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 - Michelle Tromberg (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 - Jenna Ham (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 - Tammy Murphy (tmurphy@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

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 Heather Christenson 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 YOUR ADDRESS REQUIRES SPECIAL ATTENTION, PLEASE ADD INFORMATION ON THE BACK.

Heather Christenson, Transportation Manager, 715-262-3212

Revised 1/7/25

The Wisconsin Home Language Survey

This survey is given to all students enrolling in Wisconsin Schools.

Purpose

The information on this form helps us identify students who may need help to develop the English language skills necessary for success in school. Language testing may be necessary to determine if language supports are needed for your child.

Answers will not be used for determining legal status or for immigration purposes. If your child is identified as eligible for English language services, you may decline some or all of the services offered to your child.

Student Information

Date:		
First Name:	Middle Initial:	Last Name:
School Name:	Grade:	Date of Birth (mm/dd/yyyy):
District:	District ID:	
Language(s) Used by the student:		

Parent/Guardian Information:

First Name:
Last Name:
Relationship to Student:
First Name:
Last Name:
Relationship to Student:

Parental/Guardian Language Preferences Used for School Communication (may be multiple):

Parental/Guardian Name: _____

Oral: _____

Written _____

Parental/Guardian Name: _____

Oral: _____

Written: _____

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Section 1

1. Was the first language used by this student English?
    Yes: Go to Question 2.
    No: Go to Question 3.

2. When at home, does this student hear or use a language other than English more than half of the time?
    Yes: Go to Question 4.
    No: Student is not eligible for ELP Screening. HLS is complete. Go to Section 2.

3. When at home, does this student hear or use a language other than English more than half of the time?
    Yes: Administer ELP screener. Record other language(s). HLS is complete. Go to Section 2.
    No: Go to Question 4.

4. When interacting with their parents or guardians, does this student hear or use a language other than English more than half of the time?
    Yes: Administer ELP Screener. Record other language(s). HLS is complete. Go to Section 2. No: Go to Question 5.

5. When interacting with caregivers other than their parents or guardians, does this student hear or use a language other than English more than half of the time?
    Yes: Administer ELP screener. Record other language(s). HLS is complete. Go to Section 2.
    No: Go to Question 6.

6. When interacting with their siblings or other children in their home, does this student hear or use a language other than English more than half of the time?
    Yes: Administer ELP screener. Record other language(s). HLS is complete. Go to Section 2.
    No: Go to Question 7.

7. Is this student a Native American, Native Alaskan, or Native Hawaiian?
    Yes: Go to Question 8.
    No: Go to Question 9.

8. Is this student's language influenced by a Tribal language through a parent, grandparent, relative, or guardian?
    Yes: Administer ELP screener. Record other language(s). HLS is complete. Go to Section 2.
    No: Go to Question 9.

9. Has this student recently moved from another school district where they were identified as an English Learner?
*Yes: Rescreen the student if they meet the criteria for rescreening.
    No: Student is not eligible for ELP Screening. HLS is complete. Go to Section 2.

**See EL Policy Handbook Chapter 2. Otherwise, student's ELP should be carried over from the sending district.*

Section 2

HLS Result: **Screen / Do Not Screen** (circle one)