



FOUR-YEAR-OLD HALF-DAY KINDERGARTEN REGISTRATION

Student Legal Name: _____ AS ON BIRTH DOCUMENT (Last Name) (First Name) (Full Middle Name) (Suffix – Jr. III, etc.)

Gender: Male Female Birth Date: _____ (Child must be 4 on or before 9/1/2024. DOB needs to be 09/01/2020 or before)

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

Mother's Name on Birth Document: _____

Father's Name on Birth Document: _____

Office Only: Birth document verified by (full name): _____ Document type: Birth Certificate Baptismal Certificate Passport Immigration Certificate

Student is Open Enrolled in from: _____

DPI Online Open Enrollment complete: yes no

Site assignments will be based on prior program enrollment, need for child care services, place of residence, date of registration, bus routes, and whether or not openings are available at the site you have selected. Sites could change. The site your child attends for 4K in no way indicates where they will attend 5K.

Please indicate site preference by placing 1, 2, or 3 in front of the locations listed.

- Grant Elementary Community Partner Sites Accepted Head Start Students: Pitsch Early Learning Center Building Blocks Learning Ctr Biron Head Start THINK Academy YMCA Woodside

Do you prefer a.m. or p.m.? (some sites have only one option)

Location or Session time Is a higher priority for my child's placement.

Will your child attend daycare before or after the 4K program?

No Yes- where? _____

Do you have any other children at the site you have chosen? No Yes

Name/age or grade of other children at the site you have chosen: _____

My child has been accepted to and will attend Head Start for the other 1/2 of the school day.

Head Start Location: _____

Is your child in an Early Childhood Special Education program? No Yes

PLEASE TURN FORM OVER AND COMPLETE BACK SIDE

RACE: (Federal regulations require **both questions must be answered**)

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 only one 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

Will your child need district busing?

No Yes – complete pickup/drop off information below:

(Busing is only available within the attendance area of the 4K site your child attends. Transportation routes will take priority in determining your child’s site location and time. An adult MUST be with the child at the pickup and drop off location.)

Residence child to be **picked up**

(Name/Relationship) (Address) (Phone)

Residence child to be **dropped off**

(Name/Relationship) (Address) (Phone)

Parent/Guardian Signature

Date



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

**WISCONSIN RAPIDS PUBLIC SCHOOLS
 DISTRICT STUDENT INFORMATION FORM**

Primary Phone: _____
 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

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 1. 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 1 below for the primary placement address, and section 2 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.

1 FAMILY 1

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

Guardian: _____

Relationship to Student: _____

Place of Employment: _____

YOUR Address: _____

City State Zip

Cell Phone: _____

E-mail address: _____

Work Phone: _____
 Times Worked: _____

Home Phone: _____

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: _____

Relationship to Student: _____

Place of Employment: _____

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

Cell Phone: _____

E-mail address: _____

Work Phone: _____
 Times Worked: _____

2 FAMILY 2

Relationship: Father Mother Step Parent Foster Parent Guardian Other _____

Name(s): _____

Address: _____

City State Zip

Place of Employment: _____

Home Phone: _____

Cell Phone: _____

E-mail Address: _____

Work Phone: _____
 Times Worked: _____

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: _____



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 English 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.



4K Parent Questionnaire

Directions: Please place a check mark next to the answer that best describes your child. "Yes" indicates that your child is able to complete the task most of the time without adult assistance (90% of the time).	Yes	Some of the Time	No
Communicates wants and needs using words more often than gestures (e.g. "I want a cookie..")			
Use at least three words in a sentences (Example: "I like milk")			
Do others understand your child's speech most of the time?			
Toilet trained (wears underwear, stays dry all day). Note: This is not a requirement for 4K enrollment. Please share any additional information regarding your child's toileting skills that may be helpful: _____			
Uses a fork or spoon to feed themselves with some spilling			
Tries to color in a picture (Does NOT have to stay in the lines)			
Climbs up a ladder and slides down a slide without help			
Take off open coat and puts back on (Does NOT need to button or zip)			
Uses objects in pretend play (pretends to cook or talk on the phone)			
Is interested in children near their own age (Watches other children, is excited to see other children, and plays next to or with other children.)			
Is able to separate from parent(s) for short amounts of time			
Does your child exhibit worries or fears that may affect learning or social development? Please explain: _____			
Do you notice that your child shows and handles emotions in a typical manner for 4 year old children? (e.g. displays a variety of emotions, resets in a short time after an upset, shows anger without physically harming others) If 'sometimes' or 'no', please explain: _____			
Has your child had prior experiences in any of the following settings: child care, preschool, or Head Start?			

_____ Child's Name _____ Parent Signature

_____ Parent Name _____ Phone Number

_____ Parent Email

_____ I have concerns or questions about my child's development and would like someone from the Wisconsin Rapids School District to contact me.



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)

Table with 3 columns of medical conditions: Arthritis, Asthma, Attention Deficit Disorder, Bladder/Kidney Infection, Blood Disorder, Bowel Problems, Chicken Pox, Diabetes, Ear Infections (chronic), Epilepsy/seizure disorder, Emotional/Mental Illness, Heart Disease/Defect, High Blood Pressure, Premature Birth, Traumatic Brain Injury, Other.

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

STUDENT IMMUNIZATION LAW AGE/GRADE REQUIREMENTS

The following are the minimum required immunizations for each age and grade level according to the Wisconsin Student Immunization Law. These requirements can be waived for health, religious, or personal conviction reasons. Additional immunizations may be recommended for your child depending on his or her age. Please contact your doctor or local health department to determine if your child needs additional immunizations.

**Table 144.03-A
Required Immunizations for the 2021-2022 School Year and the Following School Years**

Age/Grade	Required Immunizations (Number of Doses)								
5 months through 15 months	2 DTP/DTaP/DT		2 Polio			2 Hep B	2 Hib	2 PCV	
16 months through 23 months	3 DTP/DTaP/DT		2 Polio	1 MMR		2 Hep B	3 Hib	3 PCV	
2 years through 4 years	4 DTP/DTaP/DT		3 Polio	1 MMR	1 Var	3 Hep B	3 Hib	3 PCV	
Kindergarten through grade 6	4 DTP/DTaP/DT		4 Polio	2 MMR	2 Var	3 Hep B			
Grade 7 through grade 11	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			1 Mening
Grade 12	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			2 Mening

- Children 5 years of age or older who are enrolled in a Pre-K class should be assessed using the immunization requirements for Kindergarten through Grade 5, which would normally correspond to the individual's age.
- D = diphtheria, T = tetanus, P = pertussis vaccine. DTaP/DTP/DT/Td vaccine for all students Pre-K through 12; Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note:** A dose four days or less before the 4th birthday is also acceptable.
- DTaP/DTP/DT vaccine for children entering Kindergarten: Each student must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. **Note:** a dose four days or less before the 4th birthday is also acceptable.
- Tdap is an adolescent tetanus, diphtheria, and acellular pertussis combination vaccine. If a student received a dose of a tetanus-containing vaccine, such as Td, within five years before entering the grade in which Tdap is required, the student is compliant and a dose of Tdap vaccine is not required.
- Polio vaccine for students entering grades Kindergarten through 12; Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note:** a dose four days or less before the 4th birthday is also acceptable.
- Laboratory evidence of immunity to hepatitis B is also acceptable.
- MMR is measles, mumps, and rubella vaccine. The first dose of MMR vaccine must have been received on or after the 1st birthday. Laboratory evidence of immunity to all three diseases (measles and mumps and rubella) is also acceptable. **Note:** A dose four days or less before the 1st birthday is also acceptable.
- Varicella vaccine is chickenpox vaccine. Students with a reliable history of varicella disease are not required to receive the Varicella vaccine. A physician, physician assistant, or advanced practice nurse prescriber must document a reliable history of varicella disease by indicating that the student has had varicella and signing the Student Immunization Form (DHS Form 04020L). Current Wisconsin students with a parental report of varicella prior to February 1, 2023 are not required to receive Varicella vaccine.
- One dose of Meningococcal vaccine (serogroup A,C,W,Y) is required for students entering 7th grade, and a booster dose is required for students entering 12th grade. Students are assessed for this requirement in 7th grade and 12th grade only. Current Wisconsin students in 8th-11th grade will not be assessed for this requirement until they enter 12th grade. A second dose is not required for students who received their first dose of MenACWY at age 16 years or older.



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 Code)		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.dhfs.wisconsin.gov/immunization/registry/					
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					
Meningococcal (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. <input type="checkbox"/> I attest that this student has a reliable history of varicella disease,			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)		
_____ SIGNATURE – Health Care Provider Date Signed					

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
<p>Student Meets All Requirements Sign at Step 5 and return this form to school. _____ Or _____</p> <p>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.</p> <p><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.</p> <p>Note: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.</p> <p>Waivers (List in Step 2 above, the date(s) of any immunizations your child has already received)</p> <p><input type="checkbox"/> For health reasons this student should not receive the following immunizations _____</p> <p>_____ SIGNATURE – Physician Date Signed</p> <p><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"/> MenACWY</p> <p><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 <input type="checkbox"/> MenACWY</p>

Step 5 Signature
This form is complete and accurate to the best of my knowledge. Check one: (I <input type="checkbox"/> 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.
_____ SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed