BALDWIN-WOODVILLE AREA SCHOOL DISTRICT

550 US HIGHWAY 12
BALDWIN, WI 54002

4K REGISTRATION

STUDENT INFORMATION (PLEASE PRINT)

Office Use Only
Birth Certificate: ___Yes ___No
Verified By: _____

Male ☐ Female ☐

Legal First Name	Legal Middle Name	Legal Last Name

Student's Street Address	City/State/Zip Code	Student's Home Phone

Date of Birth (mm/dd/yyyy)	City & State of Birth	County of Birth	Country of Birth (if not USA)

What primary language does your family use at home?
☐ English ☐ Spanish ☐ Hmong ☐ Other

Race/Ethnicity Is student Hispanic or Latino? ☐ Yes ☐ No

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

Resident of B-W School District ☐ Yes ☐ No

Has your child ever been enrolled in a preschool or childcare program? ☐ Yes ☐ No

If yes, where? _____ Dates? _____

Do you have concerns about the development of your child? ☐ Yes ☐ No If yes, specify _____

Has your child ever been enrolled in Special Education, Birth to Three or Early HeadStart?
☐ Yes, currently enrolled and has an IEP
☐ Yes, was previously enrolled but dismissed
☐ No, has never been enrolled in a Special Education program

Parent/Guardian #1 _____ Relationship _____
Address (If different from child) _____ Email Address: _____
Home Phone _____ Cell _____ Work _____

Parent/Guardian #2 _____ Relationship _____
Address (If different from child) _____ Email Address: _____
Home Phone _____ Cell _____ Work _____

Student lives with: _____

The following criteria will be utilized to determine your child's site location and time:

- ***Wrap-around daycare provided by a particular location***
- ***Location during the day with respect to district bud transportation***

After site numbers are determined, a change in site may be requested by parents who are willing to transport their child.

Does your child need district bus transportation? ☐ **Yes** ☐ **No**

We will do our best to accommodate your request: Please check the box that works best for your child.

☐ **Morning Session** ☐ **Afternoon Session** ☐ **No Preference**

Baldwin-Woodville Area School District
550 Highway 12
Baldwin, WI 54002

HOME LANGUAGE SURVEY

To Be Completed For all New Students

Student's Name: _____ Grade: _____

Date of Birth _____ Country of Birth _____

Relationship to Student: ☐ Mother ☐ Father ☐ Guardian ☐ Other Specify _____

Please fill in the answer for each of the following questions.

1. What language did your child first learn? _____

2. What primary language does your family use at home most of the time? _____

3. What language do you or other parent/guardian use with your child? _____

4. What language does your child use with his/her friends? _____

5. How many years has this child lived in the United States? _____

6. Can an adult in the home read English?
   ☐ Yes ☐ No

   If not English, what language can be read? _____

7. Do you want a translator available at school conferences?
   ☐ Yes ☐ No

8. If your child qualifies for ELL services, do you give permission for your child to receive ELL services?
   ☐ Yes ☐ No

Signature: _____
Name of person completing survey *Date*

For School Use Only

ESL File Opened
☐ Yes ☐ No

ESL Test Date: _____

ESL Level: _____

ESL Evaluator: _____

BALDWIN-WOODVILLE SCHOOL HEALTH HISTORY

4K Registration

(To Be Completed By Parents/Guardian)

Name: _____ Date: _____

Parent/Guardian #1
Name & Address _____

_____

Parent/Guardian #1
Phone Number _____

Parent/Guardian #2
Name & Address _____

_____

Parent/Guardian #2
Phone Number _____

Record of Illnesses:

Allergies _____ Type of Reaction _____
Food Allergies _____
Seizures _____
Diabetes _____
Asthma/Respiratory Difficulty _____
Chicken Pox _____
Measles (Red) _____
Measles (Rubella) _____
Mumps _____
Heart Condition _____
Rheumatic Fever _____
Scarlet Fever _____

Other illnesses, injuries or operations: _____

Does child have frequent:

Headaches _____
Colds _____
Nose Bleeds _____
Sore Throat _____
Toothache _____
Eye Complaints _____
Other _____

Earaches/Infections _____
Prolonged Hoarseness _____
Prolonged Cough _____
Mouth Breathing _____
Fainting Spells _____
Skin Problems _____
Eczema _____

Behavior Habits: (Write details on line)

Poor Eating Habits _____
Speech Difficulties _____
Disturbed Sleep _____
Nail Biting _____
Finger/Thumb Sucking _____
Temper Tantrums _____
Persistent Crying _____
Shyness, Fearfulness, Timidity _____
Other _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA **PLEASE PRINT**

STEP 1

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)
☐ No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5

To the best of my knowledge this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

Clear Form and Reset

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child.		
☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

BALDWIN-WOODVILLE AREA SCHOOL DISTRICT
550 HIGHWAY 12
BALDWIN, WI 54002

PICK UP/DROP OFF REQUEST FORM

The Board of Education is not required by law to either pick up or drop off your child any place other than at your residence. We want to assist parents and children, but our primary concern is the safety of the child.

If we are not clear in our understanding of where the child is to be picked up and dropped off, the child may be put in a difficult, or even disastrous, situation. We need the complete cooperation of parents.

The B-W Schools is attempting to assist parents and to meet its responsibilities to all of the children of the district by enacting the following:

- Children will be picked up and/or dropped off at their place of residence or any child care provider within the district as long as this not require a bus to travel more than ¼ mile off a regularly established bus route.

- By the end of the school year, the parents must notify the Transportation Supervisor in writing of the intent to have their child(ren) picked up other than at their place of residence if the address has changed from the previous school year.

COMPLETE THIS SHEET AND RETURN IT TO SCHOOL, OR WE MAY NOT BE ABLE TO COMPLY WITH YOUR CHILD CARE/TRANSPORTATION NEEDS.
(We will try to accommodate your request involving one child care provider and your place of residence.)

PLEASE PRINT

Student's Name _____

Student's Address _____

Father's Name _____

Father's Address (If different from child) _____

Home Phone _____ Cell Phone _____

Email Address _____

Mother's Name _____

Mother's Address (If different from child) _____

Home Phone _____ Cell Phone _____

Email Address _____

Childcare Provider/Other _____

Address _____

Home Phone _____ Cell Phone _____

Email Address _____

PICK UP ADDRESS _____ **DROP OFF ADDRESS** _____

Baldwin-Woodville Area School District
Verification of Residency
For Non-Open Enrolled Students

The State of Wisconsin (Statute 121.77) requires that students attend school in their district of residence. The district is within its rights to investigate and verify residency, assess tuition when appropriate, and prosecute if necessary to recover tuition.

Prior to admission, students must provide proof of residency within the boundaries of the Baldwin-Woodville Area School District.

Residency type:

☐ Homeowner

☐ Renter

☐ Living with another family/other living situation (please explain) _____

I certify that my student _____ has a parent/guardian living at:
(Student Name)

_____
(Address) (City) (Zip Code)

I am aware and understand that my student will not be officially enrolled into the Baldwin-Woodville Area School District until the documentation is provided and residency is confirmed. Furthermore, should this statement be found to be false, my student may be dropped from enrollment and required to transfer to his/her resident district. It is my responsibility to notify the school district should my student or their guardian move from this address.

_____
Printed name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Relationship to Student Telephone Number

For office use only:

Proof of Residency

HOMEOWNERS ONLY		**RENTERS ONLY**		**OTHER LIVING SITUATION**	
Utility Bill		Utility Bill		DMV Car Registration	
Land/Cell Phone Bill		Land/Cell Phone Bill		Doctor or Credit Card Bill	
Property Tax Bill		Current Rental Agreement		Land/Cell Phone Bill	
Mortgage Papers		Renter's Insurance		Other:	
Homeowner's Insurance		Other:			
Other:					

Verified by: _____ Date: _____