PRESCOTT SCHOOL DISTRICT REQUEST FOR RECORDS FORM

Request for Records Date: _____

Name of Student	Date of Birth	Grade
_____	_____	_____

Name of School Last Attended: _____

School Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Expected Start Date: _____

For the Office Use of Previous District:

☐ Yes ☐ No Has the student ever been tested for **SPECIAL ED SERVICES?** ☐ Yes ☐ No **CURRENT IEP?**

☐ Yes ☐ No **DOES STUDENT HAVE A 504?** ☐ Yes ☐ No Has the Student been **EXPELLED or in the process?**

Forward Records to the Appropriate Location Marked Below:

☐ Malone Elementary School
Grades 4K-3
505 N. Campbell Street, Prescott, WI 54021
Phone: 715-262-5463 Fax:715-262-0052
Contact - Madison Garin (esoffice@prescott.k12.wi.us)

☐ Malone Intermediate School
Grades 4 & 5
125 N. Elm Street, Prescott, WI 54021
Phone: 715-262-2383 Fax:715-262-2379
Contact - Kathy Miller (isoffice@prescott.k12.wi.us)

☐ Prescott Middle School
Grades 6-8
1220 St. Croix Street, Prescott, WI 54021
Phone: 715-262-3961 Fax:715-262-3965
Contact - Katy Hillebrand (msoffice@prescott.k12.wi.us)

☐ Prescott High School
Grades 9-12
1010 Dexter Street, Prescott, WI 54021
Phone: 715-262-5389 Fax:715-262-4888
Contact - Suzi Linder (linders@prescott.k12.wi.us)

☐ Student Services
Grades 4K-12
1220 St. Croix Street, Prescott, WI 54021
Phone: 715-262-5059 Fax:715-262-2379
Contact - Barb Bowen (bowenb@prescott.k12.wi.us)

Please Include(if any): Scholastic, Psychological, Special Education (IEP/Evals/504 Plans), Health Records, Transcript, Current Grades, Standardized Test Results, and Limited English Proficiency Help.

PRESCOTT SCHOOL DISTRICT REGISTRATION FORM - 4-YEAR-OLD KINDERGARTEN

FIRST DAY OF SCHOOL: _____

District Office
1220 St. Croix Street
Prescott, WI 54021
715.262.5782 Fax 715.262.5091

GENDER: _____Male_____Female

STUDENT'S LEGAL NAME (Last) _____ (First) _____

(Middle) _____ (Preferred name, if any) _____

MAILING ADDRESS_____

BIRTHDATE _____/_____/_____ BIRTHPLACE (City/State/County) _____

VERIFICATION OF DATE OF BIRTH (BIRTH CERTIFICATE) _____ Yes _____ No

If your student was born outside the U.S.: What year did they begin attending a U.S. School? _____

ETHNICITY: Are you Hispanic or Latino? ____ No, not Hispanic or Latino ____ Yes, Hispanic or Latino

SELECT ALL OF THE FOLLOWING CATEGORIES THAT APPLY TO YOU: (You must select at least one of the following)

__ American Indian or Alaska Native __ Asian __Black or African American __Native Hawaiian or Other Pacific Islander __White

CUSTODIAL PARENT(S) _____

WITH WHOM DOES THE STUDENT LIVE:

____Both Parents ____Single Mother ____Mother/Stepfather ____50/50 Physical Placement

____Guardian ____Single Father ____Father/Stepmother ____Other, explain: _____

Is there a court order on record that we should have? ____ Yes _____No

HOUSEHOLD 1 (Primary):

HOME ADDRESS _____ HOME PHONE (____) _____

GUARDIAN 1'S NAME (Last) _____ (First) _____

RELATIONSHIP _____ CELL PHONE (____) _____

EMAIL ADDRESS _____ WORK PHONE (____) _____

In the Military: _____ No _____Yes Date Enlisted: _____ Status: _____ Branch: _____

GUARDIAN 2'S NAME (Last) _____ (First) _____

RELATIONSHIP _____ CELL PHONE (____) _____

EMAIL ADDRESS _____ WORK PHONE (____) _____

In the Military: _____ No _____Yes Date Enlisted: _____ Status: _____ Branch: _____

HOUSEHOLD 2 (Secondary):

HOME ADDRESS _____ HOME PHONE (____) _____

GUARDIAN 1'S NAME (Last) _____ (First) _____

RELATIONSHIP _____ CELL PHONE (____) _____

EMAIL ADDRESS _____ WORK PHONE (____) _____

In the Military: _____ No _____Yes Date Enlisted: _____ Status: _____ Branch: _____

GUARDIAN 2'S NAME (Last) _____ (First) _____

RELATIONSHIP _____ CELL PHONE (____) _____

EMAIL ADDRESS _____ WORK PHONE (____) _____

In the Military: _____ No _____Yes Date Enlisted: _____ Status: _____ Branch: _____

NAME(S) OF SIBLINGS (First & Last Names)	**GENDER (M or F)**	**DATE OF BIRTH (Mo/Da/Yr)**

Please Complete Both Sides

MALONE SCHOOLS REGISTRATION FORM - 4-YEAR-OLD KINDERGARTEN Cont.

IN CASE OF AN EMERGENCY AT SCHOOL, other than parents, name and phone number of person to be contacted:

NAME_____ PHONE_____

NAME OF FAMILY PHYSICIAN _____ ADDRESS _____ PHONE NUMBER _____

☐ Yes ☐ No Has your child ever been tested for **SPECIAL ED SERVICES?** Yes No **CURRENT IEP?**

☐ Yes ☐ No **DOES STUDENT HAVE A 504?**

MOST RECENT 4K/Preschool/Daycare attended: _____

During the school year, will your child be receiving regular care from a **childcare provider?**

____ Yes ____ No ____ Undecided _____
Days Hours

If YES, please supply the following information, if known:

NAME OF CHILDCARE PROVIDER _____ ADDRESS _____ PHONE NUMBER _____

Does your child currently take an afternoon nap? If so, how long of a nap?_____

Can your child separate from parent easily?_____

Does your child have any problems in the following areas?

	YES	NO	Explain
Excessive tiredness			
Headaches			
Unusual fears			
Overactivity			
Oversensitivity/upset easily			
Sleeping problems			
Temper tantrums			
Speech problems			
Motor problems			

Is there anything else about your child that you think the school should be aware of?_____

_____

Your family currently attends: (Check all that apply)

____ New Adventures Learning Center

____ Heart, Hands, and Mind Childcare

____ St. Joseph Parish School

Transportation (Your placement will be contingent on the enclosed transportation note)

____ My child will need bus services to and from 4K.

____ My child will **not** need bus services.

____ My child will need bus services only **to** 4K.

____ My child will need bus services only **from** 4K.

If transportation is not necessary, your preference for your child is: _____ A.M. _____P.M.
(Please note, there will be no changes once this decision is made)
I agree to provide transportation for my child for the school year:_____
Parent Signature

The information provided on this form is true and accurate to the best of my knowledge.

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

Revised 11/19/18

Prescott School District Health Form

Student & Parent Information

Student Last Name: _____ **Student First Name:** _____

Students Date of Birth: _____ **Grade Student will be entering:** _____

Parent/Guardian Name (#1): _____ **Phone Number:** _____

Parent/Guardian Name (#2): _____ **Phone Number:** _____

Medical Care

Primary Care Physician - First & Last Name *(MD, DO, NP, PA)*: _____

Primary Clinic Name *(ex: Alina)*: _____

Preferred Hospital that you prefer your student sent to *(default is Regina)*: _____

Health Conditions

Please list any student allergies (environmental, food or animals/bugs): _____

_____

Please select your student's diagnosed health conditions (select all that apply)

- ☐ Allergies (food, insects, medications, latex)
- ☐ Allergies (seasonal)
- ☐ Asthma or Breathing Problems
- ☐ Attention Deficit/Hyperactivity Disorder (ADHD, ADD)
- ☐ Behavioral Concerns (Hitting, biting, spitting, etc.)
- ☐ Developmental Delay
- ☐ Bladder Concerns (incontinence, frequent UTI's, etc.)
- ☐ Bleeding Concerns (disorders, heavy nosebleeds, etc.)
- ☐ Bowel Concerns (incontinence)
- ☐ Problems/Concerns
- ☐ Cerebal Palsy
- ☐ Cystic Fibrosis
- ☐ Dental Problems/Concerns
- ☐ Diabetes (Type 1 or 2)
- ☐ Head injury, concussion (Current or history)
- ☐ Hearing Concerns or deafness
- ☐ Heart Problems/Concerns
- ☐ Mental Health Diagnosis (Anxiety, Depression, OCD, etc.)
- ☐ Muscle Diseases or Syndromes
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Speech Problems
- ☐ Spinal Cord Injury
- ☐ Vision Concerns or blindness
- ☐ Other
- ☐ N/A (My child has no medical diagnoses

If any of the above medical conditions were selected or other was selected, please provide additional information about their health condition here. *(i.e. if your child has a mental health diagnosis please specify which one - such as Depression and Anxiety, etc.)* _____

_____

_____

Are there any other health conditions, medications, or special considerations that the school staff needs to be aware of in order to provide the best care to your student? *Please explain below:* _____

_____

Asthma

Does your child use an inhaler?

- ☐ Yes
- ☐ No (*Please go to Diabetes Next*)

Do you have an Asthma Action Plan currently in place?

- ☐ Yes *(Please bring this on back-to-school night)*
- ☐ No *(Please have one filled out and turned into the nurse at your child's school)*

Where will your childs Inhaler be kept?

- ☐ Nurse's Office
- ☐ Backpack
- ☐ Locker
- ☐ At Home

Diabetes

Does your child have Type1 or Type 2 Diabetes?

- ☐ Yes
- ☐ No (*Please go to Allergy & Anaphylaxis Next*)

Which Diabetic Type has your child been diagnosed with?

- ☐ Type 1
- ☐ Type 2

Does your student have a Diabetic Action Plan?

- ☐ Yes *(Please bring this on back to school night)*
- ☐ No *(Please have one filled out and turned into the nurse at your child's school)*

Do you have any questions or requests for the nurses to better manage your student's blood sugars during the school day? _____

_____

Allergy & Anaphylaxis

Does your child require an Epi-Pen or Auvi-Q for a diagnosed allergy?

- ☐ Yes - Epi-Pen
- ☐ Yes - AuviQ
- ☐ No *(Please go to Epilepsy/Seizures Next)*

Does your Child have an Allergy and Anaphylaxis emergency plan?

- ☐ Yes *(Please bring this on back to school night)*
- ☐ No *(Please have one filled out and turned into the nurse at your child's school)*

Where will your childs Epi-Pen or Auvi-Q be kept?

- ☐ Nurse's Office
- ☐ Locker
- ☐ Backpack

Epilepsy/Seizures

Does your child have a diagnosis of Epilepsy (Current or hx)**?**

- ☐ Yes
- ☐ No (*Please go to Daily Medication Next*)

What type of seizure(s) does your child experience or has your child experienced? When was their last witnessed seizure? *(Grand Mal, Absent, etc.)*

_____

_____

Does your child require emergency seizure medications?

- ☐ Yes
- ☐ No

Does your Child have a Seizure Action Plan?

- ☐ Yes *(Please bring this on back to school night)*
- ☐ No *(Please have one filled out and turned into the nurse at your child's school)*

Where will your child keep their emergency medications?

- ☐ Nurse's Office
- ☐ Locker
- ☐ Backpack

Daily Medications

Please list any medications (prescription or over the counter) that your student takes Daily or As Needed *(if your child does not take any medications please type N/A or None):*

_____

_____

Will you need your student to take their medication(s) at school?

- ☐ Yes *(please contact the school nurse)*
- ☐ No

Over-the-Counter Medications

I give Prescott School District consent to administer the following Over-the-Counter medications to my child during school hours. *(**Only selected will be administered**. ***A note will be sent home with your student at MES & MIS if administered.*

*****We have tablets, chewable and liquid available*****

- ☐ Acetaminophen (Tylenol™)
- ☐ Ibuprofen (Advil™)
- ☐ Diphenhydramine (Benadryl™)
- ☐ Tums
- ☐ Hydrocortisone Cream
- ☐ Bacitracin
- ☐ Benadryl Cream
- ☐ Band-aid Cleanser (Hurt Free)
- ☐ Cough Drops (without menthol - halls breezers)
- ☐ Loratadine (Claritin™) or Cetirizine (Zyrtec™)
- ☐ None - I do not want any medications administered to my student while at school (even during an emergency)

All Over-the-counter medications will be given in doses in accordance with the American Academy of Pediatrics.

Signature

By signing/submitting this form, you are giving the Prescott School District permission to complete the following:

- Release the provided information to school personnel or emergency medical professionals on a need to know basis (meaning they are providing direct and frequent care for your student).
- Provide basic first aid and cares in the health room.
- Call emergency medical professionals (911), in the case of an emergency, on behalf of your child.

Parent/Guardian Signature: _____

Date:_____

If you have changes in <u>any</u> area of this bus information, please contact Tim Rundquist at the bus garage. Every student must have a bus form filled out and returned to Malone Schools.

4K KINDERGARTEN BUS INFORMATION

START DATE: _____

CHILD'S FULL NAME _____

PARENT'S FULL NAME _____
(Father) (Mother)

ADDRESS _____
Street City Zip Code

NAME OF TOWNSHIP IF APPLICABLE _____

HOME PHONE _____ WORK PHONE DURING DAY _____
(Include area code) (Mother)

_____
(Father)

CELL PHONE _____ _____
(Mother) (Father)

E MAIL _____ _____
(Mother) (Father)

IF YOUR CHILD WILL <u>NOT</u> BE RIDING THE BUS, PLEASE INITIAL HERE _____ DATE _____

WILL YOUR CHILD BE COMING TO SCHOOL FROM ANY FORM OF CHILDCARE PROVIDER?

Example: Heart, Hands, & Mind; New Adventures, Etc. _____ **YES** _____ **NO**

WILL YOUR CHILD BE RETURNING FROM SCHOOL TO ANY FORM OF CHILDCARE PROVIDER?

Example: Heart, Hands, & Mind; New Adventures, Etc. _____ **YES** _____ **NO**

IF EITHER OF THE ABOVE ANSWERS ARE YES, PLEASE GIVE THE FOLLOWING INFORMATION:

_____ _____
Name of Childcare Provider Address of Childcare Provider

Childcare Provider's Phone Number _____

IF YOU LIVE IN A RURAL AREA (OR IF YOUR CHILDCARE PROVIDER LIVES IN A RURAL AREA) PLEASE GIVE SPECIFIC LOCATION OF YOUR HOME.

Tim Rundquist, Transportation Manager, 715-262-3212

Revised 9/27/17

Prescott School District

Parent/Guardian Home Language Survey

Student Name _____ Grade _____

Relationship of Person Completing Survey

☐ Mother ☐ Father ☐ Guardian ☐ Other *Specify* _____

Directions: Check the correct response for each of the following questions and indicate other languages if appropriate.

	Yes	No
1. Is there a significant amount of language other than English spoken in the home?	☐	☐
2. Is a language other than English used to communicate with family?	☐	☐
If yes to either 1 or 2, what language? _____		
3. Is your child receiving, or have received, English Language Learner's services?	☐	☐
4. Can an adult family member, or someone in your household, speak English?	☐	☐
5. Can they read English?	☐	☐
6. If not, would you need the school to provide:		
*Essential communication in the language listed above?	☐	☐
*Interpreter for parent conferences?	☐	☐

_____ _____

Signature of Person Completing Survey Date

If questions 1, 2, or 3 are answered 'YES', please send a copy of this form to the Title III Coordinator and Director of Pupil Services.

10/8/2018