

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 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:

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

SPECIAL EDUCATION RECORDS

to be released to:

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)

English Student Home Language Survey

Attention: School Staff

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: _____

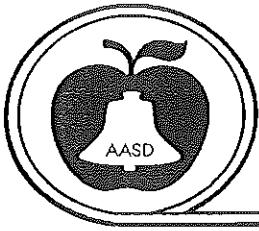
Directions: For each of the following six questions, please circle the appropriate answer.

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: _____

12/10/02



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 _____

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.

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.

PERSONAL DATA **PLEASE PRINT**

Step 1	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 ()	

IMMUNIZATION HISTORY

Step 2 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) <input type="checkbox"/> Tdap <input type="checkbox"/> 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:					
Has your child had Varicella (chickenpox) disease? Check the appropriate box And provide the year if known: <input type="checkbox"/> YES _____ year (Vaccine not required) <input type="checkbox"/> NO or Unsure (Vaccine required)					

*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.

REQUIREMENTS

Step 3 Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

COMPLIANCE DATA

Step 4 **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 INCOMPLETELY 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

SIGNATURE

Step 5 This form is complete and accurate to the best of my knowledge.

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