

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.

- | | | | | |
|---------------------------------------|--|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infections | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bone/Spine | <input type="checkbox"/> Emotional | <input type="checkbox"/> Kidney | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Hearing | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Vision |
| <input type="checkbox"/> 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.

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:	
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SPECIAL CUSTODY INFORMATION: If child lives with other than natural mother or father, please indicate:		ADDITIONAL INFORMATION	
Name:		Has the student been expelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship:		Has student been involved in Gifted Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do custodial papers exist for this student? <input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		504 Accommodation Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<input type="checkbox"/> Home/Babysitter <input type="checkbox"/> Home Daycare <input type="checkbox"/> Early Childhood			
Did your child receive any of the following services at the previous school? <input type="checkbox"/> Special Education <input type="checkbox"/> Title I <input type="checkbox"/> ESL <input type="checkbox"/> Other:			

SCHOOL AGE SIBLING INFORMATION							
Name:				Name:			
Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
School:				School:			
Name:				Name:			
Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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.