DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Fax or Mail Request to:

OCCL, Criminal History Unit
Concord Plaza, Hagley Building
3411 Silverside Road
Wilmington, DE 19810
Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed**
- **Do not use a cover sheet**
- **Do not send duplicate requests**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed**

PART I. APPLICANT INFORMATION *(PLEASE PRINT CLEARLY)*

Name: _____
Last First Middle

Other Name(s) used: _____ DE Drivers License # _____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____-____-_____ Sex: ___ Race: _____
mm / dd / yyyy

Address: _____
(Street) (City) (State) (Zip)

Have you ever been involved in a substantiated case of child abuse or neglect? [ ] Yes [ ] No

If yes, explain: _____

_____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: _____ Date: _____

Parent / Guardian Signature (If applicant is under the age of 18) _____

PART II. AGENCY/ORGANIZATION INFORMATION - (*MUST BE COMPLETED IN ORDER TO PROCESS*)

Please circle only one:

EDUCATION HEALTH CARE CHILD CARE (OTHER) **Mentoring**

Agency Identification Number (if applicable): **1300**

Requesting Agency Name: **Connecting Generations**
Address: **100 West 10th Street, Suite 115, Wilmington, DE 19801**

Phone: **(302)656-2122** Fax: **(302)656-2123** ContactPerson: **Jennifer Marek**

DSCYF USE ONLY:

The individual listed above (__ is listed) (__ is NOT listed) on the Delaware Child Protection Registry.

Date: _____ DSCYF Criminal History Unit _____

SCHOOL MENTOR PROGRAM
CRIMINAL HISTORY RECORD SCREENING AUTHORIZATION

(Please print or type all information in black ink)

VOLUNTEER:

_____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE SUFFIX

ALL OTHER FULL NAMES USED IN THE PAST:

1. _____
2. _____
3. _____

DATE OF BIRTH: _____ _____ _____ **RACE:** _____ **GENDER:** _____
Month Day Year

SOCIAL SECURITY NUMBER (REQUIRED): _____

ADDRESS: _____
STREET

_____ _____ _____
CITY STATE ZIP

TELEPHONE NUMBERS: ( ) _____ ( ) _____
HOME WORK

AUTHORIZATION TO RELEASE INFORMATION:

I authorize release of any and all information that you have concerning me, including CRIMINAL HISTORY RECORD INFORMATION and other information of a confidential or privilege nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information.

_____ _____
SIGNATURE DATE

SCHOOL PERSONNEL: It is recommended that each volunteer's driver's license be photocopied and kept on file with a copy of this form.

Forms should be mailed to:

Creative Mentoring
100 W. 10th Street
Suite 1115
Wilmington, DE 19801

For information or questions call:
Delaware State Police, Criminal History Section
1-800-464-4357 or 739-2528
(P.O. Box 430, Dover, DE 19903)

STATE BUREAU OF IDENTIFICATION USE ONLY:

_____ No Delaware Criminal History Record based on a name and date of birth check.
SIGNATURE/DATE

_____ The Delaware Criminal History Record is attached.
SIGNATURE/DATE

This Criminal History Record check is based on a name, date of birth and Social Security number only. No fingerprints were provided. Fingerprints provide the only "Positive" means of determining whether an individual has a Delaware Criminal History Record.

Volunteer Name:_____ **Date:**_____

Volunteer Signature:_____

DELAWARE DEPARTMENT OF EDUCATION[1]
CONFIDENTIAL TUBERCULOSIS (TB) HEALTH QUESTIONNAIRE
FOR VOLUNTEERS IN PUBLIC SCHOOLS

All school students, employees, and volunteers are required to be screening for Tuberculosis (TB)[2]. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. This questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further testing. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential manner. The questionnaire must be completed every five years. The volunteer may prefer to provide evidence of TB testing in lieu of completing the questionnaire.

Please consider the following questions and circle only ONE response in the box below[3]:

Can you answer "yes" to *any* of the questions below?	
1. In the past five years, have you lived or been in close[4] contact with anyone who had active, infectious TB disease? 2. Do you currently have any of the following symptoms which are unexplained and which have lasted at least three weeks? Cough Fever Night sweats Weight loss 3. Have you ever had a positive HIV test? 4. In the past five years, have you ever used illegal intravenous drugs? 5. In the past five years, have you been incarcerated? 6. In the past five years, have you been homeless which resulted in living in a shelter or with others outside of your family, who were homeless? 7. For the next two questions, refer to the TB-Endemic Countries list provided by the Delaware Division of Public Health. • In the past five years, have you stayed/lived in one of these countries for 1 month or longer? • In the past five years, have you lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?	**YES** ☐ **NO** ☐

If you checked YES, you are required (within 2 weeks) to provide verification from a licensed health care provider or the Division of Public Health that there is no communicable threat.

Have you ever had a positive skin test for tuberculosis? ☐ Yes ☐ No

If you checked yes, you are required to provide documentation related to current disease status prior to your assignment or continued assignment as a volunteer. If you have provided documentation of completing treatment for active or latent infection, no further documentation is required.

These requirements are for the safety of our school and for your personal health. Screening for tuberculosis is recommended by health professionals for any individual who is at risk. Routine screening, using a Mantoux tuberculin skin test or a TB blood test, such as the Quantiferon Gold TB Test, can detect if a person has been exposed to tuberculosis. Early identification of infection and completion of a course of antibiotic treatment significantly reduces the chance of developing active TB disease over the lifetime of infected individuals.

If you have any questions about your risk of infection, please speak with your healthcare provider or plan to discuss it at your next examination. For additional information, you can contact the Delaware Division of Public Health TB Elimination Program at 302-744-1050.

[1]Developed and revised in collaboration with the Delaware Division of Public Health: 2/2005, 7/2010, 7/2013, 5/2015.
[2]Regulation 805 can be accessed at http://www.state.de.us/research/AdminCode/title14/800.
[3]To maintain confidentiality of medical information, the employee should not provide an individual answer to each question. The employee's response of "yes" indicates that at least *one* of the seven questions is correct, which means a possible exposure. The employee should not indicate which one. The employee may prefer to provide evidence of TB testing in lieu of completing the questionnaire.
[4]CDC describes "close contact" as prolonged, frequent, or intense contact with a person with TB, while he/she was in infectious.