports. If you wish to opt-out of the district releasing this information or including your child in articles and photos, please obtain an opt-out form from your child's school office.

DEPARTMENT OF EDUCATION
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DOE WEBSITE: http://www.doe.k12.de.us

Susan S. Bunting, Ed.D.
Secretary of Education
Voice: (302) 735-4000
FAX: (302) 739-4654

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.)

THE DELAWARE DEPARTMENT OF EDUCATION IS AN EQUAL OPPORTUNITY EMPLOYER. IT DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, GENDER IDENTITY, MARITAL STATUS, DISABILITY, AGE, GENETIC INFORMATION, OR VETERAN'S STATUS IN EMPLOYMENT, OR ITS PROGRAMS AND ACTIVITIES

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