

**FOR SCHOOL USE ONLY**

ID#   
 Birth Certificate   
 Immunization   
 Legal Guardianship/Caregiver   
 In student database   
 Records requested   
 Grades received

STUDENT REGISTRATION / EMERGENCY CARD

# Student Information

Last:

First Name:

Middle:

Birthdate:

Place of Birth:

Gender:

School Year:

Current Grade:

# Student Ethnicity/Race

Is the student Hispanic/Latino? (Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino).  
  
Choose ONLY one: Yes, Hispanic or Latino   
 No, NOT Hispanic or Latino

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   
 Asian   
 Black or African American   
 White   
 Native Hawaiian or Pacific Islander

# Student Contact Information

## Physical Address:

Street Address:  
Apt. #:

Development:

City:

State:

Zip Code:

## Mailing Address: Same as the Physical? Yes No

Street Address:

Apt. #:

Development:

City:

State:

Zip Code:

# Parent/Guardian Information

## Parent/Guardian 1 Information

## Living with? Yes No

Full Name:

Relationship:

Street Address:   
Apt. #:

City:

State:

Zip Code:

Home Phone:

Unlisted?   
 Yes   
 No

Cell Phone:

Employer:

Work Phone:

Email address:

## Parent/Guardian 2 Information Living with? Yes No

Full Name:   
Relationship:

Street Address:   
Apt. #:

City:

State:

Zip Code:

Home Phone:

Unlisted?

 Yes

 No

Cell Phone:

Employer:

Work Phone:

Email address:

# Emergency Contact Information

**Important:** Must be 18 years of age or older. In the event of an emergency, individuals listed here will be contacted if parent/guardian cannot be reached.

## Emergency Contact 1 Information

Full Name:

Relationship:

Street Address:

Apt. #:

City:

State:

Zip Code:

Home Phone::

Cell Phone:

Work Phone:

## Emergency Contact 2 Information

Full Name:

Relationship:

Street Address:

Apt. #:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Work Phone:

# Special Custody Information (If child lives with other than natural mother or father, please indicate)

Full Name:

Relationship:

Do custodial papers exist for this student?

 Ye  
 No

If yes, please provide a copy of the papers to keep on file.

# Additional Information (If child lives with other than natural mother or father, please indicate)

Has the student been expelled?   
 Yes   
 No

Has student been involved in Gifted Program?   
 Yes   
 No

Does your child have an IEP (documentation required)?   
 Yes   
 No

Does your child have a 504 Accommodation Plan (documentation required)?   
 Yes   
 No

# Educational Background

Please list your child’s most recent school experience (including preschool, if applicable).

Name of Program:

Relationship:

Street Address:

City:

State:

Zip Code:

Type of Program:

 Home/Babysitter

 Home Daycare

 Early Childhood

Did your child receive any of the following services at the previous school?

 Special Education

 Title I

 ESL

 Other:

# School Age Sibling Information

Sibling 1 Full Name:

Age:

Grade:

Gender:

School:

Sibling 2 Full Name:

Age:

Grade:

Gender:

School:

Sibling 3 Full Name:

Age:

Grade:

Gender:

School:

# Daycare Arrangements

Name:

Street Address:

City:

State:

Zip Code:

Phone:

# Transportation Information

Please place a checkmark in the boxes that apply to your child. If bus stop is different from home address, please list the address in the space provided and complete a Childcare Transportation Form.

## To School

## Different from Home Address? Please list the address below.

Street Address:

City:

State:

Zip Code:

 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

## Different from Home Address? Please list the address below.

Street Address:

City:

State:

Zip Code:

 My child will be riding the bus from school to home

 My child will be riding the bus from school to daycare

 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 all the statements on this form made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith. **By signing this form, I understand giving a false or otherwise untrue answer to any of the questions in this form could result in criminal charges of making a false statement (11 Del. Code, Chapter 5, Part IV, §1233).** §1233 Making a false written statement; class A misdemeanor. A person is guilty of making a

false written statement when the person makes a false statement which the person knows to be false or does not believe to be true in a written instrument bearing a notice, authorized by law, to the effect that false statements therein are punishable. Making a false written statement is a class A misdemeanor. (11 Del. c. 1953, §1233; 58 Del. Laws, c. 497, §1; 67 Del. Laws, c 130, §8; 70 Del. Laws, c. 186, §1.)

## Parent/Guardian Signature:

## Date:

# Information Regarding How the Christina School District Shares Student Information

The Christina 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 visit: http://www.christinak12.org/FERPA.

**FOR SCHOOL USE ONLY**

Signature of District Employee Accepting Registration:

Location:

Date:

# 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. Has your child been out of the country for more than one month in the past year?   
    Yes   
    No   
   If so, where?
2. Have you, your child or anyone in your household tested positive for COVID-19?   
    Yes   
    No
3. Please check if your child has had difficulty with any of the following. Please provide updates and additional information in the comments section. \*An Asthma or Seizure Plan is required for all students with asthma or seizures.  
    ADHD  
    Asthma  
    Behavior  
    Bleeding  
    Body Piercing/Tattoo  
    Bone Problem  
    Bowel/Bladder  
    Concussion  
    Diabetes  
    Emotional  
    Hearing  
    Heart  
    Infections  
    Kidney  
    Physical Disability  
    Allergies\*  
    Seizures\*  
    Speech  
    Surgery  
    Vision  
    Other:  
    Comments:
4. Does your child have allergies to medicine, latex, insect bites or other allergies?   
    Yes   
    No  
   To what?  
   What happens?  
   Treatment?
5. Does your child have a food allergy diagnosed by a licensed health care provider?   
    Yes   
    No  
   If yes, a food allergy action plan completed by a licensed healthcare provider is required.  
   To what?  
   What happens?  
   Treatment?
6. Has your child seen a healthcare provider since school ended in June?   
    Yes   
    No  
   What for?
7. Is your child being treated or evaluated for any health conditions?   
    Yes   
    No  
   List conditions:
8. Is your child on any medication or treatment?   
    Yes   
    No  
   Name of medication/treatment:   
   Does your child need medication during school hours?   
   If yes, contact the school nurse to make arrangements.   
    Yes   
    No
9. Has your child been prescribed glasses or contact lenses   
    Yes   
    No   
   Date of last exam:   
   If your child wears glasses/contact lenses, when was the prescription last changed?
10. Has your child had any major life events, such as recent move, death, separation, divorce, etc. since the end of the last school year?   
    If yes, contact your school nurse or school counselor.   
     Yes   
     No

# Medical Information & Medicine Permission

Family Physician:   
Phone:

Family Dentist:   
Phone:

I give permission for my child to have Acetaminophen (Tylenol®) as determined by the nurse.   
 Yes   
 No

I give permission for my child to have Ibuprofen (Advil®) as determined by the nurse.   
 Yes   
 No

I give permission for my child to have First Aid Cream   
 Yes   
 No  
Caladryl®   
 Yes   
 No

Tums®   
 Yes   
 No

## 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 they become 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 home. If there is no answer, the school will call parent/guardian #1 or parent/guardians #2 place of employment.   
   If there is no answer, the school will call the other telephone number(s) listed and the physician.
2. If none of the above answer, the school will call the ambulance, and if necessary, transport the student to a local medical facility.
3. Based upon the medial judgement of the attending physician, the student may be admitted to a local media facility.
4. The school will continue to call the parents/guardians or physician until one is reached.
5. 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 judgement of the attending physician.

## Parent/Guardian Signature:

## Date: