

K4 Parent Information Sheet

Student's Name _____ DOB: _____ Male / Female

Does your child have a nickname? If yes, please list: _____

Primary Household Information:

Parent/Guardian Name(s) & Email: _____

Address: _____ City: _____ Zip Code: _____

Phone:

Home _____ Work _____ Cell _____

Name and ages of other children in the household:

Second Household Information: (if applicable)

Parent/Guardian Name(s) & Email: _____

Address: _____ City: _____ Zip Code: _____

Phone:

Home _____ Work _____ Cell _____

Name and ages of other children in the household:

Developmental / Social Information:

Age your child learned to speak: Words _____ Sentences _____

Age your child learned to: Crawl _____ Walk _____

Behavioral Information:

Does he/she play well with other children? Y / N Does he/she play well alone? Y / N

Please circle any of the following areas your child has evidenced tendency in:

Excessive Crying Frequent Nightmares Biting Nails Temper Tantrums

Sucking Thumb Bedwetting Sleeping Problems Unusual or Excessive Fears

Please describe any other behaviors or conditions that you feel we should be aware of:

Speech and Language Information:

How much of his/her speech can you understand? All Most Some None

How much can other adults understand? All Most Some None

Has he/she had speech or hearing tested? Yes No

If Yes, where? _____

Has he/she had therapy for speech, hearing, or language? Yes No

Would you like to confer with a speech pathologist? Yes No

Are there any other children in the family with speech concerns? Yes No

If yes, please list: _____

Does your child speak English: Yes No

Is any other language other than English spoken in the home? Yes No

If yes, what language? _____ Which is child's primary language? _____

Miscellaneous Information About Your Child:

What interests does your child have?

What are some of your child's greatest strengths:

What do you hope for your child as he/she grows this year in K4?

If there is additional information about your child that would be helpful for us to know:

Today's Date: _____ **Raymond School District #14 - Enrollment Form**

_____ **Female** **Male**
 Student Name Student Birthdate Grade Entering

_____ **Street Address** _____ **City** _____ **Zip** _____ **Phone**

_____ **Parent/Guardian Names**

_____ **Primary Email Address** _____ **Secondary Email Address**

Is student living with both parents? Yes No Do both parents have legal custody? Yes No
 Is this student a foster child? Yes No
 If yes, caseworker's name and phone number: _____

_____ **Rank in Family (circle one)** 1 2 3 4 5 6 7 8
 # of brothers # of sisters

Transportation Information - Estimated number of miles from student's home:
 Check one: 0-2 miles 2-5 miles 5-8 miles 8-12 miles 12 or more miles

Ethnic Background - Check all that apply:
 American Indian/Alaskan Native Asian African American Hispanic White
 Native American/Pacific Islander Other (Please specify: _____)

	For Office Use	
	Initials	Date
Administrator/Principal		
Teachers:		
Reading Specialist		
School Counselor/Psychologist		

Proof of Residency Form

Must be completed for students that reside in-district

Raymond School District #14
2659 S. 76th St. Franksville, WI 53126
(262)835-2929 raymond.k12.wi.us

_____ Male Female

Child's Name Date of Birth Grade

Parent/Guardian Name Address Phone

Please list Names/Birthdates of all children in family:

Name	Date of Birth

The children reside at this address with: Parents Other – please specify: _____
Is he/she a foster child? Yes No (If yes, caseworker's name/phone: _____)

Please check the Proof of Residency that you are attaching to this form:

- Property Tax Bill (if you are a home owner)
- Utility Bill or Lease Agreement (if you are renting)
- Proof of lot/land purchased in Raymond School District #14 and a signed schedule from the builder.
Please indicate projected date of occupancy: _____

I hereby attest that all of the above is true.

_____ Signature

_____ Date



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 2659 S. 76th St.
 Franksville, WI 53126
 (262)835-2929 Fax: (262)835-2087
 raymond.k12.wi.us

Office Use:
 Entry Date ____ / ____ / ____
 Birth Certificate
 Proof of Residency

PLEASE LIST ALL CHILDREN LIVING IN THE SAME HOUSEHOLD

1st Child LEGAL Name (Include Complete Middle Name)

_____ / _____ / _____
 Last Name First Name Complete Middle Name
 ____ / ____ / ____ ____ ____ Male Female _____
 Date of Birth Grade Age Birth County City State

Ethnicity: White Hispanic African American Native American Asian
 Native Hawaiian/Pacific Islander Other (Please Specify _____)

2nd Child LEGAL Name (Include Complete Middle Name)

_____ / _____ / _____
 Last Name First Name Complete Middle Name
 ____ / ____ / ____ ____ ____ Male Female _____
 Date of Birth Grade Age Birth County City State

Ethnicity: White Hispanic African American Native American Asian
 Native Hawaiian/Pacific Islander Other (Please Specify _____)

3rd Child LEGAL Name (Include Complete Middle Name)

_____ / _____ / _____
 Last Name First Name Complete Middle Name
 ____ / ____ / ____ ____ ____ Male Female _____
 Date of Birth Grade Age Birth County City State

Ethnicity: White Hispanic African American Native American Asian
 Native Hawaiian/Pacific Islander Other (Please Specify _____)

** Please use another sheet if you have additional children to register.*

Census and Projected Enrollment *(Please provide sibling information to help us plan for future enrollment.)*

_____	_____	_____	_____
Sibling	Birthdate	Sibling	Birthdate
_____	_____	_____	_____
Sibling	Birthdate	Sibling	Birthdate

Custody Information: Joint Mother Father Guardian Other _____

Court Ordered Custody: Yes No *(If yes, court order must be on file in the school office to be implemented.)*

PRIMARY HOUSEHOLD – (Address where child(ren) reside 50% or more of the time.)

Primary language spoken in primary household is English.

1st Adult – Primary Contact - Mother Father Step-Parent Foster-Parent Aunt/Uncle Grandparent Other

_____		_____	
Last Name		First Name	
_____			_____
Street Address			City

Zip			
Phone: (____) _____		(____) _____	
Home		Cell	
_____		_____	
Primary Email		Work Email	
_____		_____	
Employer		_____	

2nd Adult – with same address as Primary Contact

Mother Father Step-Parent Foster-Parent Aunt/Uncle Grandparent Other _____

_____		_____	
Last Name		First Name	
_____			_____
Street Address			City

Zip			
Phone: (____) _____		(____) _____	
Home		Cell	
_____		_____	
Primary Email		Work Email	
_____		_____	
Employer		_____	

SECONDARY HOUSHOLD – (Not child’s primary residence.) *Primary language spoken is English.*

1st Adult - Mother Father Step-Parent Foster-Parent Aunt/Uncle Grandparent Other _____

_____		_____	
Last Name		First Name	
_____			_____
Street Address			City

Zip			
Phone: (____) _____		(____) _____	
Home		Cell	
_____		_____	
Primary Email		Work Email	
_____		_____	
Employer		_____	

2nd Adult - Mother Father Step-Parent Foster-Parent Aunt/Uncle Grandparent Other _____

_____		_____	
Last Name		First Name	
_____			_____
Street Address			City

Zip			
Phone: (____) _____		(____) _____	
Home		Cell	
_____		_____	
Primary Email		Work Email	
_____		_____	
Employer		_____	

Emergency Contacts – If primary contacts cannot be reached in an emergency or when a child is ill, please notify: this also serves as permission for emergency contacts to pick up your child from school, if necessary.

1st Contact

Relation to Student: Grandparent Aunt/Uncle Child Care Provider Neighbor Sibling Other _____

Last Name First Name () Home Phone () Cell Phone

2nd Contact

Relation to Student: Grandparent Aunt/Uncle Child Care Provider Neighbor Sibling Other _____

Last Name First Name () Home Phone () Cell Phone

Physician: _____
Name () Phone Address

Directory Data Authorization

The Raymond School Board of Education recognizes personally identifiable information contained in students' records as directory information. Directory information may be released for any purpose at the discretion of Raymond School Board per Wisconsin Statute 118.125 (1)(b) and (2)2(j). Under the provisions of the Family Education Rights and Privacy Act (FERPA) of 1974, as amended, you have the right to withhold the release of any or all information. Failure to complete and return this form will result in the district NOT WITHHOLDING directory data regarding your child(ren).

- YES, I approve my child's information (name/image) to be released.
- NO, I do not approve my child's information (name/image) to be released.

Additional Authorizations (checking the box indicates approval)

- Authorize disclosure of student's medical condition(s) to appropriate personnel (principal, teachers, office staff, school nurse).
- Authorize school personnel to call emergency contacts and/or physician named, in event that I cannot be reached in an emergency.
- Authorize emergency first aid treatment.

Parent Signature*

Date

*Signature indicates parent/guardian authorization indicated above.

Student Health Information/Raymond Elementary School

Student Name		Grade	DOB
Parent(s) Name		Phone number(s)	
Is your child taking any medications on a regular or as needed basis?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please list: ANY MEDICATION NEEDED AT SCHOOL REQUIRES APPROPRIATE AUTHORIZATION & MEDICATION PROVIDED IN APPROPRIATELY LABELED CONTAINER. SEE SCHOOL POLICY FOR FURTHER DETAILS			
Has your child had any illnesses, injuries and/or surgeries since last school year?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please list:			
Does your child have ALLERGIES to <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Food <input type="checkbox"/> Other Specify:			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, does your child require MEDICATION at school for their allergies?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Provide name of any medication required at school: _____ Check the type of allergic reaction that occurs: <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Other: _____			
Does your child have DIABETES?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, does your child take insulin: Uses: <input type="checkbox"/> Insulin Pen <input type="checkbox"/> Pump, brand _____ <input type="checkbox"/> CGM			<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your child have ASTHMA?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, does your child require medication at school?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your child have SEIZURES?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, last known seizure: _____ Type: _____ Are medications required at school?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your child have a HEART CONDITION?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please describe:			
OTHER HEALTH ISSUES (List):			
Physician:		Phone Number:	
HEARING Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Left ear <input type="checkbox"/> Right ear	Hearing Aids: <input type="checkbox"/> YES <input type="checkbox"/> NO	
VISION Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	Other:	

I certify that the information on this form is accurate and it is my responsibility to keep the school updated to any changes that occur throughout the school year. I consent to the release of this medical information to any appropriate staff that has contact with my child for any school event including any contracted student service providers (such as bus drivers and cafeteria employees).

Signature _____ Printed Name: _____

Date _____

Raymond School District #14

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raymond.k12.wi.us

PARENT/STUDENT AGREEMENT – Concussion Law 2011 – Wisconsin Act 172

2019-20

As a parent and as a student, it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. This form must be completed for every school year in which your child will participate in any physical activity at school. This activity includes, but is not limited to: recess, physical education class, extracurricular sports, etc.

Parent Agreement:

I _____, the parent/guardian of _____ have read the Parent Concussion and Head Injury Information and understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play/class if a concussion is reported to me. I understand that my child cannot return to practice/play/class until providing written clearance from an appropriate health care provider to his/her teacher or coach. I understand the possible consequences of my child returning to practice/play/class too soon.

Parent/Guardian Signature: _____ Date: _____

More detailed information regarding concussions can be found at:

<http://dpi.wi.gov/sped/tbi-conc-guidelines.html>

<http://dpi.wi.gov/sped/tbi-conc-resources.html>

2019-20



Dousman Transport Co., Inc.
WE TRANSPORT THE WORLD'S MOST PRECIOUS CARGO

For any busing needs or changes, please fill out this form and either email as a PDF or fax back to the Union Grove terminal (262) 878-0730. Any and all information submitted on this form is considered confidential.

Today's date _____ School _____

Student's first name _____ Student's last name _____ M.I. _____

Student's Information

Street address _____ Grade _____ Student I.D. _____

Street address line 2 _____ Gender _____ Birthday _____

City _____ Zip code _____ 4K Scheduled days _____

Start date _____ End date _____ Reason for removing from route _____

In-active? Check here if the student will not be using bus transportation for an extended period of time.

(Please give a 24 hour notice prior to needing transportation.)

If student is Open Enrollment, an Open Enrollment Contract / Waiver must accompany this form.

Open Enrollment? _____

Primary Parent/Guardian Information

Name (First, Last) _____ Primary Phone number _____

Primary Emergency Phone number _____ Alternate phone number _____

Secondary Parent/Guardian Information

Name (First, Last) _____ Primary Phone number _____

Primary Emergency number _____ Alternate phone number _____

Street address (If different from above) _____ Will busing be provided for this address? _____

Street address line 2 _____

City _____ Zip code _____

Medical / Other Important Information

Please list any of the following: current medical conditions, any allergies, health concerns, or any other pertinent information.

Childcare Information

(To be completed if using a daycare or babysitter)

Childcare provider

Primary Phone number

Street address

Alternate phone number

City

Zip code

Will this be the regular pick up & drop off?

Yes - both AM & PM

Only AM

Where will they be in the PM?

Only PM

Where will they be in the AM?

Other

Please be aware that all school and bus rules apply while student is on board. Failure to follow rules may result in suspension from the bus. In-district students have first right to transportation. If the bus becomes over capacity, open enrollment students will be removed from the route to make room.

Route Information

(To be completed by bus company)

AM Route

P.U. Time

Pick up address

PM Route

D.O. Time

Drop off address

Special Instructions for Pickup/Drop Off

2019-20

Student's Last Name: _____ First: _____