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 verified:	
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 ☐ No
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 with staff and administration on a need to know basis, and with 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	☐ Behavior	☐ Bone Problem	☐ Diabetes	☐ Heart	☐ Physical Disability	☐ Surgery
☐ Allergies	☐ Bleeding	☐ Bowel/Bladder	☐ Emotional	☐ Infections	☐ Seizures	☐ Vision
☐ Asthma	☐ Body Piercing/Tattoo	☐ Chicken Pox	☐ Hearing	☐ Kidney	☐ Speech	☐ Other: _____

Comments: _____

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

To What?: _____ What Happens?: _____

Treatment: _____

3. Does your child have a food allergy? ☐ Yes ☐ No

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 nurse.

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 of providing my child with allergen-free school meals.

☐ **Yes.** I will provide the school nurse with a Food Allergy Action Plan completed by a licensed healthcare provider.

5. Has your child seen a healthcare provider since school ended in June? ☐ Yes ☐ No

What for? _____

6. Is your child being treated or evaluated for any health conditions? ☐ Yes ☐ No

List condition(s): _____

7. Is your child on any medication or treatment? ☐ Yes ☐ No

Name of medication or treatment: _____

Does your child need medication during school hours? ***If yes, please contact the school nurse to make arrangements***. ☐ Yes ☐ No

8. Has your child been prescribed glasses or contact lenses? ☐ Yes ☐ No

Date of last exam:_____ If your child wears glasses or contact lenses, when was the prescription last changed? _____

9. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June? ☐ Yes ☐ No

Please list: _____

Medical Information					
Family Physician:				Phone	
Family Dentist:				Phone	
Medical Insurance:				Type	
Certificate No:		Group No		Medicaid No:	

I give permission for my child to have the following over the counter medications as determined by the nurse *(check all that apply)*:

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

Parent/Guardian Signature: _____ **Date:** _____

School Emergency Procedures: Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. 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:**_____

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 SIBILING 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.		**Comments**: 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.

Student:	

DEPARTMENT OF EDUCATION

Townsend Building
401 Federal Street Suite 2
Dover, Delaware 19901-3639
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.)

Rev. 12.8.17