Badger Elementary School

"Together, dedicated to academic excellence, we embrace citizenship and respect diversity by providing a safe, caring, and positive learning environment for each child."

501 S. Bluemound Dr. • Appleton, WI 54914 • Phone: (920) 832-6264 • Fax: (920) 832-6149

Douglas J. Benz, Principal

New Student Enrollment Packet

If you need to enroll your child at Badger Elementary School, please follow these steps:

1. Call our office at (920) 832-6264 ASAP (leave a message if necessary).

   We will confirm you live in our attendance area and make arrangements for a time for you to come to school to complete the enrollment packet. Or, you can print out the attached forms and complete them.

2. Return the completed packet to school ASAP. You can either fax at (920) 832-6149, mail or drop them off at Badger Elementary School, 501 South Bluemound Drive, Appleton, WI 54914. (Call before coming to be sure our office is open during the summer months.)

Appleton Area School District

Badger School Student Information Sheet

Student Information

Student Name:________________________ Previous School:____________ Grade:________

Date of Birth:________________________ Gender (Circle): Male Female

Address:________________________ City:____________ Zip:________

Ethnicity:____________ State or Country of Birth:____________ Primary Language:____________

Parent/Guardian Information (Please note Parent 1 & 2 are those who live in the above address, with the child. Parent 3 & 4 are parent/guardian who live at a different address)

Parent/Guardian:____________ Relationship:____________ Home Phone:____________ Cell Phone:________

Home Address:____________ City:____________ State:____________ Zip Code:________

Place of Employment:____________ Work Phone:____________ Extension:____________ Pager:________

E-mail Address: ________________________ Work Hours: ____________

Parent/Guardian:____________ Relationship:____________ Home Phone:____________ Cell Phone:________

Home Address:____________ City:____________ State:____________ Zip Code:________

Place of Employment:____________ Work Phone:____________ Extension:____________ Pager:________

E-mail Address: ________________________ Work Hours: ____________

Parent/Guardian:____________ Relationship:____________ Home Phone:____________ Cell Phone:________

Home Address:____________ City:____________ State:____________ Zip Code:________

Place of Employment:____________ Work Phone:____________ Extension:____________ Pager:________

E-mail Address: ________________________ Work Hours: ____________

Parent/Guardian:____________ Relationship:____________ Home Phone:____________ Cell Phone:________

Home Address:____________ City:____________ State:____________ Zip Code:________

Place of Employment:____________ Work Phone:____________ Extension:____________ Pager:________

E-mail Address: ________________________ Work Hours: ____________

Emergency Information (Please note: Emergency Information must be someone OTHER than a parent and have a local phone number)

Contact Name:____________ Home Phone:____________ Work Phone: ____________ Relationship:________

Contact Name:____________ Home Phone:____________ Work Phone: ____________ Relationship:________

Contact Name:____________ Home Phone:____________ Work Phone: ____________ Relationship:________

Doctor:________________ Phone:____________ Insurance:____________

Dentist:________________ Phone:____________ Policy#:____________

Special Health Condition(s)

Information/Concerns of which school personnel should be made aware of:

Please sign to verify that the information on this form is true and correct:

Signed:________________________ Date:____________

Office Use

Student Number:____________

If not Home School, Actual School District/Neighborhood:________________________

Has your child ever attended Appleton School District________, if yes, which school ____________

Appleton Area School District

REQUEST/AUTHORIZATION TO RELEASE STUDENT RECORDS

Date: _____

To: _____
(School Name)

_____ _____
(Address) (City, State, Zip Code)

This is to request your release of the student records of:

_____ _____ _____
(Name of Student) (Date of Birth) (Grade)

_____ _____ _____
(Name of Student) (Date of Birth) (Grade)

_____ _____ _____
(Name of Student) (Date of Birth) (Grade)

SCHOOL/PROGRESS RECORDS to be released to:	SPECIAL EDUCATION RECORDS to be released to:
Badger Elementary School **501 South Bluemound Drive** **Appleton, WI 54914** **Phone: (920) 832-6264** **Fax: (920) 832-6149** • **Attendance Records** • **Cumulative Folders** • **Test Scores** • **Health Records and Immunizations** • **Standardized Achievement Tests**	**APPLETON AREA SCHOOL DISTRICT** **Special Education Department** **P.O. Box 2019** **Appleton, WI 54912-2019** **Phone: (920) 832-6129** • **Individualized Education Program (IEP)** • **IEP Team Evaluation Report** • **Consents to Evaluate and Place** • **Other Special Education Records** NOTE: Please FAX a Current IEP to (920) 832-5764

Parent/Guardian Signature*_____ Date_____

Principal Signature_____ Date_____

* Written parental permission for release of education records is not required as provided under Section 118.125(4) Wisconsin Statutes and Federal Regulations Part 99.31(a)(1) (Privacy Rights of Parents and Students)

PLEASE COMPLETE ONE PER FAMILY

Appleton Area School District
Badger Elementary
501 South Bluemound Drive
Appleton WI 54914
(920-832-6264)

LIST ALL CHILDREN WHO LIVE AT YOUR RESIDENCE

To maintain an accurate district database and correctly report the Appleton Area School District school census, please complete the following listing **ALL** children under age 19 who live in your residence:

Father's Name: _____ (Last First Middle) Mother's Name: _____ (Last First Middle)

Home Address: _____ Phone: _____

Last First Middle	M/F	School Attending	Date of Birth	Age

12/17/02

English Student Home Language Survey

Attention: School Staff

To be completed for all new students

Today's Date_____

Appendix 1

To be completed by ELL staff
ELL Test Date _____
ELL Evaluator_____
ELL File Opened
Yes _____ **No** _____
Test _____
State Level _____
School Placement _____
Student ID# _____

Appleton Area School District

Student Home Language Survey

The Appleton Area School District is interested in providing instructional programs for all students who speak more than one language. Information about the language background of each student is necessary to determine program needs. Your cooperation in providing the following information is most appreciated.

Student's Name: _____
Last First Middle

Date of Entry to United States:_____

Date of Birth: _____ **Gender:** _____Male _____Female

Address: _____ **Phone:** _____

School: _____ **Grade:** _____

Directions: For each of the following six questions, please circle the appropriate answer.

1. What language did your child speak when he or she first began to talk?

   English Hmong Spanish Other _____

2. What language does your child speak most often at home?

   English Hmong Spanish Other _____

3. What language does your child speak most often with his or her friends?

   English Hmong Spanish Other _____

4. What language do YOU use most often when speaking to your child?

   English Hmong Spanish Other _____

5. Is there an adult in your home who can read English?

   Yes No If not, what language can be read? _____

6. Do you want a translator available at school conferences?

   Yes No

Please sign the completed Home Language Survey and return it to school.

Signature: _____ Date: _____

Appleton Area School District

WISCONSIN SURVEY FOR IDENTIFYING MIGRATORY CHILDREN

Student Name:_____ Grade:_____ School:_____

Parent/Guardian Name:_____ Date:_____

Address:_____ Phone:_____

1. Have you moved within the last three years for the purpose of finding seasonal or temporary employment directly related to producing or processing crops or livestock, or dairy for employment, planting or harvesting trees, or catching shell fish or fish in natural waters?

   _____No _____Yes

If Yes,

When:_____

From Where:_____ To Where:_____

Did any children from birth to 20 years old move with you, or move to join you, related to this work search or employment: _____No _____Yes

List any children not in school (Name and Birthdate):

_____

_____

_____

_____

_____

_____

STUDENT HEALTH INFORMATION
(To be completed by parent/guardian)

Appleton Area School District
Health Services
P.O. Box 2019 - Appleton, WI 54912-2019 - 920-997-1399, ext. 2106 - FAX: 920-832-5764

A physical examination is recommended for students as they enroll for the first time. ***Return Health Information sheet (pages 1 and 2) to the School Nurse.***

*Date*_____

*Child's Name*_____ *Birthdate*_____ *Age/Grade*_____

*Parent's Name*_____ *Address*_____

*School Attendance Area*_____ *Phone*_____

*Family Physician*_____ *Date of last visit/physical exam*_____

HEALTH HISTORY

1. Does your child have any health conditions, allergies, or food intolerance? Yes_____ No_____
   If so, please explain:

2. Is your child taking a daily medication? Yes_____ No_____
   If so, please list medication(s) and reason(s):

3. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? Yes_____ No_____
   If so, when and please explain:

4. Do you have any concerns about your child's behavior? Yes_____ No_____
   If so, please comment:

5. **DEVELOPMENTAL HISTORY**
   a. Were there any complications with this pregnancy or delivery? Yes_____ No_____
      If so, please explain:

   b. Was your child considered to be in good health at birth? Yes_____ No_____
      If not, please comment:

   c. Do you have any concerns about your child's development? Yes_____ No_____
      If so, please comment:

   d. Do you have any concern about your child's growth, height or weight? Yes_____ No_____
      If so, please explain:

   e. Please complete for **elementary students only** (age in months):
      Birth Weight_____ Length_____ Apgars (if known)_____
      Length of pregnancy (months or weeks)_____ Rolled over_____
      First words_____ First sentence_____ Sat alone_____
      Bowel trained_____ Bladder trained_____ Walked alone_____

(continued on other side)

6. **HEALTH CONDITIONS** (month/year or number of occurrences)

Pneumonia	_____	Rubella	_____	Mumps	_____	Whooping Cough	_____
Scarlet Fever	_____	Measles	_____	Eczema	_____	Chicken Pox	_____
Rheumatic Fever	_____	Asthma	_____	Allergies	_____	Ear Infections	_____
Heart Disease	_____	Diabetes	_____	Headaches	_____	Muscle Problems	_____
Convulsive Seizures	_____	Genital	_____	Ear Tubes	_____	Kidney/Bladder	_____
Other Diseases	_____						

Identify any health conditions from the above list occurring in your immediate family.

7. **DENTAL HISTORY**

Do you have a family dentist? Yes_____ No_____ Dentist:_____

Has your child ever visited the dentist? Yes_____ No_____ Date:_____

Comments:

8. **VISION HISTORY**

Has your child experienced any difficulties with vision? Yes_____ No_____

Has your child ever had a professional vision exam? Yes_____ No_____ Doctor:_____

Date:_____ Results:_____

Does your child show symptoms of eye fatigue, stress or infection such as:

_____blinking, _____squinting, _____itching, _____tearing, _____redness, _____pus discharge, _____none, _____injury

Does your child hold books close to eyes or sit close to TV? Yes_____ No_____

Does your child hold books far away from eyes? Yes_____ No_____

Does your child close one eye or squint? Yes_____ No_____

9. **HEARING HISTORY**

Has your child been treated medically or surgically for ear problems or frequent ear infections? Yes_____ No_____

Was your child treated by an ENT specialist? Yes_____ No_____ Name_____

Hearing test results_____

Has your child experienced any difficulties with hearing, such as:_____tuning TV or radio louder, _____turning head to one side, _____frequently misunderstanding instructions, _____asking that instructions be repeated

10. **SPEECH**

Do you think your child's speech and language development is appropriate for his/her age? Yes_____ No_____

Is your child: _____difficult to understand, _____raspy, _____nasal, _____a snorer, _____mouth breather?

11. Is there any information about your child that would be helpful to school personnel in working with your child?

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

_____ _____

Parent/Guardian Signature Date

Please complete the immunization record on the Physical Examination form (see page 3).

PHYSICAL EXAMINATION

(To be completed by Physician, Physician Assistant or Nurse Clinician)

Appleton Area School District

Health Services

P.O. Box 2019 - Appleton, WI 54912-2019 - 920-997-1399, ext. 2106 - FAX: 920-832-5764

*Student's Name*_____ *DOB:*_____ *School/Grade:*_____

*Weight (without shoes)*_____ *Height*_____

*BP (sitting)*_____ *Pulse*_____

*Urinalysis (dip stick)*_____ *Vision (distant)* *R/20/*_____ *L20/*_____

Hearing *Rt.*_____ *Lt.*_____

	Normal	Abnormal	Comments
Skin/Scalp			
Mouth			
Teeth			
Ears, Nose, Throat			
Neck			
Lymphatics: Cervical			
Axillary			
Chest: PMI			
Rhythm			
Lungs			
Breast			
Abdomen: Organs			
Hernia			
Genitalia			
Hernia			
Orthopedic:			
Cervical Spine/Back			
Shoulders			
Arm/Elbow/Wrist/Hand			
Knees			
Ankles			
Feet			
Neurologic:			
Reflexes			

Immunizations ***(Month, Day, Year)*** ***Student's Name/Grade***_____

Vaccines		First Dose Mo/Day/Yr	Second Dose Mo/Day/Yr	Third Dose Mo/Day/Yr	Fourth Dose Mo/Day/Yr	Fifth Dose Mo/Day/Yr
DtaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, Rubella)						
Hepatitis B	3 dose pediatric formulation					
	2 dose adolescent formulation					
HIB (required for children in licensed day care only)						
Varicella (Chickenpox) Note: Vaccine is required only if your child has not had chickenpox disease. See below:						
Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known: YES _____(Vaccine not required) NO or Unsure (Vaccine required)						

Other (from positive history):_____

_____

Additional tests/evaluations recommended:_____

_____

Restriction/Handicap/Disability: Yes_____ No_____
If yes, please explain:

RECOMMENDATIONS TO SCHOOL:

Examiner's Signature_____ Phone_____ Exam Date_____

Please print full name and address of examining health professional:

_____

_____

_____

Return Physical Examination form to the School Nurse.

DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 4020L (Rev. 02/08)

STATE OF WISCONSIN
252.04 and 120.12 (16) Wis. Stats.

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission.** The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only. If you have questions on immunizations or how to complete this form, contact your child's school or local health department.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number ( )

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					

*Hib vaccine is only required for children in licensed day care centers. Do not report the dates your child received Hib vaccine on this form.

Has your child had Varicella (chickenpox) disease? Check the appropriate box
And provide the year if known:
☐ YES _____ year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

—— Or ——

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETEY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule and notify the school may result in court action and a fine of up to $25.00 per day of violation.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
SIGNATURE - Physician Date Signed

☐ **For religious reasons** this student should not be immunized.

☐ **For personal conviction reasons** this student should not be immunized.

_____
LIST VACCINE(S) WAIVED

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge.

_____ _____
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed