



# FREDERIC

SCHOOL DISTRICT

## REQUEST FOR RELEASE OF STUDENT RECORDS

To: Guidance Department

\_\_\_\_\_  
Name of School Last Attended

\_\_\_\_\_  
School Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
School Fax Number

Present Grade Level: \_\_\_\_\_

Last Date of Attendance: \_\_\_\_\_

The following student has enrolled in the Frederic School District. Please include a transcript of grades and credits including grades to date of withdrawal, testing results, health results, health records and any EEN or Special Education needs.

**PLEASE EMAIL TO ADMIN ASSISTANT: Dawn Owens [owensd@frederic.k12.wi.us](mailto:owensd@frederic.k12.wi.us)**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for request: \_\_\_\_\_

Date student will attend Frederic: \_\_\_\_\_

This student has special education needs:     Yes     No

Are you currently under an Expulsion Order with another school district?     Yes     No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**Office Use:**

Received By: \_\_\_\_\_

Date Faxed: \_\_\_\_\_



**FREDERIC SCHOOL DISTRICT  
REGISTRATION/EMERGENCY FORM**

Student Legal Last Name:	Student Legal First Name:	Student Middle Name:	Suffix: (Jr., II, etc)
Age:	Date of Birth: (mm/dd/yyyy)	City of Birth:	
Entering Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	State of Birth:	

Ethnicity Race: Is this student Hispanic/Latino:  Yes  No

Select one or more of the following categories that apply to this student: (check ALL that apply- must select at least one)

American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

ADDRESS: \_\_\_\_\_ MAIN PARENT PHONE: \_\_\_\_\_

STUDENT CELL PHONE (Only, if you would like them to be added for emergency messages): \_\_\_\_\_

Is this residence Temporary or Permanent? (Please Circle) If temporary, why? \_\_\_\_\_

Parent/Guardian #1: Are you a military parent? (Please Circle) Yes or No If Yes, Status \_\_\_\_\_ Branch \_\_\_\_\_

Last Name:	First Name:	Middle:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

Preferred Messenger Communication Method (Check ALL that apply)  Call  Text  Email

Parent/Guardian #2: Are you a military parent? (Please Circle) Yes or No If Yes, Status \_\_\_\_\_ Branch \_\_\_\_\_

Last Name:	First Name:	Middle:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

Preferred Messenger Communication Method (Check ALL that apply)  Call  Text  Email

WHO HAS LEGAL CUSTODY? \_\_\_\_\_

Child Resides with:  Both Parents  Mother  Father  Stepmother  Stepfather  
 Other \_\_\_\_\_ *Specify Relationship*

IS A SECOND MAILING REQUIRED?  YES  NO

If so, ADDRESS \_\_\_\_\_

BIRTH PARENTS NAMES: \_\_\_\_\_

BUS INFORMATION Will you child(ren) ride the bus?  YES  NO

**FREDERIC SCHOOL DISTRICT  
REGISTRATION/EMERGENCY FORM**

Other Child(ren) Residing in Household:

Name	Gender	Grade

EMERGENCY CONTACT INFO (If we cannot reach Parent/Guardian already listed):

Name:	Relationship to Child:
Cell Phone:	Other Phone:
Name:	Relationship to Child:
Cell Phone:	Other Phone:

**Do you have Internet Access in Residence?**     YES     NOT DESIRED     NOT AVAILABLE     NOT AFFORDABLE     OTHER

**How is your Internet Performance- Can you stream a video?**     YES     SOMETIMES     NO

**What is your primary Internet Access Type?**     RESIDENTIAL BROADBAND (DSL, FIBER, CABLE)     SATELLITE

CELLULAR NETWORK     DIAL -UP     HOT SPOT     COMMUNITY PROVIDED WI-FI     UNKNOWN     OTHER     NONE

**What is your Primary Learning Device Away from School?**     DESKTOP     LAPTOP     TABLET     CHROMEBOOK

SMARTPHONE     NONE     OTHER

**What is your Primary Learning Device Away from School?**     DESKTOP     LAPTOP     TABLET     CHROMEBOOK

SMARTPHONE     NONE     OTHER

**Who provided the primary learning device to the student?**     SCHOOL     PERSONAL     OTHER

**Is the primary learning device shared with anyone else in the household?**     SHARED     NOT SHARED     UNKNOWN

Does your child have unusual health conditions or other specific education considerations:     YES     NO

If so, please list: \_\_\_\_\_

Is your child allergic to medication or have any other allergies?     YES     NO

If so, please list: \_\_\_\_\_

Is this student under medication/treatment on a continuing basis?     YES     NO

If so, please list: \_\_\_\_\_

Physician or medical facility to be notified: \_\_\_\_\_

**(Prescription medication must have a physician's written consent to be administered at school. Please contact your child's school to obtain medication consent forms.)**

YES     NO    I authorize my child to receive OTC medications/treatments approved by the school district's medical advisor as needed, according to the manufacturer's guidelines for the duration of the school year. (These include: Acetaminophen (Tylenol), hydrocortisone cream, bacitracin, eye drops, and cough drops)

YES     NO    If emergency treatment is required and the emergency phone numbers cannot be reached immediately, may the school authorities use their own judgment in calling the physician indicated above, or if not available, an alternate physician? (If no, indicate plan to follow)

**Does your child have any religious beliefs that would hinder them from participating in some school events, holidays, ect.? If so, please give a brief explanation** \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Frederic School District  
Parent/Guardian Home Language Survey**

NAMES/GRADES OF <u>ALL</u> CHILDREN IN SCHOOL			
Name	Grade	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.

- |   | English                  | Other                    |
|---|--------------------------|--------------------------|
| 1. What language did the child learn when she/he first began to talk?.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What language does the family speak at home most of the time?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. What language does the parent(s) speak to her/his child most of the time?.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. What language does the child speak to her/his parent(s) most of the time?.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What language does the child hear and understand at home?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. What language does the child speak to her/his brothers/sisters?.....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. What language does the child speak to her/his friends most of the time?.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Yes                      | No                       |
| 8. Can an adult family member or extended family member speak English?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Can they read English?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do the parents/guardians request oral and/or written communication from the school to be in English?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, in what language? _____  |                          |                          |

**Signature**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR STAFF TO COMPLETE FOR ALL NEW ELL STUDENTS			
ELL File Opened <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	ELL Test Date	Test
ELL Evaluator		ELL Level	Placement



## 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 only be waived 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 purpose only. If you have questions regarding 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 (MM/DD/YYYY)	Gender	School	Grade	School Year
	Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)		Telephone Number ( )		

### IMMUNIZATION HISTORY

Step 2	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 MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
	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 <i>Vaccine is required only if your child has not had chickenpox disease. See below:</i>					
	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)	Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply) <input type="checkbox"/> Varicella <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B If YES, provide laboratory report(s)				

### REQUIREMENTS

Step 3	Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.
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### COMPLIANCE DATA

Step 4	<b>STUDENT MEETS ALL REQUIREMENTS</b> Sign at Step 5 and return this form to school. _____ Or _____ <b>STUDENT DOES NOT MEET ALL REQUIREMENTS</b> 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. <input type="checkbox"/> Although my child has NOT received ALL the 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. <b>NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.</b> <b>WAIVERS</b> (List in Step 2 above, the date(s) of any immunizations your child has already received) <input type="checkbox"/> For health reasons this student should not receive the following immunizations _____ _____ <b>SIGNATURE - Physician</b> _____ <b>Date Signed</b> _____ <input type="checkbox"/> For religious reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply) <input type="checkbox"/> DTaP/DTP/DT/Td <input type="checkbox"/> Tdap, <input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Varicella <input type="checkbox"/> For personal conviction reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply) <input type="checkbox"/> DTaP/DTP/DT/Td <input type="checkbox"/> Tdap <input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Varicella
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### SIGNATURE

Step 5	This form is complete and accurate to the best of my knowledge. Check one: ( I do <input type="checkbox"/> I do not <input type="checkbox"/> ) 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. _____ <b>SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student</b> _____ <b>Date Signed</b> _____
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## Medication Consent Form

Student Name: \_\_\_\_\_ School \_\_\_\_\_  
 DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Primary Phone#: \_\_\_\_\_

Over the Counter Medications							School shall contact the clinic for any of the following symptoms:
Medication Name:	Dosage	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration	
					From: To:		
					From: To:		
					From: To:		
					From: To:		
Prescription Medications (to be completed by Practitioner)							School shall contact the clinic for any of the following symptoms:
Medication Name:	Dosage	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration	
					From: To:		
					From: To:		
					From: To:		
					From: To:		

Emergency Medication Only. Practitioner to initial box below if student is able to carry and self-administer ie inhaler, Epinephrine.

**PRACTITIONER INFORMATION (needed for all prescription medication administered at school):**

Practitioner Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ The  
 above prescription medications will need to be administered at school:  
 Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Legal Guardian Consent (needed for all medication at school):**

**Medication will be provided by parent and in its original container or prescription labeled container.**

I hereby give permission for school personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian \_\_\_\_\_  
 Date

In the event that your child will have some unused doses of medication left at the end of the school year, please advise the school on how you would like the medication returned by completing the following:

I will arrange to pick up the unused portion of my child's medication.

Please send the unused portion of my child's medication home with him/her at the end of the school year.

**I understand that I am responsible for making sure it arrives home safely.**

