NEW STUDENT REGISTRATION FORM - SECONDARY

A NON-REFUNDABLE BOOK & MATERIAL FEE OF $45 IS DUE AT THE TIME OF REGISTRATION.

Student **Legal** Name: _____
(First Name) (Full Middle Name) (Last Name) (Suffix-Jr., III, etc.)

Place of Birth: _____
(City) (State) (County)

Birth Date: _____ Gender: ❑ Male ❑ Female

Grade Entering: _____ If born outside U.S., date first attended a U.S. school: _____

School last attended: _____
(School name)

_____
(Street) (City) (State) (Zip Code)

Date last attended at previous school: _____

- Has this student ever attended a Wisconsin Rapids Public School? ☐ Yes ☐ No
  If yes, what school? _____
- Has this student ever been enrolled in any type of special education program?
  ☐ Yes ☐ No If **yes**, please explain:
- Does the student currently have a 504 plan in place? ☐ Yes ☐ No
- Is this student currently receiving "English Language Learner" Services (ELL, EL, ESL)?
  ☐ Yes ☐ No
- Wisconsin State Statute 120.13 (1) (f) states that no school board is required to enroll a pupil during the term of his or her expulsion from another school district. Has this student ever been expelled from a school or have an abeyance agreement in lieu of expulsion? ☐ Yes ☐ No
  If **yes**, please explain._____
  _____
- Has this student participated in high school athletics prior to enrolling here? ☐ Yes ☐ No
  - If you answered yes to the question above, please list ALL years and the schools at which participation in athletic programming occurred:
    _____
    _____
- If this student qualifies for transportation services, would he/she ride the bus:

  ☐Usually; ☐Occasionally; ☐Rarely; or ☐Never
  Pease select one.

*_*Your selection above does not affect your child's ability to receive transportation now or in the future.*_

PLEASE TURN FORM OVER AND COMPLETE BACK SIDE

Revised: 11/08/23 jtw

RACE: (Federal regulations require **both questions must be answered, Part I and Part II**)

Part I: Ethnicity Designation

Is the person Hispanic or Latino? Must choose one.

☐ Hispanic or Latino *[If selected go to Question I-A]*

☐ Not Hispanic or Latino *[If no, go to Question Part II]*

Optional Question I-A: If Hispanic or Latino was chosen above, select all that apply from the list below:

☐ Columbian ☐ Ecuadorian ☐ Guatemalan
☐ Mexican ☐ Puerto Rican ☐ Salvadoran
☐ Spaniard/Spanish/Spanish-American ☐ Decline to indicate
☐ Unknown ☐ Other

Part II: Race Designation

Select one or more of the following categories that apply to this person:

☐ American Indian or Alaska Native *[If selected go to question II-A]*

Optional Question II-A: If chosen, select all that apply from the list below:

☐ Bad River Band ☐ Forest County ☐ Ho-Chunk
☐ Lac Courte Oreilles ☐ Lac du Flambeau ☐ Menominee
☐ Oneida Nation (Wisconsin) ☐ Red Cliff ☐ Sokaogon
☐ St. Croix ☐ Stockbridge ☐ Brothertown
☐ Other *Please select value form Tribal Affiliation List* _____

☐ Asian *[If selected go to question II-B]*

Optional Question II-B: If chosen, select all that apply from the list below:

☐ Burmese ☐ Chinese ☐ Filipino
☐ Hmong ☐ Indian ☐ Karen
☐ Korean ☐ Vietnamese ☐ Decline to indicate
☐ Unknown ☐ Other_____

☐ Black or African American *[If selected go to question II-C]*

Optional Question II-C: If chosen, select all that apply from the list below:

☐ African-American ☐ Ethiopian-Oromo ☐ Ethiopian-Other
☐ Liberian ☐ Nigerian ☐ Somali
☐ Decline to indicate ☐ Unknown
☐ Other_____

☐ Native Hawaiian or Other Pacific Islander

☐ White

_____ _____

Parent/Guardian Signature Date

Revised: 11/08/23 jtw

510 Peach Street
Wisconsin Rapids, WI 54494
(715) 424-6700

WISCONSIN RAPIDS PUBLIC SCHOOLS
DISTRICT STUDENT INFORMATION FORM

_____ Primary Phone: _____
Student Legal Last Name /Full First Name/Full Middle Name/Suffix *(Jr., III, etc.)*

WRPS School enrolling:_____ **Student** Cell Phone *(optional)*: _____
Are you enrolling under: ☐ *Boundary Exception* ☐ *Open Enrollment* ☐ *Neither – this is student's normal attendance area*

Grade: _____ Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Who has primary/physical custody of student? ❑ Father/Mother in Same Home Together ❑ Father ❑ Mother ❑ Step Parent ❑ Foster Parent ❑ Guardian ❑ 50/50 Joint Custody Father/Mother ❑Other _____
(Primary custodians listed under Family 1 will be contacted FIRST in cases of emergency or illness.)

Do you have a court ordered custody agreement? ❑ Yes ❑ No ❑ N/A
(**If YES, please provide a copy of the most current paperwork.**)

Who does the student live with? If child lives with BOTH parents at same address, please fill out section ❶. If child lives part-time at one residence as the primary placement address, and part-time at another address due to a custody arrangement, please fill out the information in section ❶ below for the primary placement address, and section ❷ below to indicate the *secondary* address where the child resides.

*Please include your e-mail address on this form – **it is very important for communication.***

❶ FAMILY 1
This gray section pertains to the person having primary custody who is completing this form:

Guardian:_____ Cell Phone: _____

E-mail address:_____

***Relationship to** Student:* _____

Work Phone: _____
Times Worked:

Place of Employment: _____

YOUR Address: _____

Home Phone:_____

_____
City State Zip

Other Adult Contact Person at Above Address:
NOTE: Only list parents, legal guardians, step-parents, or foster parents. All others should be listed on the back under "Emergency Contacts." (Examples: Adult Siblings, Aunts, Uncles, Grandparents, Friends)

NAME:_____ Cell Phone: _____

E-mail address:_____

***Relationship to** Student:* _____

Place of Employment: _____

Work Phone: _____
Times Worked:

If the above individual is a step-parent, do you grant permission for the school to communicate with and share information with him/her concerning the student whom you are enrolling? ❒ YES ❒ NO

❷ FAMILY 2
Relationship: ❑ Father ❑ Mother ❑ Step Parent ❑ Foster Parent ❑ Guardian ❑Other _____

Name(s): _____ Home Phone: _____

Address: _____ Cell Phone: _____

E-mail Address:_____

_____
City State Zip

Work Phone: _____
Times Worked:

Place of Employment: _____

Please turn form over to complete back side.

Revised 01/26/2021 jtw

CURRENTLY, where is the **student** living? (***Check one***) *Please note: This is a required question which affects District funding for our Homeless program. Thank you for taking the time to answer this question.*

❑ WITH parent/guardian in own home or apartment
❑ WITH friends or family members (without parent/guardian)
❑ WITH parent/guardian at another family/friend's home due to loss of housing or as a result of economic hardship
❑ IN shelter (*example: Family Center*) ❑ IN motel, car, or campsite
❑ STUDENT on own, in home or apartment ❑ OTHER (please explain) _____

Other children from your household attending Wisconsin Rapids Public Schools:

Name :_____ School: _____ Grade:_____

Name :_____ School: _____ Grade:_____

Name :_____ School: _____ Grade:_____

MIGRANT INFORMATION

- Have you moved within the preceding thirty-six (36) months for the purpose of finding seasonal or temporary employment directly related to the producing or processing of crops or livestock, dairy farm employment, planting or harvesting trees, or catching shell fish or fish in natural waters?
  ❑ YES ❑ NO

If yes: When did you move? _____
From where did you move? _____
To where did you move? _____

- Did any children from birth to twenty-one (21) years of age move with you, or move to join you, related to this work search or employment? ❑ YES ❑ NO
- Are you under twenty-two (22) years of age? ❑ YES ❑ NO
- May local or state education staff visit with you at your home for more information from you about migratory children in your household?
  ❑ YES ❑ NO Best time of availability: _____

MILITARY QUESTIONNAIRE

We are required to ask the following information (please check "yes" or "no" as appropriate):

- Is either parent or guardian on active duty in the military? ❑ YES ❑ NO
- Is either parent or guardian a traditional member of the Guard or Reserve? ❑ YES ❑ NO
- Is either parent or guardian a member of the Active Guard/Reserve (AGR) under Title 10 or full time National Guard under Title 32? ❑ YES ❑ NO

DAYCARE PROVIDER (if applicable): Does your child attend daycare? Please fill in the information below concerning daycare attendance:

NAME OF DAYCARE PROVIDER(s): _____

ADDRESS: _____ PHONE: _____

EMERGENCY CONTACTS: **List *up to* four individuals** who will assume temporary care of your child and/or has your permission to pick your child up from school if you cannot be reached:

Name**:** _____Relationship to Child: _____ Phone: _____

Name**:** _____ Relationship to Child: _____ Phone: _____

Name**:** _____Relationship to Child: _____ Phone: _____

Name**:** _____Relationship to Child: _____ Phone: _____

WHILE participating in school activities and/or attending FIELD TRIPS, I authorize treatment by a licensed medical physician/dentist of the above minor in the event of a medical/dental emergency that, in the opinion of the attending physician/dentist, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. The authority granted is only to be exercised after reasonable efforts have been made to reach me ***if time so permits***. If I cannot be reached, I authorize the school Principal, teacher certified CPR/first aide staff, or my designated contact person to call or drive my child to the physician or dentist listed above, or the nearest hospital if emergency care is needed. An ambulance may be called if necessary. This release form is completed and signed below of my own free will and is for the sole purpose of authorizing necessary medical treatment under emergency circumstances in my absence. **Special Accommodations:** Students with disabilities who need special accommodations to participate in activities should inform the school, prior to activity date.

Parent/Guardian Signature: _____Date:_____

WISCONSIN RAPIDS PUBLIC SCHOOLS

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 by 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 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) other than Enlish 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: _____

Please check "yes" or "no" and follow the instructions.

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. Survey is complete.

3. When at home, does this student hear or use a language other than English more than half of the time?
   - ☐ Yes: School District will administer ELP screener. Record other language(s). Survey is complete.
   - ☐ 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: School District will administer ELP Screener. Record other language(s). Survey is complete.
   - ☐ 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: School District will administer ELP screener. Record other language(s). Survey is complete.
   - ☐ 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: School District will administer ELP screener. Record other language(s). Survey is complete.
   - ☐ 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: School District will administer ELP screener. Survey is complete.
   - ☐ No: Go to Question 9.

9. Has this student recently moved from another school district where they were identified as an English Learner?
   - ☐ Yes: School District will re-screen the student if they meet the criteria for re-screening.
   - ☐ No: Student is not eligible for ELP Screening. Survey is complete.

NEW STUDENT MEDICAL RECORD

WISCONSIN RAPIDS PUBLIC SCHOOLS

This information will be shared with appropriate school personnel only.

Student Name:_____ Gender: M / F Birth Date: _____ Age: _____Grade_____

Parent/Legal Guardian: _____

Address: _____ City:_____ State:_____ ZIP:_____

Phone number: _____

Physician: _____ Phone # _____ Copy of Immunizations: ☐ Yes ☐ No

Dentist:_____ Phone #_____

Does your child take prescribed medication? ☐ Yes ☐ No If Yes… ☐ Taken At Home ☐ Taken At School

What medication: _____

What for: _____

MEDICAL HISTORY (check items child has had)

Arthritis	_____	Chicken Pox	_____	High Blood Pressure	_____
Asthma	_____	Diabetes	_____	Premature Birth	_____
Attention Deficit Disorder	_____	Ear Infections (chronic)	_____	Traumatic Brain Injury	_____
Bladder/Kidney Infection	_____	Epilepsy/seizure disorder	_____	Other: _____	
Blood Disorder	_____	Emotional/Mental Illness	_____	_____	
Bowel Problems	_____	Heart Disease/Defect	_____	_____	

Additional Information _____

Vision Problem (explain) _____

Does your child wear glasses? Yes _____ No _____ Does your child wear contact lenses? Yes _____ No _____

Hearing Problem (explain) _____

Student has allergies to: ☐ Animals ☐ Foods ☐ Insects ☐ Medication ☐ Seasonal

Specify Allergies:_____

Describe Allergic Reaction: _____

Does your child require an EpiPen? Yes _____ No _____ Antihistamine (Benadryl) Yes _____ No _____

Serious accidents: _____

Operations (what and when): _____

Are there any special medical or other concerns that the school should be aware of to enable us to design an educational program for your child? _____

_____

Are there any health conditions regarding your child that you would like to discuss with the school nurse? Yes _____ No _____

(For Kindergarten Only) Is your child toilet trained? Yes _____ No _____

_____ _____

Parent Signature Date

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (02/2023)

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.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Phone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations.. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: https://www.dhfswir.org/PR/clientSearch.do?language=en

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 if your child has not had chickenpox disease. See below*					
Meningoccocal (serogroup ACWY)					

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.
☐ I attest that this student has a reliable history of varicella disease,

_____
SIGNATURE – Healthcare Provider Date Signed

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)

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** 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 ☐ MenACWY

☐ **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 ☐ MenACWY

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