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

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: _____

Marcus Cornelius, 6-12 Principal
1437 Clam Falls Drive, Frederic, WI 54837
Phone: 715-327-4223

Kyle Luedtke, Superintendent
1437 Clam Falls, Frederic, WI 54837
Phone: 715-327-5630

Erin Hansford, Elementary Principal
305 Birch Street E, Frederic, WI 54837
Phone: 715-327-4221

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: ☐ Male ☐ 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 of 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 above):

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

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

How is your Internet Performance- Can you stream a video? ᛉ YES ᛉ SOMETIMES- NOT CONSISTENT ᛉ NO

What is your primary Internet Access Type? ᛉ RESIDENTIAL BROADBAND (DSL, FIBER, CABLE) ᛉ SATELLITE ᛉ CELLULAR NETWORK ᛉ DIAL -UP ᛉ HOT SPOT ᛉ COMMUNITY PROVIDED WI-FI ᛉ UNKNOWN ᛉ OTHER ᛉ NONE

What is your Primary Learning Device Away from School? ᛉ DESKTOP ᛉ LAPTOP ᛉ TABLET ᛉ CHROMEBOOK ᛉ SMARTPHONE ᛉ NONE ᛉ OTHER

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

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

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

If so, please list: _____

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

If so, please list: _____

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

If so, please list: _____

Physician or medical facility to be notified: _____

Each scheduled prescription medication to be administered at school or self-carry emergency medication requires a Medical Provider's order. These medications must be hand-delivered by the Parent/Guardian to the office, in the original bottle from the pharmacy. A new Medical Provider's order is required for any changes to an original prescription. Medications must be picked up by a Parent/Guardian before the last day of the school year.

ᛉ YES ᛉ 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: Saline eye drops, Acetaminophen (Tylenol), Ibuprofen (Advil), Diphenhydramine (Benadryl) or Loratadine (Claritin), Hydrocortisone 1% cream, Burn gel, and Bacitracin cream.)

ᛉ YES ᛉ 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: _____

Updated 4/11/2025

Frederic School District
Parent/Guardian Home Language Survey

NAMES/GRADES OF ALL 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?.....	☐	☐
2. What language does the family speak at home most of the time?.....	☐	☐
3. What language does the parent(s) speak to her/his child most of the time?.....	☐	☐
4. What language does the child speak to her/his parent(s) most of the time?.....	☐	☐
5. What language does the child hear and understand at home?.....	☐	☐
6. What language does the child speak to her/his brothers/sisters?.....	☐	☐
7. What language does the child speak to her/his friends most of the time?.....	☐	☐

	Yes	No
8. Can an adult family member or extended family member speak English?.....	☐	☐
9. Can they read English?.....	☐	☐
10. Do the parents/guardians request oral and/or written communication from the school to be in English?.....	☐	☐

If no, in what language?_____

Signature

Signature:_____ Date:_____

FOR STAFF TO COMPLETE FOR ALL NEW ELL STUDENTS			
ELL File Opened ☐ Yes ☐ No	Date	ELL Test Date	Test
ELL Evaluator		ELL Level	Placement

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2018)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

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) ☐ 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)

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)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ 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.

COMPLIANCE DATA

Step 4

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 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.

NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

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,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

SIGNATURE

Step 5

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

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:	Emergency Medication Only. Practitioner to initial box below if student is able to carry and self-administer.ie inhaler, Epinephrine.
Medication Name:	Dosage	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration		
					From: To:			
					From: To:			
					From: To:			

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.