The Laurel School District
District Office
1160 S. Central Avenue
Laurel, Delaware 19956 · (302) 875-6100 · FAX (302) 875-6106

People. Practices. Performance.

Enrollment Checklist

Date:	**Student Name:**
Current Grade:	**Previous School/District:**

Below are the required documents that must be completed/provided prior to a student starting school.

ENROLLMENT PACKET:

_____ Student Enrollment Form
_____ Migrant Education Agricultural Work Survey
_____ Delaware Home Language Survey
_____ Parental Consent Form for Photographs
_____ Home Access Center Request Form
_____ Custody Concern Form
_____ Delaware McKinney-Vento Student Residency Questionnaire
_____ Delaware Emergency Treatment Card
_____ Delaware Tuberculosis Risk Assessment Questionnaire
_____ Health History Survey
_____ Medication Administration Information Card
_____ Student Health History Update
_____ Student Uniform Policy
_____ Bus Transportation Policy (Pre-K and Kindergarten students ONLY)

TO BE PROVIDED BY PARENT/GUARDIAN:

_____ Student's birth certificate
_____ Photo ID of Parent/Guardian
_____ Proof of Residency *(Proof that the student and parent/guardian live in the school's attendance zone; Acceptable forms: current lease, mortgage, or utility bill showing name and address.)*
_____ Immunization Record and Physical to include TB and Lead test results
_____ Student health insurance card
_____ Custody/Guardianship documents (when applicable)
_____ Relative Caregiver documents (when applicable)
_____ Copy of existing IEP/504 Plan (if currently receiving special services)

STUDENTS TRANSFERRING FROM ANOTHER SCHOOL (All the Above) and:

_____ Withdrawal form from previous school (with exit grades)
_____ Current Report Card and/or Transcript

Student class assignment/schedule and transportation will be provided two (2) days after all enrollment documents are received.

Revised 7/30/2018

Enrollment Form
The Laurel School District
1160 S. Central Avenue
Laurel, DE 19956
(302) 875-6100

OFFICE USE ONLY
Proof of Residence_____
Birth Certificate_____
Immunization Record_____
Student ID#_____
Homeroom_____
Entry Date_____

School:_____ Grade:_____

Student Name:_____
FIRST MIDDLE LAST

Gender: ☐ Male ☐ Female Date of Birth_____ Place of Birth_____

Gender Identity: ☐ Female ☐ Male ☐ Unspecified

What is the student's ethnicity? Hispanic or Latino OR Not Hispanic or Latino

Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Is the student/family in a temporary living arrangement? ☐ Yes ☐ No

If "Yes", is the temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Is the student in foster care? ☐ Yes ☐ No

Does your child currently receive special services? ☐ Yes ☐ No
If Yes, circle all that apply: IEP 504 Extra Reading/Math Help Speech English as a Second Language

PARENT/GUARDIAN INFORMATION

Parents are: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced

Student resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Relative Caregiver/Legal Guardian

Custody Situation (Must have custody papers)_____

PARENT/GUARDIAN #1

Name _____ Date of Birth_____

_____
Mailing Address Development

_____
Physical Address Development

Home Phone_____ Cell Phone_____

Employed By_____ Business Phone_____ Extension_____

PARENT/GUARDIAN #2

Name _____ Date of Birth_____

_____
Mailing Address Development

Revised 7/30/18; 8/6/19

COMPLETE OTHER SIDE ⟶

Physical Address _____ Development _____

Home Phone_____ Cell Phone_____

Employed By_____Business Phone_____Extension_____

Telephone number to receive Alert Now messages_____

EMAIL? Y / N (Please circle) If Yes, please supply email address_____

SIBLING INFORMATION

Name	Age	Grade	Name	Age	Grade
Name	Age	Grade	Name	Age	Grade

INFORMATION FROM SCHOOL LAST ATTENDED (including Pre-School)

Previous School/District_____ Grade_____

Address_____ Phone Number_____

TRANSPORTATION INFORMATION (If the student will be picked up or dropped off at a place other than his/her home address, you must provide the below information).

DAYCARE/CAREGIVER BUS PICK UP INFORMATION	DAYCARE/CAREGIVER BUS DROP OFF INFORMATION
Name:	Name:
Physical Address:	Physical Address:
Phone Number:	Phone Number:

EMERGENCY CONTACT INFORMATION (This person will be contacted in the event the parent/guardian isn't available).

1. Name:_____**Relationship**_____**Phone #**_____

Address:_____

2. Name:_____**Relationship**_____**Phone #**_____

Address:_____

Parent/Guardian Signature_____**Date**_____

The Wellness Center at
Laurel High School
1133 S. Central Avenue, Laurel, DE 19956
Phone: 302-875-6164 Fax: 302-875-6166

Dear Parent/Legal Guardian

We would like to invite you to enroll your child in the Laurel High School Wellness Center. We offer an array of health services dealing with physical health, mental health, education, nutrition and limited lab screenings. The Wellness Center operates as a partnership between the school, Delaware Division of Public Health and Nanticoke Health Services.

Due to changes mandated by the Division of Public Health (who fund the centers) insurances/Medicaid will now be billed for services rendered. Therefore, if you have private insurance or Medicaid it is now imperative that we have accurate, current insurance information. **Please provide a front and back copy of your child's current insurance card.** Please notify the Wellness Center and provide updated information if your child's insurance changes.

All students who enroll in the Wellness Center will be eligible to receive services regardless of their insurance status. The Wellness Center will not charge co-pays or out of pocket fees for services.

The parent/legal guardian may choose from a menu of services and can choose to enroll their student or not. Parents may receive documentation from insurance providers when students receive services through the center.

Laurel High School students in grades 9-12 may be enrolled in the Wellness Center by their parent or legal guardian.

If you have any questions or concerns please feel free to call us at 302-875-6164 or 302-875-6165. We look forward to taking care of your child in the future.

Sincerely,

Polly C. Pusey MSN, FNP-BC
Wellness Center Coordinator/NP

THE WELLNESS CENTER AT LAUREL HIGH SCHOOL
STAFF AND STUDENT RESPONSIBILITIES

STAFF RESPONSIBILITIES:

1. Center staff will provide each student with considerate, respectful, and appropriate care.

2. Each student will be informed of his/her medical condition(s), or counseling/nutritional plan. Each staff member will encourage students to talk with their family regarding their health concerns.

3. Center staff will not disclose information without student permission. Confidentiality, as required by law, will be maintained in all but the following circumstances:
    a. A student intends to harm self or others and there is a clear and immediate danger.
    b. Reporting child abuse of any kind.
    c. Reporting of certain contagious diseases to Division of Public Health.
    d. Response to legal subpoenas.

4. When possible, staff will schedule students during study halls. When schedules do not permit scheduling during study hall, appointments will be scheduled during class times but permission to leave class is at the discretion of the teacher.

STUDENT RESPONSIBILITIES:

1. To make appointments, students are expected to visit the Center before or after school, during lunch with pass, or with a signed consent from their teacher.

2. Students with appointments must always report to class first for attendance, teacher permission, and the teacher's signature on the pass.

3. Students may not come to the Wellness Center when a test is being given in their class; they need to reschedule any such appointment.

4. Students are responsible for informing the Center in advance if they need to cancel an appointment.

5. It is expected that students do not congregate in the Center if they do not have appointments, and that they respect the privacy of others and the property of the Center.

6. In keeping with standard medical practices, each student using the Center will complete a health history and health risk assessment. All information provided is confidential and will be used only as a means of assessing health risk behaviors.

7. Each student has the responsibility to answer questions honestly and provide all pertinent information concerning his/her health so that the most appropriate care can be planned.

8. Each student has the responsibility to make the health care provider aware if they have been given any information that they do not understand.

LAUREL SCHOOL-BASED WELLNESS CENTER
PARENT/STUDENT CONSENT FOR TREATMENT

I, _____, give my consent for _____
(Parent/Legal Guardian of Student) (Name of Student)

to receive health services at the Laurel High School Wellness Center administered by Nanticoke Health Services Wellness Center Telephone Number: 302-875-6164

Note: Parents/legal guardians have a right to information about any services provided to minor (less than 18 years) children/teens other than those identified as Reproductive health/Confidential Services.

MENU OF SERVICES

1. PHYSICAL HEALTH
   - **Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury**
     (May include a urinalysis, throat culture, limited blood test, medically indicated pregnancy tests*, dispensing prescription/non-prescription medication and/or providing prescriptions for medication). Services will be coordinated with the student's primary care provider if deemed appropriate)
   - **Physical examinations** (i.e. sports/employment/college physicals)
   - **Immunizations** in accordance with the Division of Public Health Policy (Immunizations are NOT given to minor students without additional request and consents completed by parents/legal guardians)
   - **Nutritional counseling**

2. COUNSELING
   - **Individual or group counseling,** including stress management
   - **Drug, alcohol and other substance counseling** and referral if deemed appropriate

3. EDUCATION
   - **Individual and group programs** focusing on healthy life choices

4. REPRODUCTIVE HEALTH (CONFIDENTIAL SERVICES)*
   - **Condoms**
   - **Oral contraception to prevent pregnancy**
   - **Diagnosis and treatment of sexually transmitted diseases**

5. DEPO-PROVERA INJECTABLE BIRTH CONTROL OPTION (CONFIDENTIAL SERVICE)
   - **Depo-Provera is a shot given to females every 3 months to prevent pregnancy.**
     For more information visit: http://www.dhss.delaware.gov/dph/chca/dphcontraceptives.html

* According to Delaware Law (Title 13 §710) students age 12 years and older may request that information pertaining to services listed below be kept confidential

Please circle the number of any of the above services you WOULD NOT like your child to receive at the Wellness Center ("declined services").

The Wellness Center does NOT provide the following services:

- Treatment or testing of complex medical or psychiatric conditions
- Ongoing primary treatment of chronic medical conditions
- Complex lab tests
- Hospitalization
- X-Rays

PLEASE COMPLETE OTHER SIDE
PLEASE COMPLETE OTHER SIDE

By my signature below I agree, as the parent or legal guardian of the student named above, that he/she may receive services at the School-Based Wellness Center (the "Wellness Center") other than those specifically declined.

The Laurel School Board has approved that diagnosis and treatment of sexually transmitted diseases, HIV testing/counseling, and reproductive health services be provided in the Wellness Center. These services are considered confidential according to state law, and are designated "confidential" on the other side of this form. I understand that if I consent to my son/daughter receiving these services at the Wellness Center that:

- I do not have the right to access information about confidential services provided to my son/daughter, unless my son/daughter gives permission to the Wellness Center to share that information with me.

It is the Wellness Center's philosophy that parents/guardians should be involved in their child's care. Therefore, the Wellness Center strongly encourages communication and involvement among students, parents and medical providers. I have the right to know about medical care my son/daughter receives for all services that are not considered confidential according to law.

School-Based Wellness Centers are funded through state funds and reimbursement from insurance for those students who have insurance. If my son/daughter has insurance I will provide this information to the Wellness Center. I understand that the Wellness Center may bill my insurance for covered services, however the Wellness Center will not charge co-pays or out-of-pocket fees to students for services rendered. I understand that my son/daughter can receive services at the Wellness Center regardless of ability to pay.

The Division of Public Health (DPH) retains administrative authority for School-Based Wellness Centers. Designated Wellness Team members are obligated by law to disclose specific patient information to DPH for the purpose of preventing or controlling disease, injury, surveillance, or disability in Delaware and in the US. Information that will be reported includes: sexually transmitted disease, laboratory data, births, deaths, adverse medication reactions, child abuse or neglect, and domestic violence. Students enrolled in School-Based Wellness Centers may be asked to complete the Delaware School Based Health Center Periodic Questionnaire annually to identify health concerns. Other general information may be sent to DPH for statistical tracking, but this information will be de-identified during analysis, which means my son's/daughter's name will be removed. Information about services may be shared with my health insurance company for purposes of quality improvement.

I understand that this consent can be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the Wellness Center.

My son/daughter and I have read this form carefully and I understand that if I have any questions I may call the Wellness Center Coordinator for more information before I sign this authorization.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Print Name of Parent/Legal Guardian

_____ _____

Signature of Student Date

_____

Print Name of Student

_____

Address, City, State, Zip

Laurel Wellness Center
Student Registration Form

Student Information — Please Print In Ink

Today's Date:	Primary Care Provider:		
Patient's Last Name: First: Middle:		Male ☐	Female ☐
Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native		Ethnicity (please circle): Hispanic/Latino Arabic Non-hispanic/latino/arabic	
Address:		Home Phone#:	
SSN#:	Birth date:		
School		Grade: 9 10 11 12	

Parental/Legal Guardian Information

Mother's Full Legal Name:	SSN#: (optional)	Birth date:
Address:	Cell Phone#:	
Employer Name & Address:	Employer Phone#:	
Father's Full Legal Name:	SSN#: (optional)	Birth date:
Address:	Cell Phone#:	
Employer Name & Address:	Employer Phone#:	
Legal Guardian Name (if not mother or father):	SSN#: (optional)	Birth date:
Address:	Cell Phone#:	
Employer Name & Address:	Employer Phone#:	

Insurance Information

Medicaid #:	Name of Medicaid Health Plan:			
Is Medicaid your only insurance? Yes No	If Medicaid is NOT your only insurance, or you do not have Medicaid, please list your information below.			
Primary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
Secondary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
In case of an emergency contact:	Relationship to patient:		Phone #:	
Is patient employed? Yes No	Patient's yearly income (optional)			

Patient/Legal Guardian Signature: Date:

A complete and accurate health history is needed in order for Center staff to provide high quality health care. Services will not be provided unless these forms are completed.

Birth Country: United States Mexico France Germany Spain Brazil Other

Household : Student lives with (circle all that apply): Both Parents Father only Mother only

Lives alone/independent Student is a Parent Extended Family/Relative(s)

Is the home address you provided above: Permanent/Stable Foster Care Shelter Institution

Unstable/Inadequate Host Family(AFS) Other

Will your son/daughter be participating in the State Subsidized School Lunch Program this year? Y N

Is your son/daughter enrolled in Special Education courses? Y N

Has your child seen a health provider in the last year? Y N
If yes, please indicate the # of visits_____ and the reason _____

Has your child been seen in an Emergency Room in the last year? Y N
If yes, please indicate the # of visits _____ and the reason _____

Do you have any worries or questions about your teen's physical or emotional health? _____ No _____ Yes

If so, what are they? _____

_____

Has your teen ever been hospitalized for more than one day and/or had any surgery? _____ No _____ Yes

If yes, when? _____ What Hospital? _____

Reason: _____

Do any family members (parents, brother, sister, grandparents, aunts, uncles, etc.) have any of these problems or have they had them in the past? If yes, please indicate which family member(s) next to the appropriate illness.

_____ High blood pressure
_____ Heart disease/heart attacks
_____ Mental Illness
_____ Cancer (please list type)_____
_____ Diabetes (sugar)
_____ Thyroid disease
_____ Tuberculosis
____ High cholesterol
____ Stroke
____ Kidney disease
_____Asthma
_____Sickle Cell
_____Drug/Alcohol Addiction

(Mothers only) If you took any medication other than vitamins or iron while you were pregnant with your son/daughter, please list below:

_____

Please indicate any of the following illnesses or problems that your teen has ever had:

___ Asthma
___ Rheumatic heart disease
___ Convulsions
___ Ulcers
___ Fainting spells
___ Attempted suicide
___ Sleeping problems
___ Anemia
___ High blood pressure
___ Heart murmur
___ Epileptic seizures
___ Tuberculosis
___ Head injury
___ Frequent ear infections
___ Arthritis
___ Sickle Cell Anemia
___ Colitis/stomach problems
___ Measles
___ Diabetes
___ Frequent headaches
___ Skin Problems
___ Thyroid
___ Kidney disease
___ Chicken Pox
___ Mumps
___ Hemophilia

___Other (please explain)_____

Please list any allergies your son or daughter has _____

Please list any regular medication your son or daughter takes _____

Please indicate your preferred pharmacy _____ Phone_____

If you have any additional questions or concerns please call the Wellness Center at 302-875-6164 0r 302-875-6165.

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.

*Date*_____ *Parent/Guardian's Signature*_____

*Student*_____ *DOB:*_____ *Grade*_____ *Teacher*_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1.

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

[ ] OTHER_____

Comments:_____

_____

2. Does your child have allergies to medicine, food, latex or insect bites?

   NO [ ] YES [ ] To What_____ What happens_____

   Treatment_____

3. Has your child had any illnesses since school ended in June?

   NO [ ] YES [ ] Type of illness, with date(s)_____

4. Has your child had surgery since school ended in June?

   NO [ ] YES [ ] Type of surgery, with date(s)_____

5. Has your child received any immunizations since school ended in June?

   NO [ ] YES [ ] List immunizations, with dates_____

6. Is your child being treated or evaluated for any health conditions?

   NO [ ] YES [ ] List condition_____

7. Is your child on any medication or treatment?

   NO [ ] YES [ ] Name of medication and/or treatment_____

   Does your child need medicine during school hours?

   NO [ ] YES [ ] ***If yes, please contact the school nurse to make arrangements.***

8. Has your child ever been examined by an eye doctor?

   NO [ ] YES [ ] Date of last exam_____

   NO [ ] YES [ ] Glasses Prescribed

   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?

   NO [ ] YES [ ] List_____

10. What is the name of your child's dentist? _____

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

11. What is the name of your child's primary healthcare provider? _____

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

LAUREL SCHOOL DISTRICT

Child's Name: _____ Date: _____

Health History Survey

Please answer each question by writing an X in the appropriate box and providing the information requested.

	No	Yes
Has your child received all immunizations?		
Is your child on any medications? If yes, what? _____		
Has your child had a physical in the last year?		
Has your child received a TB (tuberculosis) skin test?		
Has your child had chicken pox?		
Has your child had red or hard measles?		
Has your child had German or three-day measles (rubella)		
Has your child had any other illnesses? If yes, what? _____		
Does your child have vision problems? If yes, what? _____		
Does your child wear glasses / corrective lenses?		
Does your child have chronic ear infections?		
Does your child have tubes in ear?		
Does your child wear hearing aids?		
Does your child have any hearing problems? If yes, what? _____		
Does your child have any allergies? If yes, what? _____		
Does your child have asthma?		
Does your child have heart problems? If yes, what? _____		
Has your child ever had a serious accident (for example, broken bones, bad cuts, poisoning)? If yes, what? _____		

	No	Yes
Does your child have Epilepsy?		
Does your child have Hay fever?		
Does your child have Diabetes?		
Does your child have Hemophilia (free bleeding)?		
Does your child have Rheumatic fever?		
Does your child have Cystic Fibrosis?		
Does your child have Muscular Dystrophy?		
Does your child have Cancer? If yes, what? _____		
Does your child have severe reaction to insect bites?		
Does your child have any physical handicaps? If yes, what? _____		
Does your child have mental handicaps (ie. Autism, developmental delay)? If yes, what? _____		
Does your child have any other health problems? If yes, what? _____		
Has your child ever seen, or is your child currently seeing a medical specialist (for example cardiologist, neurologist)? If yes, what? _____		
Has your child ever been hospitalized? If yes, for what reason? _____		

Please continue to back side of form.....

DELAWARE EMERGENCY TREATMENT DATA CARD

Student's Name _____ Birth Date _____

School _____ Grade_____ Teacher _____

Home Address _____ Home Phone Number _____

Resides with _____ Relationship _____

Mother/Guardian's Name _____ Father/Guardian's Name _____

Mother's Place of Employment _____ Phone _____ Cell Phone _____

Father's Place of Employment _____ Phone _____ Cell Phone _____

If Parent/Guardian cannot be reached, call:

1. _____

(NAME) (ADDRESS) (PHONE)

2. _____

(NAME) (ADDRESS) (PHONE)

3. _____

(NAME) (ADDRESS) (PHONE)

Family Physician _____

(NAME) (ADDRESS) (PHONE)

Indicate student's medical conditions:

_____

Student is allergic to: Medications: _____ Foods: _____

Latex_____ Environment (stings / pollen/ etc)_____

Other: _____ Does your child require an Epi pen _____

Medical Insurance: ____**Medicaid** _____**Other** *Certificate #*_____ *Group#*_____

*Type*_____

Your school has adopted the following procedures when she becomes sick or injured at school:
In case of a life-threatening emergency, the school will call 911 and then follow the step below. In case of other emergencies and/or need of medical or hospital care:
The school will call the home. If there is no answer,
The school will call the father's, mother's or guardian's place of employment. If there is no answer,
The school will call the other telephone number(s) listed
If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility
Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility
The school will continue to call parents, guardians, or physician until one is reached. 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, diagnosis procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

"This information may be shared only on a "need to know" basis with school personnel and emergency medical staff."

Parent/Guardian"s Signature _____ Date _____

DELAWARE DEPARTMENT OF EDUCATION
Tuberculosis (TB) Risk Assessment Questionnaire for Students[1]

Prior to use of this form, the school nurse must review the student's health record and assure that the student is compliant with the requirements for a current health examination (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person, or by phone, and signed by the person who answered the questions.

Name:_____
Last First MI

Date of Birth:____/____/____ Date Form Completed___/_ /___

1. Has your child had close contact[2] with anyone with an active infectious TB disease?
2. Was any household member, including your child, born in or has he/she traveled to area(s) where TB is common? Per the Delaware Division of Public Health, this includes birth, travel or residency in a country with an elevated TB rate for at least 1 month. This includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB (i.e., those who are HIV infected, homeless[3], incarcerated[4], and/or illicit drug users)?
4. Does your child have a history of HIV infection, living in a shelter, incarceration, or illicit drug use?
5. Does your child have any health conditions or take medications that might affect his/her immune system?
6. Has your child ever had a positive test for tuberculosis?

Any "yes" response to questions 1 - 5 is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test or a TB blood test, such as The Quantiferon Gold TB Test, to the child.

A "yes" response to question 1 -6 indicates probable previous exposure to TB, and requires medical follow-up to evaluate medical status.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

☐ **Does <u>not</u>** require a Tuberculosis Test ☐ **Does** require documentation related to current disease status

☐ **Does** require a Tuberculosis Test

TB testing and documentation must be completed and given to the school nurse by_____/_____/____(date) or your child will be excluded from school.

School Nurse Comments:_____

_____

School Nurse (signature) _____

Parent/Guardian (signature) _____

I give permission for the school nurse and my child's primary care physician _
(name of physician) to share information relating to this form.

Name_____ Date

_____Parent/Guardian (signature)

[1]TB assessment is required by Regulation 805, http://regulations.delaware.gov/AdminCode/title14/800/805. The questionnaire was developed by Delaware Department of Education and the Division of Public Health. Revised 7/1/13, 5/2015, 4/2018, 8/22/2019

[2]CDC describes "close contact" as prolonged, frequent, or intense contact with a person with TB, while he/she was in infectious.

[3]The term "homeless" means a situation where the person lived in a shelter or with others.

[4]Incarceration should be longer than one week.

DELAWARE INTERSCHOLASTIC ATHLETIC ASSOCIATION

Parents/Guardian: There are 7 pages in the DIAA pre-participation physical evaluation (PPE) and consents form. Pages one, two and four require your signature while pages five, six and seven are references for you to keep. The physician must sign page 3 on or after April 1; the physical examination must have been conducted within 12 months of the physician's signature; and the PPE is valid through June 30 of the following school year.

Athlete: _____ Phone: _____ School: _____

Age: _____ Gender: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: (Please Print: _____

PARENT/GUARDIAN/STUDENT CONSENTS

_____ Has my permission to participate in all interscholastic sports NOT checked below?
(Name of Athlete)

NOTE- If you check any sport below the athlete will NOT be permitted to participate in that sport.

	Baseball		Basketball		Cheerleading		Cross Country		Crew
	Field Hockey		Football		Golf		Ice Hockey		Lacrosse (B)
	Lacrosse (G)		Soccer		Softball		Squash		Swimming
	Tennis		Track		Volleyball		Wrestling		

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the **Parent/Player Concussion Information Form; Symptoms and Risk Factor for Sudden Cardiac Arrest form;** and the list of items that protect against the loss of athletic eligibility, with said participant and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities NOT checked above.

   Parent Signature: _____ **Date:** _____

   Student Signature: _____ **Date:** _____

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

   Parent Signature: _____ **Date:** _____

3. I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

   Parent Signature: _____ **Date:** _____

4. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

   Parent Signature: _____ Date: _____

5. By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

   Parent Signature: _____ Date: _____

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and if you do not practice abstinence are you using protection?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ___/___ (___/___) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PM)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Provider (Print/type) _____ Date _____

Address _____ Phone _____

Signature of Health Care Provider _____, MD, DO, PA, or NP

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: CONTACT/PERSONAL INFORMATION

NAME:_____ SPORT(S):_____

AGE:_____GRADE:_____ BIRTH DATE:_____ GUARDIAN NAME:

ADDRESS:_____

PHONE: (H)_____ (W)_____ (C)_____(P)_____

Other authorized person to contact in case of emergency:

NAME:_____PHONE(s):

NAME:_____PHONE(s):_____

Preference of Physician (and permission to contact if needed):

NAME:_____ PHONE:_____

HOSPITAL PREFERENCE:_____INSURANCE:_____

POLICY #:_____ GROUP:_____PHONE:_____

Section 2: MEDICAL INFORMATION

MEDICAL ILLNESSES:_____

LAST TETANUS (mo/yr):_____ALLERGIES:_____

MEDICATIONS:_____

(any medications that may be taken during competition require a physician's note)

PREVIOUS HEAD/NECK/BACK INJURY:_____

HEAT DISORDER, OR SICKLE CELL TRAIT:_____

PREVIOUS SIGNIFICANT INJURIES: _____

ANY OTHER IMPORTANT MEDICAL INFORMATION:_____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

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

Athlete's Signature:_____ **Date:**_____

Section 4: Clearance for Participation

__ Cleared without restrictions __ Cleared with the following restrictions:

Health Care Provider's Signature:_____MD/DO, PA,NP Date:_____

For office use only: This card is valid from April 1, 20_____ through June 30, 20_____

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: _____ *Name of ATC:* _____

PROTECT YOUR ATHLETIC ELIGIBILITY

YOU ARE NOT ELIGIBLE:

1. If you attend a high school and become 19 years of age before June 15 immediately preceding that school year. (Reg. 1009.2.1.1)
2. If you attend a junior high/middle school that terminates in the 8th grade and become 15 years of age before June 15 immediately preceding that school year. (Reg. 1008.2.1.1.1)

*3. If you are not legally enrolled at the school which you represent. (Reg. 1008.2.3.1 and Reg. 1009.2.3.1)

4. If you are not residing with your custodial parent(s), court appointed legal guardian(s), Relative Caregiver, or are a student 18 years of age or older and living in the attendance zone of the school you attend unless you are participating in the Delaware School Choice Program, attend a private school or are a boarding school student. **IF YOUR CUSTODIAL PARENT(S), LEGAL GUARDIAN(S) OR RELATIVE CAREGIVER(S) RELOCATES TO A DIFFERENT ATTENDANCE ZONE, YOU MUST NOTIFY YOUR ATHLETIC DIRECTOR IMMEDIATELY.** (Reg. 1008.2.2.1 and Reg. 1009.2.2.1)

*5. *If you were absent unexcused or absent due to illness or injury; have been suspended (in-school or out-of-school); or have been assigned to homebound instruction or an alternative school for disciplinary reasons.* (Reg. 1008.2.3.4 and 1008.2.3.5 Reg. 1009.2.3.5 and 1009.2.3.6)

6. If you failed to complete the preceding semester for reasons other than personal illness or injury. (Reg. 1008.2.3.6; Reg. 1009.2.3.7)

*7. If you do not pursue a regular course of study and pass at least five credits per marking period (equivalent of four credits in junior high/middle school), two credits of which must be in the areas of Mathematics, Science, English, or Social Studies. **IF YOU ARE A SENIOR, YOU MUST PASS ALL COURSES WHICH SATISFY AN UNMET GRADUATION REQUIREMENT.** (Reg. 1008.2.6.; Reg. 1009.2.6.1)

8. A student who has previously participated in interscholastic athletics that transfers more than one time during their first year of eligibility shall be ineligible in any sport for a period of ninety (90) school days commencing with the first day of official attendance in the receiving school. The period of ineligibility shall continue to the next grade/school year until 90 school days have passed.
9. If you transfer after the first day of school of your second year of high school, you are ineligible to participate in any sport you previously participated in for a period of one school year (Reg. 1009.2.4)
10. If you participated in the Delaware School Choice Program during the previous academic year and transferred to your "home school" for the current academic year without completing your two-year commitment or receiving a release from the sending school. (Reg. 1008.2.3.3; Reg. 1009.2.3.4)
11. If you participated in the Delaware School Choice Program during the previous academic year and transferred to another "choice school" for the current academic year unless you are playing a sport not sponsored by the sending school. (Reg. 1008.2.4.6.1; Reg. 1009.2.4.7.1)
12. If you reached the age of majority (18), occupied a residence in a different attendance zone than your custodial parent(s) or court appointed legal guardian(s), and have not been in regular attendance at your receiving school for at least 90 school days unless you are participating in the Delaware School Choice Program and your application was properly submitted prior to your change of residence. (Reg. 1009.2.2.1.7)
13. If you attend a high school and more than four years has elapsed since you first entered 9th grade, or more than five years has elapsed since you just entered 8th grade in schools with 8th grade eligibility for high school sports. (Reg. 1009.2.7.1 and 2.7.2.1)
14. **If you attend a junior high/middle school in which only grades 7-8 are permitted to participate in interscholastic athletics and more than two years has elapsed since you first entered 7th grade. (Reg. 1008.2.7.1)**
15. **If you attend a junior high/middle school in which grades 6-8 are permitted to participate in interscholastic athletics and more than three years has elapsed since you first entered 6th grade. (Reg. 1008.2.7.2)**
16. If you have played on or against a professional team or have accepted cash or a cash equivalent (savings bond, certificate of deposit, etc.); a merchandise item(s) with an aggregate retail value of more than $150; a merchandise discount; a reduction or waiver of fees; a gift certificate or other valuable consideration for athletic participation. (Reg. 1009.2.5.1.4 and 2.5.1.5)
17. If you have used your athletic status to promote a commercial product or service in an advertisement or personal appearance. (Reg. 1009.2.5.1.7)
18. If you have not received a physical examination from a licensed physician (M.D. or D.O.), a certified nurse practitioner or a certified physician's assistant on or after April 1 and written consent from your custodial parent(s) or court appointed legal guardian(s) to participate in interscholastic athletics is not on file in the school office. (Reg. 1009.3.1.1.1 and Reg. 1008.3.1.1)
19. If you participate in an all-star game not approved by DIAA before you graduate from high school. (Reg. 1009.5.4)
20. If you are a foreign exchange student not participating in a two-semester program listed by the Council on Standards for International Educational Travel (CSIET). (Reg. 1009.2.8.1.2)
21. If you are an international student not in compliance with all DIAA regulations including Reg. 1009.2.2 residency requirements. (Reg. 1009.2.8.2)

*IF YOU ARE NOT IN COMPLIANCE WITH THESE REQUIREMENTS, YOU MAY NOT TRY-OUT,PRACTICE, SCRIMMAGE OR PLAY IN A GAME.

NOTE: Consult with your coach, athletic director, or principal for information concerning additional eligibility requirements.

Delaware Interscholastic Athletic Association

Parent/ Player Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

Headaches	Pressure in head	Nausea or vomiting
Neck pain	Balance problems	Dizziness
Disturbed vision	Light/noise sensitivity	Sluggish
Feeling foggy	Drowsiness	Changes in sleep
Amnesia	"Don't feel right"	Low energy
Sadness	Nervousness	Irritability
Confusion	Repeating questions	Poor Concentration

Teammates, parents and coaches may notice these:

Appears dazed	Vacant facial expression
Confused about assignment	Forgets plays
Unsure of game/score, etc.	Clumsy
Responds slowly	Personality changes
Seizures	Behavior changes
Loss of consciousness	Uncoordinated
Can't recall events before or after hit	

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. The injury may also require the student to be withheld from school until cleared by the physician. Close observation of the athlete should continue for several hours. You should also inform your child's coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information from the CDC on concussions you can go to:
http://www.cdc.gov/concussion/HeadsUp/youth.html

For a current update of DIAA policies and procedures on concussions you can go to:
http://www.doe.k12.de.us/diaa

For a free online training video on concussions you can go to:
http://nfhslearn.com/

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.

Adapted from the KHSAA, CDC and 3rd International Conference on Concussion in Sport, 4/2011

SUDDEN CARDIAC ARREST AWARENESS FORM

Revised August 2013

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- The DIAA *Pre-Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?

- Contact your primary care physician
- American Heart Association (www.heart.org)
- August Heart (www.augustheart.org)
- Championship Hearts Foundation (www.champhearts.org)
- Cypress ECG Project (www.cypressecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)

Delaware Department of Education

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

Dear Parent/ Guardian,

Date: _____

In order to serve your child, _____, the _____ District/Charter School is
(Insert District/Charter School Name)
helping the State of Delaware identify students who may qualify to receive additional education and support services.

The information provided below will be kept confidential with in the Department of Education and will be used for planning purposes only. Please answer the following questions 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; 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 Title I, Part C Office within 10 days of the student's enrollment by State Mail Code D370B or by U.S. Postal Service to 401 Federal Street, Suite 2, Dover, DE 19901. 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.

Depatman Edikasyon Delaware
Pwogram Edikasyon pou Migran
Sondaj Travay Agrikòl

Chè Paran(yo),

Nan lide pou pi byen sèvi pitit ou a, _____, _____la_____Distri
(Antre Distri lekòl/ Chatè)

Lekòl/Chatè yo ap ede Eta Delaware idantifye elèv ki ka kalifye pou resevwa plis edikasyon ak sèvis sipò.

Enfòmasyon yo bay pi ba ap rete konfidansyèl. Tanpri reponn kesyon sa yo epi retounen fòm sa a nan lekòl pitit ou .

1) Nan twa (3) dènye ane yo, eske fanmi ou te chanje soti nan : a) yon distri lekòl pou al nan yon lòt ; b) yon eta pou ale nan yon lot eta ; c) yon lòt peyi pou vin nan US
_____Wi _____Non

Si w reponn « Non » ou pa bezwen ranpli res sondaj la. Si w repon « Wi » tanpri kontinye.

2) Eske rezon kif è chanjman sa yo sete pou w chache si w jwen oswa aksepte yon djob nan jaden oswa nan yon nan aktivite sa yo ki nan lis anba a. Reponn kesyon sa a mem si w gen yon lòt kalite travay kl diferan kounye a.
_____Wi _____Non

Si "wi", tanpri fè yon sèk tout sa ki aplike si ou menm oswa mari ou / madanm, oswa yon moun lakay ou te travay ak yo, sou, oswa nan yon:

fèm	Usine ki prepare poul	Fwi a kepis sech epi santibon	Pepinyè / lakòz efè tèmik
letye	Usine kote yo prepare vyann / pwason	Kote yo van sèl pwason	Kote yo plante pye bwa oswa rekòlte
elvaj	Kote ki gen Cseriz	Usine Kote yo anbale vyann ak manje	Faktory kote yo met manje nan mamit
konsèrveri	Ji fresh / jele	dyondyon	Preparasyon manje pou bet
Kay Poul	Lapèch	Plante ,ranmase, anbale fwi, legim, vyan, nwa	Netwayaj, saklay te plantasyon

Tanpri ajoute nenpòt lòt travay ki gen rapò ak aktivite agrikòl oswa lapèch ke w ka fè :_____
_____

Tanpri fè lis tout ti moun laky ou ki gen laj 3-21 ane. Mete sak pa inskri nan lekol tou

Non/sinyati	Dat timoun nan fèt	Laj li	Clas li	Lekòl li

Paran/ moun responsab :_____ Dat :_____

Apt. No _____Katye _____Kòd _____

Phone _____Pi bon lè pou rele w _____AM/PM Lòt telefòn/ selilè Nimero telefòn li _____

DISTRICTS: 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. The ORIGINAL document must be submitted to the Delaware Department of Education Migrant Education Program Office via State mail to Code D370B or by U.S. Postal Service to 401 Federal Street, Suite 2, Dover, DE 19901.

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

Delaware Department of Education

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

Departamento de Educación de Delaware - Encuesta sobre el idioma que se habla en el hogar

Spanish

Fecha: _____ **Escuela:** _____

El Departamento de Educación de Delaware exige a las escuelas que determinen el/los idioma(s) que los estudiantes hablan en el hogar. La información proporcionada solo será utilizada para decidir si el estudiante reúne los requisitos para comenzar el proceso de adquisición del inglés como segunda lengua y no será utilizada para temas relacionados con la inmigración ni se informará a las autoridades migratorias.

Información sobre el estudiante			
Nombre:		**País de origen:**	
Apellido:		**Fecha de ingreso en EE. UU.:**	
Fecha de nacimiento:		**Fecha en la que el estudiante se inscribió por primera vez en una escuela de EE. UU.:**	

Haga un círculo en los grados a los que su hijo asistió en escuelas de EE. UU.

PK K 1 2 3 4 5 6 7 8 9 10 11 12

¿Durante cuántos meses el estudiante ha estado inscripto en una escuela de EE. UU? _____

1. ¿Cuál fue el primer idioma que aprendió su hijo?

   Idioma: _____ | Dialecto: _____

2. ¿Cuál es el idioma que su hijo usa con mayor frecuencia en el hogar?

   Idioma: _____ | Dialecto: _____

3. ¿Cuál es el idioma que usted utiliza con más frecuencia para hablar con su hijo?

   Idioma: _____ | Dialecto: _____

4. ¿Qué idioma (s) aparte del inglés se hablan en su casa?

   Idioma: _____ | Dialecto: _____

5. ¿Con qué idioma preferiría recibir información de la escuela?

   Idioma: _____ | Dialecto: _____

_____ _____ _____

Nombre del padre Firma del padre Fecha

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 Laurel School District
District Office
1160 S. Central Avenue
Laurel, Delaware 19956 • (302) 875-6100 • FAX (302) 875-6106
People. Practices. Performance.

PARENTAL CONSENT FORM
RELEASE OF CHILD'S PHOTOGRAPH AND OTHER INFORMATION

During each school year, occasions arise when students are photographed or interviewed by school district officials during special events such as assemblies, awards presentations, concerts, sporting evets and education-related news reports. For the protection of every student, we seek parental permission prior to a child's photograph and name being published in local newspapers, district press releases, informational pamphlets, the district newsletter, the school district calendar and school and/or district web sites.

Please indicate your preference below and return this form to your child's school. If this form is not returned, it will be implied that permission is NOT granted. This form does not apply to yearbook photos. All students' images will appear in the yearbook unless that parent makes a separate request to the school principal for his/her child's photo to be excluded.

Check one:

_____ **YES,** I grant permission for my child _____(name) to have his/her photograph taken, to be interviewed by the media and to have his/her name and /or image and likeness published.

_____ **NO,** I do not grant permission for my child _____ to have his/her photograph taken, to be interviewed by the media and/or to have his/ her name published.

Student's Name: (please print) _____ Student's Grade_____

Print name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date:_____

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Home Access Center Request Form

The Laurel School District offers Home Access Center as a complimentary service provided by the state of Delaware. Home Access Center is an online communication tool between the school and home that will allow parents and guardians with school authorized accounts and passwords to view limited student information from the eSchoolPLUS database through the internet. The required information must be completed below for an account to be established. For families who are unsure of account status or new to Home Access Center an email will be generated to the email address listed below to complete sign-up.

Home Access Center Account Information:

Parent/Guardian Name: _____
Email Address: _____
Student Name: _____
ID#: _____ **Grade:** _____
School: _____

_____ I currently have a Home Access Account.
_____ I do not have a Home Access Account and would like to sign-up.
_____ I am unsure if I have a Home Access Account.

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

For Office Use Only

Authorization Granted By _____

Authorization Date _____

Revised 7/30/2018

Delaware Department of Education

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', you may stop here. You do not need to complete this form.

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 8/2017)

Request for Permission to Evaluate

LAUREL SCHOOL DISTRICT - Office of Special Education
1160 S. Central Avenue - Laurel, DE 19956 (302) 875-6105

Date: _____ Student Date of Birth: _____

Dear Parent:

To assure that your child, _____, has an appropriate educational program, the Laurel School District would like to provide an evaluation for your child. This student has been referred for the following reasons: *transfer student currently receiving special education services.*

Our plan for evaluation includes: (Type of Test/Procedure)

education assessment (as needed)

psychological assessment (as needed)

speech/language assessment (as needed)

If this evaluation shows that your child is eligible for special educational programs and services, we will ask for your assistance in preparing an individualized educational program.

You may already have enough information to reach a decision about evaluation without reviewing records or requesting a conference. If this is the case, please indicate your decision by signing in the appropriate space. If you do not agree to this evaluation, the District will not conduct it without first having a hearing on the matter. Enclosed for your information is a copy of procedural safeguards applicable to the identification, evaluation, and placement of children with disabilities.

Please return this letter in the enclosed addressed envelope within ten (10) days of receipt. Thank you for your cooperation.

_____ _____
Name Telephone Number
Educational Diagnostician

Yes	NO
If you **AGREE** to an evaluation as outlined above, please sign below; you may revoke this permission at any time.	If you do **NOT AGREE** to an evaluation as outlined above, at this time, please sign below. We will contact you to arrange a personal conference as soon as possible. You also have the right to request a hearing concerning this proposed evaluation.
_____ (Signature of parent, guardian or surrogate parent, or student if over 18 years of age)	_____ (Signature of parent, guardian or surrogate parent, or student if over 18 years of age)
(Date) _____	(Date) _____
(Phone Number) _____	(Phone Number) _____

Special Education Placement for Transfer Students

LAUREL SCHOOL DISTRICT - *Office of Special Education*
1160 S. Central Avenue - Laurel, DE 19956 - (302) 875-6105

Parent Section

I. Student Name: _____ Grade: _____

Date of Birth: _____

Entry Date: _____

School Enrolling in: Laurel Elementary School ☐ Laurel Middle School ☐

North Laurel Early Learning Academy ☐ Laurel High School ☐

School Withdrawing From: _____ Phone _____

Educational Diagnostician Section

II. Documentation of Telephone Conference

Date: _____ Person: _____ Title: _____

Pertinent Information

Classification: _____ Time Per Day Part Time ☐ Full Time ☐

Subjects in Special Education: _____

III. Least Restrictive Environment

Placement: Pullout ☐

Inclusion Half Day ☐ Full Day ☐

Special Discipline ☐

Date of Last Evaluation Report _____

Other Information

Mainstreamed For _____ _____ _____

IV. Temporary Placement

Classification _____ *(same as above)*

Time Per Day _____

LRE _____

V. Records Requested _____ *(date)*

Records Received _____ *(date)*

IEP Scheduled _____ *(date)*

Copy to Teacher ☐

Laurel School District – Laurel, Delaware

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

State of Delaware

☐ North Laurel Early Learning Academy
600 Wilson Street
Laurel, DE 19956
(302) 875-6130

☐ Laurel Elementary School
815 South Central Ave
Laurel, DE 19956
(302) 875-6140

☐ Laurel Middle School
1131 S. Central Ave
Laurel, DE 19956
(302) 875-6110

☐ Laurel High School
1133 S. Central Ave.
Laurel, DE 19956
(302) 875-6120

Student Identification Information

Student Name _____ Parent/Guardian/Surrogate (Circle One) _____

DOB ___/___/___ Grade _____ Address 1 _____

_____

Student ID # _____ Home Phone _____ Wk Phone _____

Student Address _____ Address 2 _____

_____ _____

Telephone _____ Home Phone _____ Wk Phone _____

Disability _____

IEP Status

Initial Date ___/___/___ IEP Meeting Date ___/___/___ Revised Date ___/___/___

Temporary Placement Date ___/___/___ IEP Initiation Date ___/___/___ IEP Ending Date ___/___/___

Assigned To _____ IEP Initiation Date ___/___/___ IEP Ending Date ___/___/___

Principal _____ IEP Initiation Date ___/___/___ IEP Ending Date ___/___/___

Parent

Participants Attending IEP Team Meeting Of ___/___/___ (Date)

Name	Role	Signature
	Parent/Guardian/Surrogate	
	Student	
	General Education Teacher	
	Special Education Teacher	
	Administrator/Designee	

Student Uniform Policy

Laurel School District
Student Uniform Policy

School uniform policies have many advantages. They contribute to a sense of school and community pride, de-emphasize economic differences, lessen peer-pressure, and have a positive impact on student behavior and academic achievement. The purpose of this policy is to identify what may be worn in school during the regular school day. All students are expected to take pride in their appearance with dress and grooming that contribute to the health and safety of the individual, without disrupting the educational process. The student uniform policy is in effect during each instructional day unless otherwise indicated by a district or school administrator. This policy will also be in effect during academic and professional activities outside the school day when students are representing the school. This uniform policy is not subject to interpretation. It is intended to eliminate questions on what can and cannot be worn. Students will wear a style of dress based upon the following standards:

Tops:
All tops must be a long sleeve/short sleeve collared shirt with buttons, in solid white, red, black or gray:

1. Only the top button of a shirt can be unbuttoned.

2. All tops should be of appropriate size so as not to cause stretching or gapping of the material. Tops should not be tight to the skin or overly baggy. Tops may be tucked in or worn at mid-hip. If a top is not at mid-hip, it needs to be tucked in. No skin should be visible between the waistband of the pants and the bottom of the shirt.

3. Crewneck, Cardigan, and V-Neck sweaters, vests or fleece pullovers in solid white, red, black or gray may be worn with the appropriate collared shirt underneath.

4. A long sleeve or short sleeve t-shirt or turtleneck in solid white, red, black or gray may be worn underneath a collared shirt. No writing is allowed on any visible part of the shirt.

5. Hooded attire is not permitted at any time.

6. Team and club attire must be administratively approved to be worn as part of the school dress code.

7. The Laurel School District provided competition jersey attire is acceptable on team event days, as long as the appropriate collared shirt is worn under the jersey. Team uniform bottoms may not be worn.

8. Anything designated as an undergarment should not be seen (e.g. camisoles, undershirts).

9. All logos shall be no larger than the size of the student's closed fist.

Bottoms:
Khaki/dress style pants, capris, shorts, skirts, skorts, corduroy, or jumpers in solid black, gray or tan.

1. Males may wear khaki/dress style pants or shorts in black, gray or tan.

2. Females may wear pants, shorts, skorts, skirts, capris and jumpers in black, gray or tan. Solid color white, tan, natural, black, gray tights or pantyhose may be worn, under an approved bottom.

3. The bottom of shorts, skorts, jumpers and skirts must be modest in length. Modest in length is defined as the width of a student's hand from the bottom of the article of clothing to the top of their bended knee.

4. Jumpers must have the appropriate collared shirt underneath.

5. Bottoms must be worn no lower than the natural waist. Bottoms cannot be "sagged" and pant legs may not be rolled up.

6. Bottoms may be cargo style; however, there may not be chains, writing or any other adornments on the pants.

7. All bottoms should be of appropriate size so as not to cause undo stretching or gapping of the material. Bottoms should not be tight to the skin or overly baggy.

8. Jeans, exercise apparel (sweatpants, yoga pants, leggings, nylon pants, pajama bottoms, etc.) and jeggings are NOT permitted.

Footwear:

1. Shoes must be worn at all times. Footwear must be appropriate for the student's designated activity.

2. Shoes that have shoe-laces must be tied. Shoes with Velcro must be properly fastened.

3. Clogs, flip-flops, slides or slippers are not permitted.

Spirit-Wear Fridays

1. All uniform provisions apply to bottoms and footwear.

2. Students may wear Laurel Bulldog Spirit wear tops in lieu of an approved uniform top each school week on Fridays.

3. Students who choose not to wear Spirit wear tops on Fridays are to adhere to the Uniform Top Policy.

Clarifying Statements:

1. Ties are acceptable but not mandatory. Team coaches and club advisors can designate certain days for participants to wear a tie.

2. Cut-offs, frayed seams, and holes are not permitted on any clothing. Belt loops should not be cut off.

3. Sweat pants or warm-up pants will not be permitted.

4. Hats, head coverings, visors, scarves, bandanas, combs/picks and sunglasses may not be worn in the building. Hairbands for students should be no wider than 2 inches and they should be logo free. Hair should be neat and well-groomed.

5. No accessories, costumes, or unusual attire that is inappropriate or disruptive to the normal operation of the school may be worn.

6. Writing is not allowed on any clothing. Logos are not considered writing.

7. Students must remove and store coats, gloves, scarves, and hats in their locker or designated area upon entering the building.

8. On designated casual days students will be allowed to wear blue or black jeans. No holes, writing, or adornments may be on the jeans. Tops must be appropriate and not be a disruption to the educational process.

Procurement:
Procurement may come from any vendor that meets the basic requirements as stated above.

Consequences:
The discipline/consequence and or reward policy will be developed at the school level in accordance with the discipline matrix as all school rules/consequences are determined.

Adopted: March 15, 2017
Revised: January 18, 2017; February 15, 2017; March 7, 2017
Laurel School District
Laurel, DE