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)
☐	Prescott 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

FIRST DAY OF SCHOOL: ______________________

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

GRADE: ______________________

GENDER: _____Male______Female

STUDENT'S LEGAL NAME (Last) ____ (First) ______________________________________

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

MAILING ADDRESS____

BIRTHDATE ______/______/______ BIRTHPLACE (City/State/County) ____

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: ____________ End Date: ____________ Status: ____________ Branch: __________

GUARDIAN 2'S NAME (Last) _____________________________________ (First) ____

RELATIONSHIP ____ CELL PHONE (____) ______________

EMAIL ADDRESS ____ WORK PHONE (____) ______________

In the Military: ___ No ___Yes Date Enlisted: ____________ End Date: ____________ 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: ____________ End Date: ____________ Status: ____________ Branch: __________

GUARDIAN 2'S NAME (Last) _____________________________________ (First) ____

RELATIONSHIP ____ CELL PHONE (____) ______________

EMAIL ADDRESS ____ WORK PHONE (____) ______________

In the Military: ___ No ___Yes Date Enlisted: ____________ End Date: ____________ Status: ____________ Branch: __________

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

PRESCOTT SCHOOL DISTRICT REGISTRATION FORM Cont.

Non Household Emergency Contact (Not Parent) Information Parents are always contacted first. Emergency contacts should be available to pick up an ill or injured student. Be sure anyone you put down knows that they are on your student's emergency contact list.	
Emergency Contact #1:	**Relationship:**
Cell Phone:	
Other Phone:	
Emergency Contact #2:	**Relationship:**
Cell Phone:	
Other Phone:	

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

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

SCHOOL LAST ATTENDED:

School Name: ______________________________ ☐ Public ☐ Private

Address: ______________________________

Phone Number: ____________________ Fax Number: ____________________

Any other information you feel we need to know regarding your student:

____

____

____

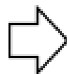
____

Please read, and then place your initials by <u>each</u> statement below.

____ I declare that my son/daughter has not been expelled or was under the process of expulsion, from a previous school district pursuant to Section 120.13(1)(f) of the Wisconsin Statutes. I understand and acknowledge that my failure to provide a true response to this statement is grounds for expulsion of my son/daughter, pursuant to Section 120.13(1)(f) of the Wisconsin Statues.

____ I have the legal authority to enroll this child in school.

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

 **Parent/Guardian Signature:** ______________________________ **Date:** ____________

Revised 9/20/19

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:________________

BUS INFORMATION

Start Date: ____________________

Child's Name:____ Grade_________________

Parents Name: ____

Address: _______________________________________ _________________________ ________________
Street City Zip Code

Will your child be coming to school from any form of childcare provider?

Ex: Heart, Hands, & Mind; New Adventures, Etc. _____ **Yes** _____ **No**

Will your child be returning from school from any form of childcare provider?

Ex: Heart, Hands, & Mind; New Adventures, Etc. _____ **Yes** _____ **No**

If either of the above answers are Yes, please give the following information about the Childcare Provider.

Name: ____

Address: ____

Phone: ____

If you live in a rural area (or if your childcare provider lives in a rural area) please give a specific location of your home.

Tim Rundquist, Transportation Manager, 715-262-3212 Revised 10/22/18

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