

Student:		School:		School Year: 2025
Grade:	HMRM:	Bus #	Student ID#	



**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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
First Name:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Middle Name:		Birth Date:		
Last Name:		Home Phone:		Unlisted?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Generation:	<input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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.				
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander				
ADDRESS: Please indicate Physical (home) and Mailing address if they are different.				
Physical Address		Mailing Address Same as Physical? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Apt #:		Apt #:		
Address:		Address:		
Development:		Development:		
City, State, Zip:		City, State, Zip:		

PARENT/GUARDIAN CONTACT INFORMATION				
First Name:		Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father		
Middle		<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other (please list):		
Last Name:				
Generation:	<input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Living With:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Apt #:		Cell Phone:		
Street		Home Phone:		Unlisted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Developme		Work Phone:		
City:		Birth Date:		
State/Zip:		Employer:		
Please provide one email address:				
Email:				
First Name:		Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father		
Middle		<input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Other (please list):		
Last Name:				
Generation:	<input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	Living With:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Apt #:		Cell Phone:		
Street		Home Phone:		Unlisted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Developme		Work Phone:		
City:		Birth Date:		
State/Zip:		Employer:		
Please provide one email address:				
Email:				

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

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

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

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

TRANSPORTATION INFORMATION:		
Please place a checkmark in the boxes that apply to your child.		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
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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
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Student: _____	ID# : _____
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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.

- | | | | | | |
|--|---|-------------------------------------|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infections | <input type="checkbox"/> Speech | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bone Problem | <input type="checkbox"/> Emotional | <input type="checkbox"/> Kidney | <input type="checkbox"/> Surgery | |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Hearing | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Vision | |
| <i>An Asthma or Seizure Action Plan is required for all students with either Asthma or Seizures</i> | | | | | |

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, | 5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility. |
| 2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer, | 6. The school will continue to call the parents, guardians or physician until one is reached. |
| 3. The school will call the other telephone number(s) listed and the physician. | 7. The information on this form may be shared with emergency medical staff. |
| 4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility. | |

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

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