

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.)

Badger School Kindergarten Registration Student Information Sheet

Student Information

Student Name: _____ Previous School: _____
 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 _____

PLEASE COMPLETE ONE PER FAMILY

Appleton Area School District
Badger Elementary School
501 S. 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

English Student Home Language Survey

Badger Elementary School

To be completed for all new students

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# _____

Today's Date _____

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: _____

FULL DAY - HALF DAY KINDERGARTEN
(PREFERENCE)

Student Name: _____

Parent/Guardian Name: _____

Phone: _____

(Please put a (X) by your preference.)

I prefer to have my child in a full-day kindergarten program: _____
The full-day kindergarten day will be the same as the existing elementary school day for
grades 1-6: 8:27 am - 3:16 pm, with hot lunch available.

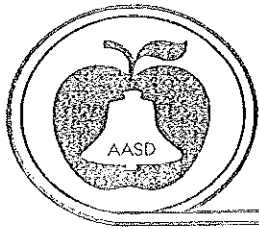
I prefer to have my child in a ½ day kindergarten program: _____
(The ½ day kindergarten program will be in the AM).
AM: 8:27 am - 11:03 am)

NICKNAMES

If your child has a particular nickname that they go by other than their formal name,
please fill in the spaces below. (If no nickname, please put (none) on line

First name: _____ Nickname: _____

No nickname (_____)_____



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):

BADGER ELEMENTARY SCHOOL KINDERGARTEN PARENT SURVEY

Please complete and return this survey to the Badger Elementary School's office.

Student's name, as it appears on birth certificate:

_____ M _____ F
Last First Middle

Name the student will use/write in kindergarten:

_____ Birth Date
First Name (Example: Jennifer or Jenny)

Student's primary language: _____

Name of person completing this form: _____

Relationship to student: _____

*You have the option of having your son/daughter attend half or full-day kindergarten at Badger Elementary School. Depending upon enrollment, the **half-day session** will either be a stand-alone half-day section or the morning portion of a full-day section of kindergarten. The **full-day session** will mirror the start and ending times of grade 1-6.*

Please select one:

Please enroll my child in *half-day* kindergarten: _____

Please enroll my child in *full-day* kindergarten: _____

- Has your child had any preschool or child care experiences? If so, where, when, how long?

- Has your child participated in the 3-5 year old developmental screening process through the Appleton Area School District? _____ yes _____ no

Would you like to be contacted to schedule a developmental screening before Kindergarten?

- OVER -

Please complete the following questionnaire. The readiness skills listed are not expectations for entering kindergarten, but will help us better know your child.

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_____

Length of pregnancy (months or weeks)_____

First words_____ First sentence_____

Bowel trained_____ Bladder trained_____

Apgars (if known)_____

Rolled over_____

Sat alone_____

Walked alone_____

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. _____

	<u>Normal</u>	<u>Abnormal</u>	<u>Comments</u>
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.