Student:			School:	School Year
Grade:	HMRM:	Bus #	Student ID#	

CHRISTINA SCHOOL DISTRICT

Parent/Guardian MUST sign all shaded areas

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

Student Registration/Emergency Card

Current guidelines for Coronavirus, from Delaware Public Health (DPH), Center for Disease Control (CDC) & World Health Organization (WHO) will be followed for the school year.

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				
Last Name:				
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No	
Apt #:		Cell Phone:		
Street		Home Phone:		Unlisted? ☐ Yes ☐ No
Developme		Work Phone:		
City:		Birth Date:		
State/Zip:		Employer:		

Please provide one email address

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

Please provide one email address

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:		**ID# :**

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

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

SCHOOL AGE SIBLING INFORMATION

Name:						Name:					
Age:		Grade:		Gender: ☐ Male ☐ Female		Age:		Grade:		Gender: ☐ Male ☐ Female	
School:						School:					
Name:						Name:					
Age:		Grade:		Gender: ☐ Male ☐ Female		Age:		Grade:		Gender: ☐ Male ☐ Female	
School:						School:					

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

TRANSPORTATION INFORMATION:

	Please place a checkmark in the boxes that apply to your child.		**Comments**: If bus stop is different from home address, please list the address in this column and complete a Childcare Transportation Form
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 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/Relative Caregiver 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.

Signature of District Employee accepting Registration	Location	Date

Student:		ID# :

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

If Yes, please contact your School Nurse

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

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

☐ Other: _____

An Asthma or Seizure Action Plan is required for all students with either Asthma or Seizures

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

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.

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 condition(s): _____

8. 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

9. 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? _____

10. Has your child had any major life events, such as recent move, death, separation, divorce, etc. since the end of last school year? ☐ Yes ☐ No

If Yes, please contact your School Nurse or School Counselor.

Medical Information			
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_____ Caladryl®_____ 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 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: _____ _____