4850 South 60th Street ▪ Greenfield, Wisconsin 53220 ▪ Phone: 414-855-2050 ▪ Fax: 414-855-2051

Enrollment Checklist

Please return this sheet with all forms when registering

Student Name: ________________________________

_____ Proof of residency
Own: *tax bill (if just buying, closing statement [address/signature page])*
Rent: *lease (MUST have landlord's name, signature, address, phone number)*

_____ WE Energies bill within the last 30 days

_____ Child's Birth Certificate (*original certificate for verification)*

_____ Student Registration and Information Forms (1 for **each** student)
- ☐ Student Enrollment Form
- ☐ Annual Student Health Update
  - Prescription Medication at School Form (if applicable)
  - Non-Prescripition Medication at School (if applicable)
- ☐ Child Development Review
- ☐ Residency Information Form
- ☐ Student Immunization Record
- ☐ Home Language Survey

_____ Custody Documentation if applicable

_____ Transportation Information

K4 ONLY BELOW

_____ K4 Session Preference – AM/PM/No Preference (Please Note: Ranked preference does not guarantee session placement). You will be notified of placement prior to start of school.

(Rank 1 top preference, 2 secondary)

_____ AM _____ PM _____No Preference

STUDENT ENROLLMENT

Please complete for EACH student.

STUDENT INFORMATION (PLEASE PRINT)

Last	First	Middle	Gender (M/F)	Date of Birth (mm/dd/yyyy)	Grade	Has student previously been enrolled at Greenfield Schools? ☐ Yes ☐ No	Does student have an Individualized Education Plan (IEP) ☐ Yes ☐ No

Ethnicity/Race (Please complete BOTH questions)

1. Is the student Hispanic/Latino ☐ Yes ☐ No
2. Is the student one or more of these races? (check all that apply)
   - ☐ White
   - ☐ Black/African American
   - ☐ Asian
   - ☐ Native Hawaiian/Pacific Islander
   - ☐ Native American/Alaskan Native

Student lives with: (check one)

- ☐ Both Parents
- ☐ Mother
- ☐ Father
- ☐ Foster Parent
- ☐ Legal Guardian
- ☐ Other ______________

School name student last attended:

School Name: ______________

____
City State

Has your child ever been expelled?

Yes No Date: ______________

OFFICE USE ONLY:
Entrance Date: ______________
Grade level: ______________
Birth Certif. Verified: ______________
District Resident: Yes No
Proof of Residency: ______________
Open Enroll: _____ Res Verification: _____

EMERGENCY CONTACT INFORMATION List 3 local relatives or friends to use for contacts

Last Name	First Name	Relationship to child	Home Phone	Cell/Work Phone
Last Name	First Name	Relationship to child	Home Phone	Cell/Work Phone
Last Name	First Name	Relationship to child	Home Phone	Cell/Work Phone
Last Name	First Name	Relationship to child	Home Phone	Cell/Work Phone

LIST ALL CHILDREN (Age 18 and under) RESIDING IN THE PRIMARY HOUSEHOLD): complete ALL Information (PLEASE PRINT)

Last Name First Name Middle Name	Relationship	Gender (M/F)	Date of Birth (mm/dd/yyyyy)	Grade	School

Parent/Guardian Signature: ______________________________ Date: ______________

Complete backside of this form

STUDENT HEALTH INFORMATION

STUDENT INFORMATION (PLEASE PRINT)

Last	First	Middle	Gender (M/F)	Date of Birth (mm/dd/yyyy)	Grade	Does child have an existing medical condition? ☐ Yes ☐ No	Does child wear glasses and/or contacts> ☐ Yes ☐ No

MAIN HOUSEHOLD (WHERE STUDENT RESIDES) CONTACT INFORMATION (PLEASE PRINT)

Home Phone: ____________ Student Lives with: ____________

Parent/Guardian Name: ____________ Relationship to Student: ________ Cell Phone: ____________

Employer Name: ____________ Hours: ______ Work Phone: ____________

Parent/Guardian/Other Name: ____________ Relationship to Student: ________ Cell Phone: ____________

Employer Name: ____________ Hours: ______ Work Phone: ____________

HEALTH INFORMATION

Please check the appropriate box if your child's physician has diagnosed him/her with any of the following conditions.

- ☐ Arthritis
- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD, ADHD)
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Seizure/Epilepsy (last seizure was ____________)
- ☐ Takes prescription medications *

____

____

- ☐ Other health conditions:

____

- ☐ Surgery in the last 12 months: List: ____________

____

Parents may be asked to complete a Health Care Plan for their child.

Other General Information:

____

____

ALLERGY INFORMATION

☐ Yes ☐ No Does your child have severe or life-threatening allergies?

If Yes, please indicate below by checking the box(es):

- ☐ Food Allergy: ____________
- ☐ Medication Allergy: ____________
- ☐ Insect (Bite/Sting) Allergy: ____________
- ☐ Other: ____________

☐ Yes ☐ No Does your child have an Epi-pen?

*****When an Epi-pen is required, a Greenfield School district Medication Administration Consent Form must be completed and an Epi-pen sent to school.**

The above information will be shared with the appropriate school staff to meet the educational and safety needs of your child. If you have any concerns regarding the health of your child, please contact the District Health Nurse at (414) 281-6200 x 2439.

Parent/Guardian Signature: ____________ Date: ____________

Health Services ♦ 4800 South 60th Street ♦ Greenfield, Wisconsin 53220 ♦ 414-281-6200 X 2439 ♦ FAX: 414-8552497

MEDICATION REQUEST AND AUTHORIZATION

Complete one form for each prescribed medication. Guidelines on reverse side ➪

Student: ______________________ School: _________ Grade/Room: ______ School Year: ____________

Date of Birth: ____________ Parent/Guardian: ______________________ Teacher: ________________

Home Phone:__________________ Work Phone: _________________ Cell: ____________________

TO BE COMPLETED BY LICENSED PRESCRIBER ~

Name of Medication: ______________________________ Strength_ ______________________

Reason for Medication: ____________________________ Dose/Route:____________________

Time(s) to be given at school: ________________________ Frequency: ___________________

For PRN Orders: Specific symptoms or conditions under which medication is to be given: ______________

____

Possible Adverse Reactions/Side Effects: ____

Actions to take if Observed: ____

For Insulin, PRN Asthma Inhalers or Epi-Pens only, complete if applicable:

☐ Yes ☐ No This child has received adequate instruction about how and when to administer this medication and in my professional opinion is capable and responsible to self-administer it.

☐ Yes ☐ No Due to the need for this child to have this medication immediately accessible, I recommend he/she be allowed to have this medication in his/her possession and to use it as prescribed.

Date of expiration: ___________ Phone: __________________ Fax:____________________

Licensed Prescriber's Name/Address: ____
(Please Stamp or Print)

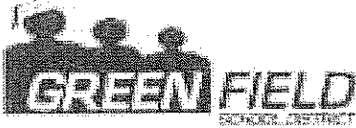
Licensed Prescriber's Signature:________________________ Date: ___________________

I, the parent or legal guardian of the above named student, have read and understand the Medication Guidelines on the reverse side. I understand that medications are NOT given by licensed medical personnel but by designated trained school personnel. I give permission for designated school personnel to administer the above prescribed medication to my child or for my child to carry and self-administer this medication, if so authorized. I further give permission for designated school personnel to request and share relevant health information about my child and the administration of this medication with appropriate school personnel.

I agree to do the following:

- **Deliver or assume responsibility for safe delivery of this medication to school.**
- **Notify the school in writing if this prescription is discontinued.**
- **Submit a new written authorization form and labeled pharmacy container if this prescription changes in any way.**
- **Pick up any unused medication.**

Parent/Guardian Signature: ________________________________ Date: __________________



Policy 5330 F2 Revised 6/07

Health Services ♦ 4800 South 60th Street ♦ Greenfield, Wisconsin ♦ 53220 ♦ 414-855-2439 ♦ FAX 414-855-2497

AUTHORIZATION TO ADMINISTER NONPRESCRIPTION MEDICATION

Complete *one form for each medication.* Guidelines on Reverse Side ⇨

PLEASE PRINT

School Year: ________ School: ________ Grade: _____ Room: _____ Teacher: ____________________

Student: __________________________ Date of Birth: ____________ Home Phone: ________________

Parent/Guardian: ___________________ Work Phone: ______________ Cell Phone: _______________

I, the parent or legal guardian of the above named student, have read and understand the Medication Guidelines on the reverse side. I understand that medications are NOT given by licensed medical professionals but by designated trained school personnel. I give my permission for designated school personnel to administer to my child the nonprescription (over the counter or OTC) medication listed below according to my written instructions. I further give permission for designated school personnel to request and share relevant health information about my child and the administration of this medication with appropriate school personnel.

I agree to:

- Deliver or assume responsibility for safe delivery of the medication to school.
- Provide the medication in the original, labeled, unopened manufacturer's container with my child's name clearly written on it.
- Submit a new written authorization form if any change in taking this medication occurs.
- Notify the school in writing immediately if there is a discontinuation of this medication.
- Pick up any unused medication

Medication: ____________________________________ Strength: ________________

Taken for: ______________________________ Amount to be given: ______________________

Time(s) to be given: ____

How often to be given: ____

If given ***as needed*** state specific symptoms or conditions for which it is to be given: ____________

____

Parent/Guardian Signature: _________________________________ **Date:** _________________

"Children are the highlights of our lives"

4850 South 60th Street ■ Greenfield, Wisconsin 53220 ■ Phone: 414-855-2050 ■ Fax: 414-855-2051

Residency Information Form

1. Are you currently a resident of the School District of Greenfield? Yes____ No____
2. Student's Name ____
3. Mother's Name ____
4. Mother's Address ____
5. Father's Name ____
6. Father's Address ____
7. Are the student's parents divorced or legally separated? *Yes____ No____ (If no, skip to question 10)

   *If yes, please provide a copy of the custody documentation within the certified court order and indicate child's primary address below in item 8.

Please note the following information regarding students of divorced parents:

- The School District of Greenfield maintains neutrality between parents unless otherwise directed by a court order, which has been provided to the District.
- Unless otherwise directed by a court order, which has been provided to the District, both parents may request and receive information regarding the student and participate in the student's school and district activities.

8. Student's primary residence____
9. Is the student living with someone other than the student's mother or father? *Yes___ No___ (If no, skip to signature at the bottom of the page)

   *If yes, please complete a Verification of Residency Form and complete questions 10&11.

10. Name of person student is living with__________________ Relationship _______________
11. Address____

I hereby certify that the information furnished on this form is true and correct to the best of my knowledge, and the School District of Greenfield may rely on this information to determine the residency of my child.

Parent Signature______________________________________ Date_____________________

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 07/12)

STATE OF WISCONSIN
252.04 and 120.12 (16) Wis. Stats.

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.

Step 1 PERSONAL DATA — PLEASE PRINT

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 ( )	

Step 2 IMMUNIZATION HISTORY

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, Tdap or Td. 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) ☐ Tdap ☐ 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:
☐ YES __________ year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Step 3 REQUIREMENTS

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

Step 4 COMPLIANCE DATA

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 INCOMPLETEY 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

Step 5 SIGNATURE

This form is complete and accurate to the best of my knowledge. Check one: (I do☐ I do not☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

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

STUDENT IMMUNIZATION LAW
AGE/GRADE REQUIREMENTS
2014 SCHOOL YEAR and Beyond

The following are the minimum required immunizations for each age/grade level. It is not a recommended immunization schedule for infants and preschoolers. For that schedule, contact your doctor or local health department.

Age/Grade	Number of Doses					
Pre K (2 yrs through 4 yrs)	4 DTP/DTaP/DT[2]		3 Polio	3 Hep B	1 MMR[5]	1 Var[6]
Grades K through 5	4 DTP/DTaP/DT/Td[1,2]		4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]
Grades 6 through 12	4 DTP/DTaP/DT/Td[2]	1 Tdap[3]	4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]

1. DTP/DTaP/DT vaccine for children <u>entering **Kindergarten:**</u> Your child must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
2. DTP/DTaP/DT/Td vaccine for all students <u>Pre K through 12:</u> Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
3. Tdap means adolescent tetanus, diphtheria and acellular pertussis vaccine. If your child received a dose of a tetanus-containing vaccine, such as Td, within 5 years of entering the grade in which Tdap is required, your child is compliant and a dose of Tdap vaccine is not required.
4. Polio vaccine for students entering grades <u>Kindergarten through 12:</u> Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
5. The first dose of MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).
6. Var means Varicella (chickenpox) vaccine. A history of chickenpox disease is also acceptable.

Home Language Survey
School District of Greenfield

Complete this form ONLY if you are new to the School District of Greenfield

	PARENT/GUARDIAN HOME LANGUAGE SURVEY		
Student's Name			Grade
Relationship of Person Completing Survey ☐ Mother ☐ Father ☐ Guardian ☐ Other *Specify*			
Directions: Answer questions #1-5.			
1. What is the **first date** your child enrolled in a school in the United States? ____/____/____ Month/ Day /Year			
	English	**Other**	**Other language(s)**
2. What language did your child speak when he or she first began to talk?	☐	☐	
3. What language do you use most of the time when talking to your child?	☐	☐	
4. What language does your child speak most of the time at home?	☐	☐	
5. What is your preferred language for home/school communication?			

	SIGNATURE	
Signature of Person Completing Survey ➢		Date Signed

	FOR STAFF COMPLETION TO BE COMPLETED FOR ALL NEW STUDENTS	
ELL File Opened ☐ Yes ☐ No	ELL Evaluator	Today's Date

SCHOOL DISTRICT OF
GREENFIELD
Learning - Growing - Succeeding
4850 South 60th Street ▪ Greenfield, Wisconsin 53220 ▪ Phone: 414-855-2050 ▪ Fax: 414-855-2051

Transportation Information

Student Name: ____

My child requires busing: ____ Yes ____No *(STOP HERE IF YOUR CHILD DOES NOT REQUIRE BUSING)*

Your home address: ____

Use HOME address for pick up and drop off: ____ Yes ____ No*

*If no, please indicate the address that should be used for pick up and/or drop off.

IF DIFFERENT THAN HOME ADDRESS COMPLETE BELOW

What is the pick-up address? ____ Daycare ____ Relative ____ Other

Pick-up:

Name: ____

Address: ____

____

Drop Off: Name: ____

Address: ____

____

**As a general rule, students are transported to and from their home address. If your child's pick up and/or drop off needs to be another location within the School District of Greenfield attendance boundaries, the student must designate this non-home address as the permanent pick up or drop off address.