



SCHOOL DISTRICT OF
GREENFIELD
Learning · Growing · Succeeding

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-Prescription 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



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Dear Parent/Guardian:

Welcome to the School District of Greenfield! Registration for enrollment in K4 and K5 Kindergarten for the 2016-17 school year begins on Monday, February 15th.

K4 Kindergarten is a two and a half hour program that is available in the morning or afternoon and is open to all students in the District who will be four years of age on or before September 1, 2016. K5 Kindergarten is a full day program open to all students in the District who will be five years of age on or before September 1, 2016.

K4 and K5 classes are offered at all four elementary schools. District students are placed at their home neighborhood school unless there is a need to shift students to accommodate appropriate class sizes.

School District of Greenfield Elementary Schools:

- Edgewood Elementary, 4711 S 47th St
- Elm Dale Elementary, 5300 S Honey Creek Dr
- Glenwood Elementary, 3550 S 51st St
- Maple Grove Elementary, 6921 W Coldspring Dr

Families new to the School District of Greenfield are encouraged to register their children for the new school year as soon as possible to help ensure placement in their attendance-area school.

Registration materials are available online at www.greenfield.k12.wi.us. Materials may also be obtained by contacting the School District of Greenfield Administration Center in person or by phone at (414) 855-2043. To complete the enrollment process, please return all registration materials to the Greenfield Administration Center, located at 4850 S. 60th Street. The Administration Center is open Monday through Friday from 7:30-4:00.

In addition to the completed registration forms, you will need to bring the following verification forms along with you:

- A current occupancy lease (if renting) or current tax bill (if own)
- WE Energies bill (within the last 30 days)
- Child's birth certificate for verification of date of birth
- Child's immunization records

On behalf of the staff, we welcome you to the District and look forward to our continued partnership throughout your child's educational experience in Greenfield.

Sincerely,

Lisa Elliott
Superintendent



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Special Notice Regarding K4 Students

Students enrolled in K4 Kindergarten are expected to be independent in his/her use of the bathroom and toilet. Independence in this area includes: securing the bathroom door, cleaning themselves, flushing the toilet, fastening clothes and washing their hands.

If a student should have a bathroom accident at school that cannot be taken care of independently by the child, the parent/guardian will be contacted and asked to come to school to help their child clean him/herself and change his/her clothes before returning to class. If a student should have a minor bathroom accident, he/she will be prompted to clean him/herself and change his/her clothes. All K4 students should have an extra change of clothes that are kept at school.



FAMILY CENSUS INFORMATION

Please provide the information as clear as possible.

Main household is where the child resides

MAIN HOUSEHOLD CONTACT INFORMATION (PLEASE PRINT)			
Guardian Last Name #1:	Guardian First Name #1:		Email Address:
Employer Name	Cell Phone:		Work Phone
Guardian Last Name #2:	Guardian First Name#2:		Email Address:
Employer Name	Cell Phone:		Work Phone

MAIN HOUSEHOLD ADDRESS INFORMATION (PLEASE PRINT)

MAIN HOUSEHOLD ADDRESS: _____ Street Address _____ City _____ State _____ Zip _____

Household Phone Number: _____

Is there a Secondary Household? Yes No *If Yes provide below:

Check this box with "X" if legal restrictions are in effect for this student.
(A copy of the court order must be provided to the Principal.)

SECONDARY RESIDENCY PARENT/GUARDIAN INFORMATION (PLEASE PRINT)

Parent/Guardian Name:	Address:
Relationship to Student:	Home Phone:
Cell Phone:	Work:
Parent/Guardian/Other Name:	
Relationship to Student:	
Cell Phone:	Work:

Parent/Guardian Signature: _____ Date: _____



STUDENT ENROLLMENT

Please complete for EACH student.

STUDENT INFORMATION (PLEASE PRINT)							
Last	First	Middle	Grade				
Ethnicity/Race (Please complete BOTH questions) 1. Is the student Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is the student one or more of these races? (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaskan Native		Student lives with: (check one) <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____	Date of Birth (mm/dd/yyyy) _____ Gender (M/F) _____ Has student previously been enrolled at Greenfield Schools? <input type="checkbox"/> Yes <input type="checkbox"/> No Does student have an Individualized Education Plan (IEP) <input type="checkbox"/> Yes <input type="checkbox"/> No				
School name student last attended: School Name: _____ City _____ State _____ Has your child ever been expelled? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Proof of Residency: _____ Open Enroll: _____ Res Verification: _____		OFFICE USE ONLY: Entrance Date: _____ Grade level: _____ Birth Certif. Verified: _____ District Resident: Yes <input type="checkbox"/> No <input type="checkbox"/>					
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				
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/yyyy)	Grade	School

Parent/Guardian Signature: _____

Date: _____

Complete backside of this form



STUDENT HEALTH INFORMATION



Last		First		Middle		Gender (M/F)		Date of Birth (mm/dd/yyyy)		Grade		Does child have an existing medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does child wear glasses and/or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

***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: _____



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: _____

"Children are the highlights of our lives"



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: _____

DEVELOPMENTAL MILESTONES

Name of Student	Sex	Date of Birth (mm/dd/yyyy)	Age
Parent/Legal Guardian Name			
Address			
Phone			
Email			

What are your child's strengths?

Do you have any concerns regarding your child's development, or does your child have a disability? If so, please describe.

(Continue on reverse if necessary)

The following statements describe developmental milestones that most children have reached by their 4th birthday. Please check each statement that describes your child. Remember all children develop at different rates, and these statements are meant to provide a guideline to typical behavior.

<p style="text-align: center;">Social/Emotional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Engages in pretend play <input type="checkbox"/> Cooperates with other children <input type="checkbox"/> Talks about likes and interests <input type="checkbox"/> Is able to pay attention to a story being read 	<p style="text-align: center;">Cognitive (learning, thinking, problem-solving)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Names some colors and some numbers <input type="checkbox"/> Understands the idea of counting <input type="checkbox"/> Draws a person with 2 to 4 body parts <input type="checkbox"/> Uses scissors <input type="checkbox"/> Starts to copy some capital letters
<p style="text-align: center;">Language/Communication</p> <ul style="list-style-type: none"> <input type="checkbox"/> Knows some basic rules of grammar, such as correctly using "he" and "she" <input type="checkbox"/> Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus" <input type="checkbox"/> Can say first and last name <input type="checkbox"/> Speaks clearly <input type="checkbox"/> Follows a 3 step direction 	<p style="text-align: center;">Movement/Physical Development</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hops and stands on one foot up to 2 seconds <input type="checkbox"/> Catches a bounced ball most of the time <input type="checkbox"/> Is toilet trained



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 _____

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					
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) <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)					

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 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 _____

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 entering Kindergarten: 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 Pre K through 12: 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 Kindergarten through 12: 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 <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other <i>Specify</i>																
Directions: Answer questions #1-5.																
1. What is the first date your child enrolled in a school in the United States? ____/____/____ <div style="text-align: right; margin-left: 300px;">Month/ Day /Year</div>																
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">English</th> <th style="width: 15%;">Other</th> <th style="width: 25%;">Other language(s)</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td colspan="3">5. What is your preferred language for home/school communication?</td> </tr> </tbody> </table>	English	Other	Other language(s)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		5. What is your preferred language for home/school communication?		
English	Other	Other language(s)														
<input type="checkbox"/>	<input type="checkbox"/>															
<input type="checkbox"/>	<input type="checkbox"/>															
<input type="checkbox"/>	<input type="checkbox"/>															
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 <input type="checkbox"/> Yes <input type="checkbox"/> No	ELL Evaluator	Today's Date														



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.